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Darlington Safeguarding Partnership

Protecting Children and Adults

Local Child Safeguarding Practice Review

Child J

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1: Introduction and summary of learning

Introduction

1.1 Darlington Safeguarding Partnership commissioned this Local Child Safeguarding Practice Review (LCSPR) to consider systems and practice within and between partner agencies regarding the multi-agency responses following the death of a child under two years old. He had stopped breathing at home in the care of his mother's partner and was subsequently found to have died from a head trauma consistent with a non-accidental injury. To support the anonymisation, he will be known as Child J.

1.2 Child J lived with his mother and elder half-sibling (Sibling D). At the time of the significant incident, the mother's partner was at the family home, although he did not live there.

1.3 The family were involved with universal[1] and voluntary services at the time of the significant incident. There had been previous statutory involvement with all of mother's children with issues relating to maternal mental health problems [2] and neglect. Whilst mother's history is significant to the review, this will not be explored in great detail. It will support analysis, including future risks regarding neglect and possible harm in the light of known information. The focused period, often called the scoping period of the review agreed upon by the Learning and Development Group's Learning and Development Group's Case Review Panel, covered the period of mother's pregnancy with Child J till his death [3] a period of some twenty-eight months.

1.4 Parallel Criminal investigations regarding Child J and Care proceedings regarding Sibling D were ongoing during the review period and at the time of writing mother's partner was on remand, charged with murder and mother was on bail, charged with neglect.

Summary learning

1.5 The following key learning points are detailed in the report and summarised here.

- Understand the significance of vulnerability, harm, adversity, and trauma by exploring and understanding parental history.
- Appreciate what it is like to be an infant and/or child in the family. Ensure all family work focuses on the infant/child's lived experience.
- Ensure managers and practitioners regularly reflect on and sense-check the information they have, seek, and share through curiosity and multi-agency critical thinking. This is particularly important where there is strong strength-based practice.
- All adults/carers associated with the household should be involved in assessment and planning so support, protective factors, vulnerabilities, and risks can be clearly understood from the infant/child's perspective.
- Strengthen knowledge and skills in recognising and understanding neglect and its impact on child development and wellbeing.
- Improve understanding of long-term parental mental health difficulties and their effects on parenting and family functioning across adult and child-facing services.

[1] Universal services are services provided to all children and their families regardless of their needs or circumstances, for example, health visitors, GP's schools and leisure and community services.
[2] For the purpose of this review, this means there is a diagnosable mental health condition Mental health conditions - NHS (www.nhs.uk)
[3] This refers to the timeframe in which events relating to the case are reviewed

- Establish whole family working that ensures shared responsibility where there are parental mental health difficulties. This means taking a whole-family approach to risk assessment and support, particularly at critical times such as pregnancy.
- Multi-agency assessment and planning meetings must bring together the family, community network and the agencies involved for the whole family to seek and share information.

2. Child(ren) overview

2.1 Historical concerns related to Mother's three elder children (two now adults). They did not live with her, following significant neglect concerns related to her mental health and her ability to meet the children's needs. Criminal investigations did not progress fully at the time due to her mental health difficulties. The two elder children went to live with their father through private arrangements, and a younger child was adopted.

2.2 Mother became pregnant with Sibling D around twelve years ago; she shared that at the time, she had been experiencing mental health difficulties, including self-harm and an eating disorder. A Pre-Birth Assessment was undertaken, and Sibling D was placed on a Child Protection Plan. Sibling D was subsequently stepped down to early help Building Stronger Families (BSF)and then closed to services following positive assessments aged around 12 months. Two more recent periods of early help were triggered by worries about Sibling D's behaviour and presentation. (see timeline 1)

2.3 Child J was under two years of age when he died; his parents were White British. He was vulnerable due to his mother's long-standing mental health difficulties; her reported childhood trauma, relationships with several males where domestic abuse featured (in at least two situations) and neglect of her elder children. Child J was born prematurely and struggled to gain weight in the first three months of his life. Child J was not brought WNB [4] for a number of health appointments. Mother had an accepted diagnosis of an Emotionally Unstable Personality Disorder.[5]

2.4 During Child J's pregnancy, Sibling D's father reported concerns about neglect and physical assault regarding his daughter; there was a public altercation witnessed by Sibling D where Unborn Baby J's father was said to have assaulted Sibling D's father. (see timeline) Sibling D had not had contact with her father for some time.

2.5 Child J had contact with his father, but this stopped a couple of months before the significant incident due to his mother reportedly distancing herself from him. Several men were associated with the family at different times, including fathers, partners, extended family members, and an elder adult sibling. While they were known and talked about, little information was known about these males or their role in the family.

2.6 At the time of the significant incident, Child J lived with his elder half-sibling (Sibling D) and mother. Sibling D's lived experience is relevant to this review and included as she was in the same household. Mother had been in

[4] Was nor Brought (WNB) is the phrase used to record the non-attendance of children for appointments, using the phrase **did not attend** implies that the child is somehow responsible for not attending. Children are dependent on adults to take them to appointments or meetings.

[5] Overview - Borderline personality disorder - NHS (www.nhs.uk)Borderline personality disorder (BPD) is a disorder of mood and how a person interacts with others. It's the most commonly recognised personality disorder. Emotional instability (affective dysregulation) means an individual has difficulties in managing feelings and emotions.

a relationship with her current partner for around 10 months before the incident. He had his own home and a child that he cared for. It was understood he spent periods of time in the family home.

2.7 Mother was working during the scoping period for the review and also undertaking academic study.

2.8 Mother continued to experience periods of difficulties with her mental health as well as periods of stability. She has been proactive in accessing support and help from a range of services and professionals which was positive. This includes several voluntary services that have been key participants in the review. It is noteworthy that the family, over the past five years, has received support from 26 different agencies, including voluntary sector providers. Evidence shows that vulnerable parents may need access to a wide range of interventions to address multiple issues[6] However, to be helpful, it must be effectively coordinated, outcome-focused and reviewed.

2.9 A high-level timeline was developed to support analysis of the multi-agency chronologies and information provided by the Partnership. This timeline has been used to help understand the key periods of intervention and the multi-agency response to the children's and adults' needs and how they correlate.

3. Engagement with family

3.1 Involving family members in any learning review is expected and good practice, including any surviving children. It has not been possible to include the mother and the mother's partner due to parallel criminal proceedings. Child J's father was contacted on two occasions to inform him of the review and to invite him to meet with the lead reviewer, but at the time of the review he did not respond or make contact. It has been possible to include Sibling D and her father. Sibling D's experiences are particularly relevant to this review as they reinforce some key learning from this review about children living with parental mental health difficulties and the invaluable role of enduring relationships within schools in building resilience for vulnerable children.

Sibling D

3.2 The author appreciated Sibling D's willingness to meet and share some of her thoughts and feelings. She engaged well in an activity that provided a safe space to talk about her family, experiences, and things she felt comfortable with. She is a delightful young girl, excited and a little apprehensive when we met at starting a new term at school. She appeared comfortable in her current cared-for arrangements and talked easily about seeing her mother and the activities they did together. She shared that she was seeing her father and described this as going well.

3.3 When talking about family life, it is clear that her family, her mother, Child J, and her elder half-brother were the important people in her life. She was very sad about her brother, Child J and wanted me to know how she helped and supported her mum in caring for him. She described a family life with really good periods where she and her mum did many fun activities together. She skirted over other things and wanted me to know how helpful she had been with caring for her brother, Child J. She spoke jokingly but affectionately about her elder half-sibling who '*made a mess and never tidied up'*, who was a key part of the household. She missed him when he moved out following a falling out with his mother.

[6] https://www.nationalcentreforfamilyhubs.org.uk/

3.4 When discussing family life, Sibling D mentioned two agencies and key staff within them—her school and a charity—that were significant to her and the family. The charity workers seemed there for the family and stepped in to provide help for her mum. This has supported the family and was mentioned by Sibling D as providing spaces and people that helped them. There is positive learning about the importance of the voluntary sector providing long-term help and relationships for vulnerable families.

3.5 She valued key people within the school and spoke positively and energetically about her school, particularly a staff member with whom she had clearly developed a positive relationship. These are significant in that they show the importance of schools in providing space to help children manage stress and emotions and create relationships that can help to build resilience.

Sibling D's father.

3.6 Sibling D's father was spoken to in order to establish his involvement with the family. Whilst not directly involved with his daughter around the time of the significant incident, he had periods of contact with his daughter before the birth of Child J. The couple separated around the birth of his daughter after being together for around eighteen months. It was clear in my discussion with him that the relationship was affected by mental health difficulties, leading, on occasion, to poor living conditions, poor self-care, and relationship difficulties. Sibling D's father also experiences his own mental health needs.

3.7 His current role is focused on supporting the care of his daughter. His descriptions of home life reflect the fluctuating patterns of behaviour associated with long-term mental health episodes; from his point of view, "*there were extremes of behaviour more bad than good".*

4. Timeline:

See table 1 below:

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Timeline Child J

Darlington Safeguarding Partnership

Historical information

Month /Year	Siblings
2006	Three elder siblings (now adults) Concerns about neglect. Two elder children went to live with their father and remained on a Residence Order. The youngest child was placed in care and subsequently relinquished.
2013	Sibling D was born. A pre-birth assessment was undertaken due to concerns about mother's mental health, neglect and three children not in her care. Baby was made subject to a Protection plan for Neglect. Statutory intervention ceased in 2018.
2018	The first period of early help support ended after 5 months.

Scoping period September 2021 – January 2024

Month /Year	Siblings	Child J	Mother and associated adults
September 2021	Mother reports to the School she is having difficulties with Sibling D's behaviour and shared her mental health issues.		
		Pregnancy booked	Child J's parents do not live together. Historical information known and shared .
October 2021	Domestic Abuse Incident in a public place, present was Sibling D. Also present was one of mother's elder children, now an adult.		Sibling D's father reported the incident with him as the victim being assaulted by the father of unborn baby J. Allegations were made by Sibling D's father that she was being neglected and physically assaulted by her mother.
Month /Year	**Siblings**	**Child J**	**Mother and associated adults**
November 2021			The family moved back to Darlington Mother requests support worried about coping with a new baby. Mother asking for support from Safer Families.
	Worries about neglect reported from School.	Second period of early help. Family assessment to commence from Early Help Building Stronger Families (BSF).	
December 2021	Further indicators of neglect from school Information from mental health screening and assessment indicate mother's elder son lives at home and supports the family.	Monthly review of pregnancy with and across health-established.	Request for Safer Families Involvement made. TEWV telephone screening presenting issues of anxiety and depression. Initial Assessment completed by Perinatal mental health team including PAMIC tool. Assessed as low risk and practical support requested. Dis-charged by the perinatal team

February 2022	Sibling D was in attendance		Mother attended the Emergency Department with an episode of exacerbated mental health.
March 2022	**Case closed to Building Stronger Families**		
		Child J was born prematurely at 31 weeks by emergency caesarean. He remained in the hospital. Traumatic delivery.	Mother reports low mood, referral for liaison psychiatry was made. Mother reports feeling overwhelmed with low mood and anxiety. Financial and practical support worries.
	Case reopened to BSF		
April 2022	Limited information about Sibling D	**Child J** discharged from hospital	
		Home is seen as unkempt. Range of early help services in place to support. Voluntary services including dedicated neonatal mental health charity.	
May 2022		**Child J** was admitted to the hospital for observations regarding feeding problems and'faltering growth'	Voluntary services raise concerns about home conditions and self-reports about mother's stress. Mum reports to agencies feeling low.
		Weight improved by the end of the month.	Home conditions improved mother was ready to return to work few hours. Reports mental health improved.
Month /Year	**Siblings**	**Child J**	**Mother and associated adults**
June 2022	BSF to end involvement range of voluntary support services in place.		
	Intermittent reports of poor home conditions . Number of WNB for health appointments for both children.		
September 2022			Mother requested a referral to the mental health perinatal team. Mother advised to contact her GP who was leading on her mental health.
October 2022			GP screening call mother reported relapse in low mood, struggling to remember to take medication regularly. Referral made to Access team for mental health support.
November 2022		Mother and **Child J** were discharged from neonatal mental health service due to non-engagement.	GP screening call mother reported relapse in low mood, struggling to remember to take medication regularly. Referral made to Access team for mental health support.
		Concerns were raised from school about children being collected from the nursery and presentation of Sibling D. EHA to commence.	
December 2022		Concerns were raised at the GP safeguarding liaison meeting that **Child J** had not had a weight review for 3 months had outstanding immunisations and had not attended for hip screening.	
January 2023		Mother calls 111 with worries about **Child J** vomiting. Bruising was disclosed and an explanation was provided. Seen at Urgent Care Centre. Discharged with advice.	Telephone mental health review consultation with GP. Mother requested to restart her antidepressant medication. Prescription not collected.
		Child J's 12-month health review with HV.	Mother disclosed at **Child J's** review she is feeling overwhelmed with anxiety. Financial worries, and house and garden had deteriorated.

Month /Year	Siblings	Child J	Mother and associated adults
February 2023	Sibling D WNB for paediatrics appointment.	A & E attendance minor head injury and viral infection. **Child J** attended with mother and volunteer. Sibling D was cared for by a family member. **Child J** was examined no issues were raised; he went home with his mother. Contact made to Children's Front Door. Visit made by BSF worker. Family to be allocated BSF worker. Third period of early help intervention.	Self-presentation at A & E seen by liaison psychiatry. Reported 3-week period of irritability and thoughts of self-harm and harm towards her children. Shared she would not act on these or harm her children. Showed chaotic thinking, feelings of being overwhelmed and irritability. PAMIC tool utilised to support assessment. Mother and child discharged home.
March 2023	Mother did not engage in a telephone discussion regarding Sibling D.		Initial mental health assessment. Mother reported managing her mental health better but had some practical issues i.e. money that caused stress. Referred on to support services and back to GP.
April 2023			Mother shared she had a new partner, and her mood was improved.
May 2023	School raise worries about Sibling D relating to attendance and general wellbeing. Sibling D shared that her elder sibling supervises the children, and this led to arguments.	Hospital raise concerns about possible NAI. **Child J** had bleeding from his nose and ear and a bruise on his eye and head. Medical investigation was undertaken. Strategy held; outcome suggested caused by scratching due to ear infection No further police investigation. Section 47 undertaken, step down and continue with early help.	
June 2023	Additional support was provided to sibling D within the school		
July 2023		**Child J** attended nursery with a bruise on his chin and the inside of his arm.	Mother seen by GP for mental health review. not taking antidepressants agreed to try again.
August 2023	Sibling D shared that her mother often shouts at her, and Sibling D has been staying with a family member.		Telephone consultation by GP for mental health review. Deterioration in mental health alluded to '*things happening at home*'. Referred to aligned mental health team.
		Child J was observed to have a purple mark on the eyelid. Explanation provided. Good interaction is seen between children and mother.	Mother reports to BSF she is struggling to get help, and reports Crisis Team will not see her as she is not suicidal with her mental health. She felt like self-harming. Face-to-face consultation with aligned mental health service. Taking antidepressants and reported to be helping.
Month /Year	**Siblings**	**Child J**	**Mother and associated adults**
September 2023			Two failed appointments to review with GP aligned mental health service.
			GP telephone mental health review, reports more stable mood and returning to work.
October 2023	Referral to CAHMS for Sibling D	Two WNB paediatrics appointments.	Did not attend review with GP aligned mental health service. Disclosed childhood sexual abuse and to receive DBT
	Telephone screening with mother Disclosed historical domestic abuse with sibling D's father. To be referred for ASD assessment.		
			Did not attend GP mental health review.
November 2023	Referral to School nursing service for Sibling D, hygiene concerns.		Discharged from GP aligned mental health service due to non-engagement.
December 2023	Sibling D WNB for paediatric appointment.		
	The family closed to BSF		
January 2024	**Significant incident:** Child J had sustained a non-accidental head injury that led to his death.		

5: The review methodology

5.1 The Learning and Development Group's Case Review Panel agreed on the methodology and Terms of Reference for the review and has provided oversight and quality assurance. The Rapid Review identified initial learning and key lines of enquiry that focused on unseen men and caregivers, parental mental health and its impact on parenting, the children's lived experiences, and multi-agency working.

5.2 The LCSPR has been undertaken in two phases, with the first phase involving an in-depth examination of the multi-agency chronologies and key documents. This informed a summary analysis report that reflected the lead reviewer's initial findings. The second phase involved engagement in two learning events with front-line practitioners and then strategic leads to reflect on the initial findings, consider what happened and reflect on practice and systems at the time. The review process was reflective and proportionate and involved practitioners and strategic managers at two reflective learning events. This included representatives from the voluntary services involved with supporting the family.

5.3 The following practice themes were identified and formed a framework in which to analyse the findings, enquire and develop an understanding of what was happening and what it meant in the circumstances for Child J and Sibling D. The learning events also used the system's framework, Pathways to Harm, Pathways to Protection (Brandon Sidebotham et al)[7] to support broader system understanding. Practitioners and managers attended the learning events and reflected on the key findings in relation to systems and practice and considered W*hat was helpful. What got in the way and an appreciation of the children's lived experiences?* These were helpful sessions which have directly informed this report and supported wider learning and single agency learning and improvements.

5.4 Family views are important and integral to LCSPRs and are considered best practice. In this instance, the ongoing criminal investigation has meant engagement with mother and her partner has not been possible. However, Child J's father, elder stepbrother, Sibling D's father and Sibling D have been offered an opportunity to engage, and their views will inform the review.

Thematic focus
1. The children's lived experiences (vulnerability, adversity, and risk)
2. Parental mental health difficulties and their impact on parenting and family functioning.
3. Multi-agency working providing help support and protection
4. Unseen men/caregivers.

[7] Figure 2 Pathways to harm, pathways to protection https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

6: Thematic Analysis and key learning

6.1 The children's lived experiences.

What was it like to be an infant and child in this family?

6.1.1 This section explores the importance of understanding what life was like for Child J and Sibling D and an appreciation of their needs and vulnerabilities. Most of the professionals involved with the family were aware of mother's history due to her openness about her difficulties and requests to support her to parent well. Indeed, mother asked for more information about how her own Adverse Childhood Experiences (ACEs)[8] could impact her own child's emotional well-being. This theme will also explore how neglect is understood, recognise the difficulties in identifying if the care children receive is neglectful, and significantly reflect on what it was like to be a child in this family.

"Adverse childhood experiences (ACEs) are traditionally understood as a set of 10 traumatic events or circumstances occurring before the age of 18 that have been shown through research to increase the risk of adult mental health problems and debilitating diseases. Five ACE categories are forms of child abuse and neglect, which are known to harm children and are punishable by law, and five represent forms of family dysfunction that increase children's exposure to trauma."

Early Intervention Foundation Feb 2020 ACEs what we know, what we don't know, and what should happen next.

6.1.2 There was limited information about what it was like to be a child in the family, particularly for Child J. Early help services (Building Stronger Families) and the school had developed good relationships. Appropriate services were in place to help and support Sibling D, such as intervention targeted at supporting and developing her emotional resilience. The school have provided a consistent and nurturing environment for her, and the author has observed a high level of support to help her to thrive. They saw and identified when her physical care was poor, and she presented as unkempt, and when her attendance and punctuality deteriorated. Building Stronger Families (BSF) and voluntary services provided help with routines and boundaries and practical and financial support in improving home conditions following these instances.

6.1.3 In this period (see timeline), there were allegations of physical abuse and neglect perpetrated by mother and the public domestic violence incident between Sibling D's father and father of unborn Baby J. The family had moved to a refuge, and although she had moved back within a short space of time, it had led to a school move and interruption of requested early help support relating to her mental health and managing Sibling D's behaviour.

6.1.4 Information about Child J's experiences is more limited; positively, there was a Building Stronger Families Family Assessment. Mother had engaged well in antenatal care and a community Wellness group. Child J's birth was premature[9] (31 weeks). It is noteworthy that the birth was traumatic. Mother and baby had extensive separation following delivery due to Child J needing care in a neighbouring hospital. Child J spent four weeks in neonatal care. Mother visited regularly, and there were no concerns about her care; however, this was a period when

[8] Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation (eif.org.uk)

[9] Premature babies born at 31 weeks require specialised care to support their development during their early days.

adult mental health services saw mother following a self-report of feeling overwhelmed with low mood and anxiety about returning home with limited support. Liaison Psychiatry undertook an assessment, and whilst this was shared with adult social care and the GP, this did not lead to any specific mental health support or coordinated support plan. It was not shared with children's services. (see section 4.3) Over the next three months, Child J experienced feeding difficulties and faltering growth[10]; this improved after three months. Of concern was a number of health appointments that, in particular, Child J was not brought for (WNB). Research and local policies, and guidance show that not meeting a child's health needs can be an indicator of neglect. Whilst there was some curiosity, this was not robustly challenged on behalf of Child J, nor were the patterns recognised, and professionals reflected that this may have been alleviated by some appointments being attended.

6.1.5 The chronology showed that Child J experienced a number of bruising 'accidents;' whilst causal evidence is difficult to evidence from broader research, it was a factor in this case and may indicate a lack of appropriate supervision in the context of the mothers' history.

6.1.6 All agencies involved with the family identified the relationship between the mother and her daughter, Sibling D, as problematic and very different from the relationship and bonding they witnessed with Child J. Several professionals, while acknowledging that mother loved Sibling D, shared that the relationship was more of a sibling relationship and that the mother struggled to meet her daughter's emotional needs.

6.1.7 Sibling D's immediate neglect and behavioural needs were well responded to, and direct work was undertaken. However, there was limited exploration of what could be going on behind the behaviour, meaning its impact was not fully known for her. Sibling D's problematic behaviour was the focus and the reason given for services to be involved. Plans and interventions centred on how she reacted to situations and displayed negative behaviours and how she could manage her emotions differently. Behaviour must be seen as a form of communication[11] and may be linked to possible harm, trauma and neglect she may be experiencing. The findings and the learning events reflected that Sibling D took on a caring role towards Child J and stepped in when mother's mood had

"It is important for practitioners to build a trusting and respectful relationship with the child, which goes beyond listening and recording the child's views, to critically reflect on what the child is trying to communicate through their behaviour, interaction with others and physical presentation."

Understanding what the child's daily life is like. Key learning from case reviews (12)

deteriorated.

6.1.8 Although mother's mental health needs are captured, any impact is not always linked to the children, meaning for Sibling D, emotional neglect was not fully appreciated; there is a description of her earlier experiences relating to her mother's long-standing mental health difficulties, domestic abuse, and attendance with her mother for mental health crisis episodes. Sibling D had several professionals with whom she worked directly; she was seen and spoken to, and good relationships were developed to support her. However, her voice and appreciation of what life was like for her were inconsistent and underdeveloped, as seen in the focus on managing her behaviour. For example, there was no exploration of the domestic abuse from mother's partners, including when

[10] A term used to describe children with a slower weight gain rate. Previously known as 'failure the thrive.'
[11] The_Child_Safeguarding_Annual_Report_2020.pdf (publishing.service.gov.uk)

she witnessed a physical conflict between her father and mother's partner at the time. It is unclear what mother's fluctuating moods meant for her, and the learning events reflected the level of optimism services had for the mother, seeing her difficulties, meaning professionals tended to be incident-led. Whilst these reflections were now with hindsight, we can see there were clear factors that got in the way of recognising cumulative neglect. Cumulative harm in the context of neglect here describes patterns of poor caregiving or omissions of caregiving that occur and build over time and affect a child's sense of well-being and safety. *"The impact of neglect is not only widespread, affecting a wide range of developmental domains, it is also cumulative."* Cumulative neglect is also the "*most likely form of maltreatment for a child to experience".*[12] Good practice here was the interventions for Sibling D to increase protective factors through the work on resilience. While we know that neglect in early childhood can have serious long-term effects, "not all children will have the same trajectory of development," there are factors known to influence resilience and support repair. Similarly, good practice from planned work with a Neonatal charity had the potential to support the mother in repairing and building resilience around the traumatic birth of Child J and exploring her own history. Mother did not follow through on this work and the service was ended. This meant the impact of this was unassessed for Child J.

6.1.9 While Sibling D's voice and Child J's experiences were captured in a recorded positive interaction, this is not found routinely. It was missing at some critical moments, for example, the family conflict where Sibling D's father made allegations of physical harm and neglect, around the birth of Child J, during known mental health relapses, in the Section 47 assessment following the suspected physical harm of Child J (see timeline). These were some key events where the children's voices and lived experiences appeared to be lost, and mother's needs became the focus.

6.1.10 Genograms were good practice in BSF; however, they required some triangulation with other services and people in the network and sense checking to be helpful. Patterning the information through the use of chronologies would have supported analysis and the inconsistencies in mothers' engagement with services (coordination will be considered in section 4.3), where she actively sought support from a wide range of services (adult and child-focused). This was crisis-led, and because take-up was inconsistent, services were stopped due to a lack of engagement. This meant it was more difficult for professionals to coordinate and evaluate their responses, and work became incident-led and siloed.

6.1.11 It is unclear why neglect was not explicitly considered and how it was understood by services involved with the family. There appeared to be a lack of clarity about what neglect looked like, and mothers' frequent requests for help seemed ambiguous. Whilst categories of neglect [13] can be helpful in understanding neglect, it can often be affected by perceptions of neglect. Effectively assessing child neglect requires a holistic approach that considers all family members' needs and the roles they hold. It appreciates history and identifies any cross-generational patterns and unresolved childhood trauma and its likely impact.[14] The Partnership provides multi-agency Practice Guidance[15] and promotes the use of several tools that support the assessment of neglect, such as the Graded Care Profile 2 [16]. No tools were used, and while neglectful behaviours were identified and support put in place, this did not address what really needed to change or be supported and the likelihood of long-term

[12] Brandon, M et al RR404_-_Indicators_of_neglect_missed_opportunities.pdf (publishing.service.gov.uk)
[13] Horwath, J (2013) Neglect Identification and assessment
[14] Sharley V and Rees A (2023)Working with Children who have experienced neglect CoramBAAF
[15] child-neglect-practice-guidance-july-2019-dsp-1.pdf (darlington-safeguarding-partnership.co.uk)
[16] gcp2-case-study-evaluation.pdf (nspcc.org.uk) Graded Care Profile 2 (GCP2) is an assessment tool that helps practitioners take a strengths-based approach to measuring the quality of care a child is receiving and supports them in identifying neglect.

harm. Research shows that there is a lack of knowledge about the threshold for intervention when neglect is cumulative from professionals[17].This needs to be understood in the wider context of how the Safeguarding Partnership identifies and meets the needs of children in need of help and support[18] Where there are identified needs and vulnerabilities and how this underpins systems and practice for Neglect. (REC)

6.1.12 Critical thinking about neglect was missing in these instances for the children. Recurrent and historical themes included a focus on the adult's needs, a lack of overview or reflection on the patterns in the case, limited multi-agency assessment and analysis, not recognising indicators of harm, evaluation of parental progress, and over-optimism about parental capacity in difficult circumstances.

"The most common issue featuring in review reports …. concerned assessments not involving all family members or carers and not considering the impact of identified vulnerabilities on household dynamics. Reviews featured a mixture of good practice and missed opportunities around building relationships with children, not using their voice to effectively understand their lived experience and inform assessments and plans."

The Child Safeguarding Practice Review Annul Report 2022/23

Why does it matter?

6.1.13 Reflecting on the findings here shows that understanding the child's lived experience should not be seen in isolation. To ensure we assess and appreciate the circumstances of children and understand individual strengths and vulnerabilities, we also need to identify **why** their needs may not always be met and consider why parents/ carers may behave as they do. This means understanding the lived experiences of parents /carers, thinking about what they need to help their children thrive, and understanding the impact of harmful behaviours. This can support an understanding of parental ability as well as any factors that may be affecting family life, such as new relationships, domestic abuse, and financial issues. A stronger multi-disciplinary assessment would have supported the appreciation of the complexity of the mother's known history and needs, which are discussed in Sections 4.2 and 4.3.

Understanding the significance of predisposing vulnerabilities, harm, adversity, and trauma.

6.1.14 Being curious and exploring parental history is critical to understanding parental capacity, risk, and safety. The current discussion about ACEs [19] supports our understanding of the evidence base and informs strategies for systems and practice (trauma-informed approaches). Its relevance here is that mother openly shared her own childhood experiences, including sexual harm that was causing her distress. This is important because it is known that Adverse Childhood experiences can contribute to poor outcomes and have a *"devastating impact on children's physical health, mental health and social well-being across their life course"* [20] . In simple terms,

[17] Social Workers' Perceptions of the Nature of Child Neglect: A Systematic Literature Review | The British Journal of Social Work | Oxford Academic (oup.com)
[18] Chapter 3 Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf (publishing.service.gov.uk)
[19] Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation (eif.org.uk)
[20] A practical handbook on Adverse Childhood Experiences https://phwwhocc.co.uk

these experiences are likely to have impacted these children intergenerationally, (12). something mother herself was exploring. Mother's history as a parent highlights the difficulties she experienced in her childhood. "*The roots of adult personality and borderline personality disorders are thought to lie in attachment relationships and the impact of early negative childhood experiences, including emotional, physical, and sexual abuse* (Fonagy et al. 2003).[21] We know that mother opened up about historical sexual abuse, which had the potential to re-traumatise and increase her vulnerability at this time.

6.1.15 It is known that ACEs can indicate some of the most intense sources of stress for children growing up, and this would be replicated in her own children's lived experiences vicariously. It matters, therefore, that we fully appreciate the lived experiences of these children. Services clearly understood that the family needed help and implemented interventions to mitigate (practical support) and build resilience (for Sibling D). A clear understanding of the child's lived experience was needed to be most effective, specifically considering neglect for these children and avoiding focusing too much on the adult's problems. Working Together 2023[22] Chapter 1 clearly shows the shared responsibility of a child-centred approach within a whole family focus. This approach "*sits within a whole family culture in which the needs of all members of the family are explored as individuals and how their needs impact on one another."*

Appreciating what it was like to be an infant and child in this family

6.1.16 Studies into practice with child neglect show that the family's history is not sufficiently taken into account or adequately considered regarding the impact of neglect on the child from adult behaviours[23]. A number of case reviews support this over the years. What matters here is an analysis of the impact of the adult behaviours on children; this means understanding the child's lived experiences and observing interactions between them and their parents/carers to support this. Studies show that historical and current themes in cases of neglect are complex and often include "a multiplicity of factors – such as social and economic deprivation combined with parental difficulties." Financial difficulties were a consistent feature in the family since Child J was an unborn baby. Whilst practical support and guidance were provided several times, it was not seen as an indicator of neglect. Furthermore, reflection on whether Sibling D was a young carer was discussed at the learning event and was evident from what she shared with practitioners. Considering her needs as a young carer was a gap in identifying her needs.

Over-optimism and the role of Critical Thinking

6.1.17 It is important that practitioners and managers regularly reflect and sense-check their practice and thinking. Where strength-based practice places a focus on what (in this instance) the mother was doing well by actively seeking help and support, there is a risk that this positive help-seeking behaviour could be confused with engagement and change and lead to an optimistic view of how the mother was functioning, for example, she did not sustain the engagement with services for her mental health. Lord Laming, in 2003, following the death of Victora Climbie, highlighted the concept of ***'respectful uncertainty'*** that should be at the heart of the professional relationship, and this would facilitate some critical challenge of the information given by mother to professionals. The use of critical thinking strengthens analysis and understanding and ensures practice remains child centred.

[21] Quoted in Cleaver, et al (2011) Children's Needs – Parenting Capacity 2nd Edition
[22] Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf (publishing.service.gov.uk)
[23] Professional responses to neglect: in the child's time - GOV.UK (www.gov.uk)

What needs to happen - Learning points	
1	Strengthen the knowledge and skills of the adult and children's workforce in recognising and understanding neglect and its impact on infant and child development and well-being. This requires: • An evaluation of current training needs in relation to neglect and what strategies and interventions can support families to help their children thrive. • Practitioners and managers across adult and child services should be supported to strengthen their professional curiosity[24] and critical thinking skills where adult issues and needs are likely to impact their capacity to meet their children's needs and understand the family context in which they occur. • This means, in practice, keeping an open mind and not making assumptions through observation, listening, understanding through questions, triangulating information, and noticing differences. This can be supported through reflection in supervision, with peers and the family. (Child Safeguarding Practice Review Panel Report 2021)
2	Practitioners and managers in services undertaking work with families must include an appreciation and understanding of *what it is like to be an infant and child in this family.* This must be informed by family observations, direct work and understanding that children also communicate through their behaviour and physical presentation. This can be supported by reflective supervision and multi-agency discussions.
3	Chronologies are a tool that can support analysis, particularly where neglect is being considered. They are a patterning tool that can help understand the family's situation and history; they very quickly highlight gaps and inconsistencies, what is working well, and any worries that need further assessment and identification. National and local reviews highlight the importance of chronologies in supporting effective multi-agency practice.
4	Improved understanding of parental history (ACEs) and adult issues and how they can influence parental ability to respond to their children's needs over time and the impact of a range of adverse experiences on children's development and wellbeing.
5	Ensure that children's needs as young carers are fully considered when there are parental issues, and that appropriate support is put in place.

[24] Professional curiosity was described by Lord Laming (Victoria Climbie inquiry 2023) as **'respectful uncertainty.'** To explore and understand what could be happening within a family.

6.2 Parental mental health difficulties and their impact on parenting and family functioning.

How did professionals understand these issues?

6.2.1 This theme will consider the understanding of the mother's mental health difficulties and what it meant for the children in the family, the extent of the knowledge about her history, the support she received from adult mental health services and how this appreciation impacted the lives of these children. The family circumstances and understanding of preventative and protective factors are significant regarding the children's needs and parental capacity. It is important to understand history to explore and assess the complexity and capacity of mother to meet the children's needs. Finally, this section will examine approaches that consider the whole family's needs to realise the complexity of the family's functioning.

6.2.2 It is important to recognise that many parents who experience mental ill health can and do care for their children satisfactorily. This is helped by clear protective and resilience factors such as a consistent partner/carer with good mental health. It was clear there was a strong strengths-based approach towards the mother's difficulties in this family from services that were involved with her. The time that the mother had cared for Sibling D without worries from statutory services was balanced against the need for statutory intervention when mother became pregnant with Child J. This demonstrates positive relational practice. The practitioner learning event evidenced enduring relationships with mother and Sibling D and a respectful attitude towards the mother's abilities rather than focusing solely on risks or concerns. This is strong practice.

6.2.3 On the other hand, this review has highlighted the focus on mother's needs and a limited understanding of the child's experiences concerning mother's fluctuating behaviours, needs, and the relationships she has entered into overtime. It became clear in the learning events that not all practitioners involved with the family had full knowledge of the mother's history or what mother's mental difficulties meant. It was clear that the mother was open about her difficulties and diagnosis, and she proactively asked for help when she felt her mood dipping. (the response of services will be discussed in section 4.3) However, there was limited reflection and curiosity about mother's problems and family functioning from the children's perspective, particularly with the added stress of a further pregnancy, which is known to be an increased strain for families that are vulnerable and for parents with pre-existing mental health difficulties. There was curiosity and reflection at the learning events about mother's diagnosis, which had not been reviewed and mother narrated it. It was suggested this could equally be symptomatic of complex trauma and that her Emotional Borderline Personality Disorder symptoms did not fit with the help-seeking behaviour. Whilst there was a range of adult service responses and assessments to mothers' mental health needs (see below timeline), these were not widely shared, understood or used to inform family assessment.

6.2.4 The Rapid Review discussed how professionals understood mother's diagnosis and what this could mean. This is challenging for children's professionals because it explicitly concerns the adult, and definitions of mental health problems do not address the child or parenting role and the impact of parental mental problems.[25] Assessing the impact of adult mental health on parenting and family functioning is complex[26] and studies show

[25] Murphy M Rogers, M (2019) Working with Adult -orientated issues
[26] Murphy M Rogers, M (2019) Working with Adult -orientated issues

it is the *family disruption* that the mental ill health causes that can present the most significant harm. Duncan and Reader[27] talk about availability and predictability when considering the impact of mental ill health on children. This unpredictability is evident in the experiences of these children; for Sibling D, we have explored how her anxiety and behavioural issues are directly linked to what was happening at home and who was providing care. (See also 4.2.) It is noteworthy that there is evidence to support a correlation between mother's fluctuating mental health and incidents involving the children, in particular, Child J (see timeline).

6.2.5 There was a long-standing history of maternal mental health difficulties that directly led to her not caring for her elder children. She went on to parent Sibling D without long-term service intervention until the pregnancy of Child J. In addition to mother's borderline personality disorder diagnosis, she self-reported bipolar symptoms, substance misuse, self-harm (cutting) and an eating disorder. Her moods fluctuated and whilst she was fully open about these episodes, Sibling D witnessed these episodes, including accompanying mother to the hospital when she sought help. This coincided with neglectful home conditions. Practical support was provided to the family; however, the underlying reasons were not fully appreciated and did not assess the underlying reasons, meaning there were short-term improvements.

6.2.6 Within the first three months of booking the pregnancy for Child J, there were worries about neglect from the school regarding Sibling D, and mother requested support from a range of services, including family support from a charity, telephone screening for anxiety and depression, and the peri-natal mental health team completed an initial assessment that utilised the procedure for Assessing the Impact of Parental Mental Ill Health on Children PAMIC[28] screening checklist. This is a screening tool used by adult mental health services; wider services were not fully familiar with it. Although its efficacy was seen as limited, without broader analysis, it was used here to determine its impact. The outcome assessed the mother as low-risk, and practical support was advised based on mother's self-report. Using the tool was good practice; however, this was limited as it appears to have been completed in isolation and based on mother's self-report, meaning any risk assessment was not fully informed, and any risks to the children were not triangulated with services involved with the family and what might be needed. Consequently, mother was discharged from this service. Given mother's long-term history, the impact on her elder children and the subsequent traumatic birth of Child J, it is difficult to understand why this specialist service only provided episodic adult screening in this instance.

Findings from the latest Child Safeguarding Practice Review Panel report highlight:

"The Need for practitioners to use the 'Think Family' approach: using holistic assessments to identify vulnerabilities for each family member and their impact on the family dynamics, which can in turn facilitate robust safeguarding plans"

6.2.7 The following table details the mental health services offered to mother in the period and the outcomes. They indicate a pattern of help-seeking behaviour, some were not progressed by mental health services, others not taken up by mother. Whilst there is an immediate response to the mother's crisis, these appear to be dealt with episodically and as a single agency; there does not seem to be a reflective and holistic multidisciplinary assessment of the mother's mental health needs. It did not consider what non-engagement could mean, why this could be happening, and the likely impact on the children. This could provide an analysis of her mental

[27] Duncan, Reder (2003)How do Mental health problems affect parenting

[28] This is a checklist tool for professionals involved in providing services to adults who are parents or caregivers. It evaluates impact in terms of likelihood and severity. It should be used with other assessment processes.

health history and needs and, significantly, how this is impacting the children's needs and what would be most helpful to develop longer-term resilience and protection for these children.

6.2.8 There are some critical moments where the experience and skills of adult-facing services and children-facing services should have collaborated in an approach that could look to assess and support the needs of the whole family and consider harm and protective strategies to support the wellbeing of the children. Significant here is the role of the GPs, who have a crucial role in supporting maternal mental well-being: "*They have an overview of issues affecting individual family members of a family which in combination may impact on the welfare of a child."* [29] There was good oversight and review of mother's mental health by the GP; however, there is no evidence of this taking a whole family approach to consider the impact on the children. A wider multi-agency lens and information sharing and seeking could have strengthened this response and supported effective multi-agency practice (see Section 4.3). It is a concern that the children witnessing these mental health crises were not given greater attention and curiosity; this should have generated critical reflection and exploration about what life was like for these children. This requires proactive information-seeking and sharing for the whole family and critical thinking. There should have been collaboration from adult services about the likely impact on mothers' mental health following the mental health crisis. Also, some reflection about her intermittent take up of mental health support and treatment concerning her role as a parent. Professional curiosity is a key barrier to effective information sharing and is of relevance here.[30]

Professionals in adult services do not always know, or did not demonstrate professional curiosity about children in the family or household of the adults they were working with. This meant that potential safeguarding concerns were not identified or passed onto children's services."

6.2.9 Timeline 2 illustrates the mental health response for the mother and the outcomes; it demonstrates the need to include adult services, including the GP, in multi-agency working; there are complex needs irrespective of threshold to consider and meet the needs of the children and fully understand what it was like to be a child in this family. [31] There is learning and opportunity for adult services here for the joint Adult and Children Safeguarding Partnership in line with Working Together 2023 to strengthen whole family working (REC). There appeared to be some uncertainty about how and if this information from adult services was shared, and this can be seen to have prevented a more holistic approach to the families' needs.

[29] GPs and primary healthcare teams: learning from case reviews | NSPCC Learning

[30] Multi-agency working and information sharing: learning from case reviews | NSPCC Learning

[31] DFE-RR045.pdf (publishing.service.gov.uk) The use of family assessment to identify the needs of families with multiple problems.

Timeline Child J

Darlington Safeguarding Partnership

Child J	Mental health response	Outcome
Early months of pregnancy	**TVEW telephone screening** Self-referral: Presenting issues of anxiety and depression.	Initial Assessment completed by Perinatal team. Assessed as low-risk practical support advised. Case closed.
Mid pregnancy	**Mother attended ED** with an episode of exacerbated mental ill health. Thoughts of self-harm. Sibling D is in attendance.	No further action for mental health episode. Referrals made to Stronger families.
Birth of Child J **Traumatic delivery**	Following birth Mother reports low mood, financial and practice worries, reported. **Referral made to Liaison Psychiatry.**	Assessment shared with adult social care. Advised may need further support regarding her mental health once Child J returns home. No role for LP. Assessment emailed to GP.
Postnatal day 5	**Crisis Resolution team review**	Crisis numbers were given to mother. Building Stronger Families(BSF) practitioner was contacted.
Child J 1 month	**Self-referral to neonatal mental health charity**	Support commenced.
Child J, 8 months	**GP screening Call.** Mother reporting low mood and struggling to take medication. Mother discharged from neonatal mental health charity due to lack of engagement.	Referral to the Access team for mental health support. Mother reported difficulty with emotional dysregulation and loss of interest /motivation. Self-harm with razor blade reported twice a month. Mother requested a face-to-face assessment aware it would not be possible for 2-3 months.
Child J 10 months	**GP mental health review** (telephone)	Mother requested re start antidepressant medication not taken for four months. Prescription not collected.
Child J 11 months	**Mental health crisis seen by Liaison Psychiatry at ED.** Three-week period of irritability towards children and self-harm thoughts. Chaotic thinking overwhelmed and irritable. Children present. Mother supported by volunteers. Sibling D went to stay with her uncle.	PAMIC tool used. Mother and Child J were discharged home following the assessment. Information that Mother's adult sibling would provide safety. Referral to GP Aligned Mental Health Services. Contact to Children's Front Door passed to BSF.
Child J 12 months	Mother did not attend the first Access appointment **Access mental health appointment**	Further appointment offered. Mother reported managing her mental health better but needed help with practical issues. Referred back to GP and to support services BSF.
Child J 15 months	**GP mental health review** (telephone)	Mother reports not taking antidepressants and agreed to restart again.
Child J 16 months	**GP telephone consultation.** Mother reports deterioration in mental health, 'things happening at home.'	Referred to GP Aligned Mental Health Services.
Child J 17months	**Face to face Consultation with GP.**	Reports antidepressants working agreed to increase.
Child J 19 months	**GP mental health review** (telephone).	Mother reports she is more stable and has returned to work.
Child J 20 months	**GP Aligned mental health service closed due to non-attendance.**	This was closed after 4 failed appointments over a three-month period.

Why does it matter?

6.2.10 Reflecting on these findings increases understanding of ***why*** the impact of mother's mental health on her parenting was not fully appreciated, how this can identify other children in similar situations, and how help, support, and protection could be improved across adult and children services through an approach that enables child-centred interventions within a family context. This is supported by national research, learning from local reviews [32] and forms a core element of Working Together 2023. It means ensuring all household members, whether they live there or not, are included and that there are clear pathways to work collaboratively with services that support adults who are parents/carers.

Appreciating mother's mental health problems.

6.2.11 Analysis of Serious Case Reviews between 2017 – 2019 [33] highlighted the prevalence of mental health problems (over half of the reviews), particularly for mothers when considering parental characteristics. Learning from case reviews where parental mental health difficulties featured highlights a lack of understanding about the issues and meant that professionals did not always fully understand the potential harm to a child, the children's needs or identify support networks. Professionals did not fully appreciate the nature of the mental health difficulties and any situational risks around this for the family; this was because they were not fully aware or did not understand the nature and characteristics of the diagnosis. It is recognised that assessing parenting capacity is complex and features changeable parenting relating to mental health episodes. Duncan and Reder[34] highlight the dilemma when assessing parenting capacity: **"The question is whether the periods of good parenting can compensate for the episodes of adverse care and so help the child to tolerate them and make progress in all aspects of their development."** It was important, therefore, to know if anyone else could support and meet the children's needs. There was insufficient understanding or assessment of partners, the wider family and community network to be assured of this. Working Together 2023[35] Chapter 1 clearly shows the shared responsibility of a child-centred approach within a whole family focus. This approach ***"sits within a whole family culture in which the needs of all members of the family are explored as individuals and how their needs impact on one another."***

6.2.12 This meant the children's needs were not always fully known or understood. Research shows[36] that mothers with borderline personality disorders have difficulties responding to a child's emotions; this difficulty with empathy meant that mother could struggle to understand her children's perspective, feelings, and behaviours, which was observed for Sibling D. Impulsivity and mood swings, a feature of Borderline Personality Disorder particularly at times of stress, are influential for shaping a child's emotional regulation skills.

Parental mental health issues - children's needs.

6.2.13 There were early indicators that mother was struggling to meet the children's basic needs at different times in terms of their basic care and emotional needs, as well as evidence of disputed relationships with key family members. There were referrals indicating that Sibling D came to school unkempt; her behaviour was reported to be challenging, mother approached services and professionals on a number of occasions to report that she was not coping, and she self-referred to the hospital in crisis; this was directly related to how she was coping

[32] Patterns in Practice Theme: The importance of a whole family approach to risk assessment and support. Child_Safeguarding_Review_Panel_annual_report_2022_to_2023.pdf (publishing.service.gov.uk)
[33] Learning_for_the_future_-_final_analysis_of_serious_case_reviews__2017_to_2019.pdf (publishing.service.gov.uk)
[34] Duncan and Reader (2003) referenced in Murphy, M & Rogers, M in Working with Adult orientated issues.
[35] Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf (publishing.service.gov.uk)
[36] Cleaver, et al. (2011) Children's Needs – Parenting Capacity 2nd Edition

with a new baby on her own. Whilst practical help and support were offered by a range of professionals who clearly tried their best to help, the focus was on mothers' needs, and there was insufficient attention given to the children's needs and the impact on her parenting and maintaining family relationships.

Child-centred practice with a focus on the whole family.

6.2.14 The adult issue here of maternal mental ill health is a prevalent theme in reviews and a 'think family; the whole family approach' is forefront and central to the latest Working Together 2023 (Chapter 1). The latest Safeguarding Review Panel annual report mirrors the findings in this review; *"The most common issues featuring in review reports in this latest analysis concerned assessments not involving all family members or carers and not considering the impact of identified vulnerabilities on household dynamics. Reviews featured a mixture of good practice and missed opportunities around building relationships with children and using their voice to effectively understand their lived experience and inform assessments and plans."* [37] It goes on to provide evidence that focusing on one specific family member, usually the mother, can lead to overlooking the child's needs and the impact of parental vulnerabilities on the child's lived experience. Therefore, it is important that there are clear pathways between adult and children's services that support assessment and information sharing. (REC)

What needs to happen - Learning points	
6	Practitioners and managers in adult and children's services to strengthen their knowledge and understanding of the impact of parental mental health difficulties on the care of children and family functioning. This must include: • An understanding of adult mental health diagnosis, history and lived experiences, presenting difficulties and behaviours, vulnerabilities, severity, predictability, and treatment/service response. • The use of Collaborative multi-agency family and community Networks. • Parental strengths and support to sustain wellbeing. • Identification of protective and resilience factors for the child(ren).
7	Practice **whole-family working,** where identified parental adult issues impact the well-being of children through improved communication and collaboration between adult-focused and children-focused services to inform family assessment, planning, and review.
8	Ensure all family work keeps a focus on the child(ren), their lived experience and voice, including observations of their behaviour and relationships. (see learning points 1 & 2)
9	The potential impact of an additional pregnancy where there are prior concerns around maternal mental health and significant neglect needs careful interdisciplinary assessment and a coordinated safety/support plan for the whole family.

[37] Child_Safeguarding_Review_Panel_annual_report_2022_to_2023.pdf (publishing.service.gov.uk)

6.3 Multi-agency working - providing help, support, and protection

How effective was the multi-agency response in identifying and meeting the children's needs?

6.3.1 This section explores multi-agency working and how it provided the children with help, support, and protection. Professionals worked hard to engage with the family and provided a wide range of support and help. Positive relationships were developed, and mother was proactive in asking for help. The range of services was extensive, from across adult and children's services, and in addition, the mother sought specific voluntary services to support her. The support she has received from one charity has been enduring, and other charities have all provided periods of support from volunteers/peer mentors. This section will explore who coordinated the multi-agency response, the mothers' response to this, and how it met the family's needs.

6.3.2 This meant there was a wide range of services, all committed to helping and supporting the family. In the scoping period, there were three periods of family help: one pre-birth, a second period for a few months following the birth of Child J, and the third period following a mental health crisis when mother presented at the hospital with the children and a volunteer. Child J was eleven months old; this was the longest episode and ended within weeks of the significant incident (see timeline). There was an opportunity when the mother was referred to the perinatal team to complete/contribute to a multi-disciplinary pre-birth assessment and to formulate prognosis and safety planning with appropriate mental health expertise. Thereafter the mental health response (Timeline 2) shows the siloed response to the mother's mental health crisis within and across services and a limited whole-family approach.

6.3.3 There appeared to be overconfidence that the range of services meant that the family's situation was fully supported, and mother was working well with services. What could be seen on closer analysis was that this was intermittent, and there was a lack of clarity about who was doing what, when and with who and significantly, as we have seen, who knew what. Unusually, there was significant involvement from voluntary agencies which the mother had proactively sought help from; they provided a high level of practical and emotional support. There was no sense that they formed part of a multi-agency or community support network[38], which would have been a valuable opportunity to understand their contribution and support as part of a family network. The learning event reflected that many professionals did not know the full background and relied on mother's narratives. Mother sought help often independently, and agencies were often unaware of each other; ***"No one knew the full picture"*** *(*practitioner learning event). Mother sometimes failed to take Child J to health appointments; these were not patterned and viewed in the context of the WNB policy and wider neglect factors for both children. Similarly, mother sought services and help for herself but then did not engage (see timeline 2), which meant she was closed to services put in place. Disguised compliance [39] was not considered, nor were the characteristics of her diagnosis, given her fluctuating engagement. Services were available across adult services, children's health, education, and the voluntary sector to help the children and their mother; it is important here that discrepancies are considered, and professional curiosity is used to reflect on the patterns of non-attendance across adult and children's services. What can help here is respectful challenge and risk

[38] Community_Mapping_tool_0.pdf (SECURED) (wvi.org)

[39] Disguised compliance involves parents/carers giving the appearance of cooperating with agencies

approaches such as Munro's [40]Asking the Right Questions or Signs of Safety[41] to help structure thinking and analysis.

6.3.4 There was evidence of multi-agency meetings and services; the learning event saw this as helpful and positive for Sibling D, and good partnership working was evidenced. However, this was limited because this only involved one or two agencies, which meant that information was seen in isolation. Professionals involved with Child J (nursery /health visitor/GP) did not appear to be involved, meaning Child J's vulnerability did not appear to be included. Adult mental health services were not involved, and information was based on mother's self-reporting. All parts of the family and multi-agency system must be actively engaged in triangulating information to support analysis and ensure help and support can fully meet the children's individual needs within the family. We have seen that where adult mental health issues are prevalent, this must include expertise from adult mental health services.

6.3.5 There was a brief Child Protection investigation after a hospital attendance for suspected non-accidental injury where Child J had bleeding from his ear and eye and bruising to his eye and head. A Strategy Meeting and Section 47 investigation were appropriately undertaken. The outcome was accidental injury, and following the Section 47 investigation, the recommendation was for early help to continue. The rapid review identified that the family should have formally stepped up to level 4 [42] and completed a social work assessment. This could have provided an opportunity to reflect and analyse the family's history, circumstances, needs, worries, and protective factors. This process has now been strengthened with children's social care, where a social work assessment now occurs.

6.3.6 It is noteworthy that Child J experienced four reported incidents of bruising to the head in his life. His prematurity contributed to his faltering growth in his early months; this would have contributed to his vulnerability and some additional worry for the family. While the bruising was explored, there was limited critical thinking about what might be going on in the context of the family situation and who else was involved in the care of the children (see Section 4.4). The Strategy Meeting appropriately received police checks on mother's partner, and although there was no indication that he presented any risks to the children, further exploration of his role in the family was missing. Additional information shared by the police was that mother appeared to have a number of different aliases. The mother's report that her partner did not stay overnight was not challenged and accepted at face value. With hindsight, the group questioned possible disguised compliance relating to mother's past experiences and /or possible benefit evasion.

6.3 7 Multi-agency assessment and planning meetings are central to effective practice as they bring together the family, the family and community network, and the professionals involved. The periods of BSF intervention were task-focused, and this was the focus for case closure without a wider consideration of the complex history and understanding of increased mental health difficulties in pregnancy. Voluntary services were involved but not included in the assessment, review, and planning. During their involvement, there was communication with a family charity, which provided practical and financial support, but they were not involved in Team around the Family meetings. It was unclear how the various voluntary and universal support services were coordinated in the periods following BSF closures. Given the complexity of the family's issues and needs, the author believes it does not follow the partnership's continuum of needs. This led to case closure of the family before the birth of

[40] Munro, E (2012)
[41] Signs of Safety is the established approach used across the Partnership What Is Signs of Safety? - Signs of Safety
[42] darlington-continuum-of-need_april-2017-final.pdf

Child J, which is difficult to understand given there had been an emergency department attendance with an episode of exacerbated mental health just before closure. Positively, the children and family were re-opened to BSF following the traumatic premature birth and mother's reported stress. (see timeline 1).

Why does it matter?

6.3.8 The findings show that a wide range of universal, targeted, and voluntary sector services were involved with the family, and many had a continuing and positive relationship with the family. However, services and professional responses tended to be singular and reactive, and a coordinated multi-agency interdisciplinary response that attended to both the adult and children's needs could have benefitted the family. The partnership has strong relational practice, and this is the platform to develop strong inter-system collaboration to develop a holistic family culture and approach around adult issues that impact children's needs.

Multi-agency and interdisciplinary practice

6.3.9 When adult issues are identified with the appropriate adult services and/or children's services, a multi-agency collaborative discussion needs to take place. Responsibility for this must be shared. Adult mental health services and GPs who have the knowledge and skills about adult issues must be curious and collaborate to support a wider understanding of mental health diagnoses and its likely impact on caregiving and family functioning. This will help understand what needs to be done to improve the systems and support around the family and support practice. This must include discussions about thresholds and information sharing for whole-family interventions that consider vulnerabilities, children's needs, strengths, and risks.

Multi-agency meetings

6.3.10 These are central to multi-agency working as they bring together the family network and the professionals involved. It is a space to share information, think critically about what is going on for the family, and determine safety and support plans. This matters here because they did not include all professionals, and the wider family network was not considered. This meant practitioners did not have all the information they needed to determine the individual children's needs, vulnerabilities, and support. Practitioners worked well together, but because they only focussed on the child or adult, they were responsible for, they did not have access to more comprehensive contextual information and were not aware of who else needed to contribute.

The importance of seeking and sharing information

6.3.11 Seeking and sharing information underpins effective multi-agency practice, and when this is missing, as when services respond as a single agency and did not fully include relevant agency information, it can *"undermine the ability of practitioners to fully understand what is happening to children and significantly consider any risk of harm"*[43]. This must also include a level of professional curiosity.

[43] The Child Safeguarding Practice Review Panel 2022/23 Annual Report highlighted three cross-cutting themes across national, thematic Reviews, Rapid Reviews and LCSPRs, including information sharing and working across agency boundaries.

What needs to happen -Learning points	
10	Where adult mental health difficulties are identified in families, this must include collaboration with the relevant adult and children's services and expertise. This is a shared responsibility; assessments and mental health screening should not be undertaken in isolation.
11	Multi-agency assessment and planning meetings are central to effective multi-agency practice as they bring together the family, the wider family and community network, and the professionals/agencies involved. It is important that they include all household members, so the needs of all family members are considered and how they impact each other.
12	The importance of seeking and sharing information during assessment and at multi-agency meetings is crucial to thinking critically about a family's circumstances and individual needs and to ensuring that information is not seen in isolation.

6.4 Unconsidered men/caregivers

What was known about the men associated with the family

6.4.1 This section explores unconsidered men and male caregivers within the household, what was known about them, and their role with regard to the children. These men were not unseen or hidden but unconsidered. It will also consider the vulnerability of babies and children where there are co-existing adult issues and how these situational risks were appreciated.

6.4.2 In the scoping period, there was information about three males: the father of Sibling D, the father of Child J and mother's partner who is charged with the death of Child J. There were other males involved with the children's lives and were referenced as supporting and caring for the children at various times. This included one of mother's elder sons and a maternal uncle. Whilst these men were known in general terms and were in and out of the children's lives, there was limited professional curiosity about them to explore how involved they were in the children's lives.

6.4.3 BSF practitioners tried hard to engage Child J's birth father in the pre-birth period, but this was not successful, and no attempts were made to engage with other men visiting/living in the household. The impact of these men coming in and out of the children's lives did not form part of the assessment or support plan, and it is noteworthy that mother's partner was involved and known about at the strategy meeting in May, but there was no engagement with him or understanding about him and his relationship with the children.

6.4.4 There were opportunities to explore who was living in the household; in relation to the mother's elder son, there was no curiosity about his relationship with his mother, how long he had lived there, and what his role was in the household. Given the known history, all services involved with the family should have explored and considered this. It was known that Sibling D reported her unhappiness about family conflict between her mother and elder half-sibling. A further incident occurred when the family went to the emergency department following a mental health crisis; her son was given responsibility for ensuring her well-being, indicating his role in managing her mental health episodes. Sibling D also shared that she was spending periods living with her maternal uncle and was sad that this was ending, and her mother had been shouting at her. These are not

isolated incidents and indicate that these adults had a significant role in caregiving. Despite being fully visible and known by all services and agencies, these men remained unconsidered.

6.4 5 There is very little known about mother's then-partner; he was included in the statutory investigation following the bruising of Child J in May but was not spoken to because he was reported not to have care of the children unsupervised and did not live in the family home. This was based only on the mother's information, and professionals accepted the mother's reporting that he was not 'living 'at the family home. Regardless, it is a poor decision not to include all persons who have contact with the children, particularly as the incident was said to have happened over a period of time, including a holiday that included mother's partner. There should have been greater curiosity about him and some exploration of his role in the household; there may have been an assumption that he cared for his child and was seen as a capable and safe parent. Best practice[44] is ensuring assessments take into account contextual factors, including relationships, and" these include parental vulnerabilities, such as childhood trauma and mental health." This should have been included in the Section 47 assessment and informed the assessment of the family, all the adults, and the needed support. This was a vulnerable family, and this was an opportunity to consider the history, the mother's mental health episodes, relationships, and the children's needs. We know that Sibling D was not directly spoken to as part of this assessment, which meant her voice did not inform the assessment.

6.4.6 Recognising and responding to babies' vulnerability was a key theme identified in the National Review about the Myth of Invisible Men in 2021; this theme continues with babies and infants being the largest groups featured in Rapid Reviews and presents a key practice theme.

"The most prominent issues that emerged centred on the challenges practitioners face when exploring the vulnerability of babies with parents and wider family, and whether and how they recognise contextual factors, such as parental mental health and trauma, when assessing risk to babies."

The Child Safeguarding Practice Review Annul Report 2022/23

6.4.7 The particular vulnerabilities of the children and mother were evident. Whilst there should have been greater curiosity about the men in the household, there was little to indicate that mother's partner could pose a risk to Child J; he was not known to the police and was involved with his child, who had additional needs. The ongoing police investigation means further understanding about the mother's partner, and the relationship is unknown at the time of writing.

Why does it matter?

6.4.8 Knowing who is involved in the household is important when providing help and support to families and considering risks, vulnerabilities, and support they could provide. Assessment must consider the impact of parental and adult experiences, strengths, and difficulties. There was limited consideration of partners and males who formed part of the household, associated with the family, and supported the caring responsibilities for the children. Clearly, these males were known by professionals involved with the family, so they were not hidden or unseen and were known to take on a caring role for the children, particularly Sibling D.

Professional curiosity about males associated with and in the household

6.4.9 It is important that professionals show curiosity about all household members and review this at subsequent visits. There was an overreliance on mother's narrative without triangulating this with the many other professionals involved with the family. Sibling D shared information and worries about changes, care, and

[44] Child_Safeguarding_Review_Panel_annual_report_2022_to_2023.pdf (publishing.service.gov.uk)

conflicts associated with men in the household, which should have been explored further. It is important that family relationships and caring roles are fully appreciated, and men engaged with. The history, vulnerabilities and nature of mothers' mental health difficulties and her parenting difficulties should have led to greater critical thinking. Historical domestic abuse and the altercation between Sibling D's father and unborn Child J's father. Sibling D's voice was not fully considered. This matters because of the evidence about the vulnerability of very young children and the known risks regarding unknown and unseen men associated with vulnerable families.

The singular focus on mother's caregiving role

6.4.10 When working with the family, the focus was on the mother's role as a caregiver, reducing opportunities to involve or understand the men's roles and any vulnerabilities or worries. Whilst BSF professionals tried hard to engage with Child J's father and voluntary services were actively involved in the family home, there was no significant engagement or attempt to understand other male/partner/family member roles or what they could offer in this situation, such as providing possible resilience and safety when mother's mood was dipping. It was clear that mother's elder son had a role in supporting her mental health crisis. There was no consideration of this, his own experiences, or the conflicts Sibling D described. Instead, they were accepted at face value or not known about by other services/practitioners involved. Sibling D spent time in the care of her uncle, but there is no sense of what the wider family network could contribute or how this could be brought together. (see Section 4.3)

What needs to happen -Learning points	
13	Section 47 enquiries must always include an assessment of all men (and adults) living and associated with the household and their roles and relationships within the family. This must include a home visit/direct engagement with males associated with the household. Reliance on a mother's self-reporting requires appropriate curiosity and critical challenge.
14	Practitioners should be curious about **all** household members and the role of fathers and male caregivers in their interactions with children and families. They should challenge any gender stereotypes and consider opportunities for them to be actively engaged with professionals. This will help identify their needs and any protective factors they could contribute.

7: Summary

7.1 This practice review has identified learning for the partnership to consider and reflect upon regarding current systems and practice. The purpose of this review has been to identify learning following the sad death of Child J. Its role is not to investigate or apportion blame but to try and understand the circumstances that led to the serious incident from a multiagency safeguarding perspective, to support learning and understanding, identify good practice and to help leaders and practitioners consider other vulnerable children preventatively. No known or specific patterns or events indicated Child J was at risk of imminent harm. The full details of how he died are subject to a criminal investigation about the adult(s) who had responsibility for him at the time.

7.2 Child J was an infant with increased vulnerability due to his premature birth, his mother's long-standing mental health difficulties and adversity, and unexplored male associations with the household. Historical family functioning and history were known but not fully considered. Therefore, its impact on the children's lived experiences was not fully appreciated. The learning review has reflected on the broader family circumstances, the vulnerabilities and needs of the children, the parents/carers, and how services worked together to support

the family and help the children thrive. Practitioners and services worked hard to engage and support the family over time, and a particular strength was some enduring relationships for Sibling D and her mother. However, there are important improvements that will support change that can make a difference in practice; these include being curious, reflective, and having a questioning mind about family history, current family functioning, and relationships, appreciating the impact of adult vulnerabilities upon infants/ children in the household, including domestic abuse. It is important that the range of multi-agency colleagues across adult and children's services working with the family at different times, including the voluntary sector, take a whole-family approach that focuses on the children's needs in the context of their experiences. Child D was not recognised as a young carer, meaning she did not always get the help and support she needed. Child J's lived experiences were not fully known, meaning his needs and vulnerabilities were not fully appreciated.

7.3 It is noteworthy that some of the learning from this review mirrors key learning from a local CSPR published in November 2023[45] around the child's lived experience, professional curiosity, unseen adults, and information sharing. While the family circumstances differ, transferable learning can support the partnership and strengthen its application of these fundamental concepts into organisational practice. (REC)

7.4 In addition to the learning identified throughout the report and the single-agency Action Plans, the following recommendations are made to the Partnership.

8: Recommendations for the Partnership

Practice

1. Darlington Safeguarding Partnership to evaluate the impact of the learning transfer from recent work undertaken regarding Family H which mirrors key learning from this LCSPR. This can strengthen and provide assurance concerning knowledge, skills, and confidence in the following areas of practice:
    - Understanding children's lived experiences and appreciating what life is like for infants and children.
    - The use of critical thinking to fully consider a family's circumstances and understand the child's lived experience, known as 'professional curiosity.'
    - Ensuring all men associated with the family /adult caregivers are fully considered.
    - Effective information sharing and seeking about the adults and children in the family during multi-agency discussions/meetings.
2. Darlington Safeguarding Partnership to strengthen knowledge and understanding of the following practice areas across the multi-agency workforce, including the Voluntary Sector.
    - Increased understanding of adverse childhood experiences and how they can impact and what can help.
    - Increased understanding of parental mental health difficulties on parenting, family functioning and impact upon infants /children.
3. Darlington Safeguarding Partnership to update its multi-agency practice guidance about neglect and provide a good level of knowledge and expertise to support the identification of neglect and pathways of support and intervention. This should be informed by how its identified Practice Tools can help practice and improve outcomes for children.

[45] Family H Darlington Safeguarding Board - Child Safeguarding Practice Reviews (darlington-safeguarding-partnership.co.uk)

Systems

1. Darlington Safeguarding Partnership to have clear systems in place to support collaboration across adult support services (including but not limited to community and hospital services, GP's commissioned services) and children's services where there are parental mental health difficulties to support information sharing and assessment. This assessment must focus on the infant/child's needs, vulnerabilities, protective factors, and risks to inform parental capacity and understand the lived experience of the children.
2. The Partnership's Neglect Strategy to reflect on the research and understanding about adverse childhood experiences and building resilience for families through multi-component programmes, family-based interventions, trauma-informed approaches, and prevention strategies[46] to support wider system change and build resilience and repair for children.
3. The Statutory Partners to provide leadership and guidance about developing a ***child-centred approach within a whole family focus,*** in line with the multi-agency expectations in Working Together 2023 that supports the needs of all family members and considers how they interact.
4. Partners should ensure that **all** adults associated with the family and their roles are identified and considered within their services. This reflects national learning and local briefings about 'unseen' male and female roles within the family. [47]

5. The learning from this LCSPR is disseminated across the Partnership and partner agencies to provide evidence to the partnership of how the learning is making a difference in practice to children and families they work with, particularly at a universal and early help level (all learning points).

9: Addendum to Report – Child J's Father

The reviewer and the partnership's business manager met with Child J's father, his partner, and Child J's grandfather in January 2025 after the conclusion of the criminal trial. This was at the father's request. The meeting provided information about his involvement in his son's life and the complexity of managing contact with his son, this discussion has helped strengthen the learning in the review regarding the involvement of separated fathers. This has led to two further specific recommendations for the partnership.

Whilst this information was not known at the time of undertaking the review, it has also highlighted additional reflection and learning from the partnership about the importance of ***how*** we engage with family members to ensure we are able to include all family narratives and share the importance of any concerns they may have. The family shared they hadn't been in touch earlier due to dealing with the loss of their son but also had not felt confident about coming forward and replying to the letters sent. Father explained this was because he and the family did not understand the review process, and he had not fully absorbed the letter or leaflet contents and what this meant for him.

1. This leads the reviewer to recommend that the Darlington Safeguarding Partnership should consider how any written correspondence is followed up to help support family understanding of the process as well as importantly, providing reassurance.

The father's relationship with Child J's mother was limited; he shared that he did not know her history. He shared that his ex-partner's contact with him was led by her and centred on her needing help and support with childcare.

[46] A practical handbook on Adverse Childhood Experiences (ACEs) Delivering prevention, building resilience, and developing trauma-informed systems. PHW-WHO-ACEs-Handbook-Eng-18_09_23.pdf (phwwhocc.co.uk)
[47] unseen-adults-and-safeguarding-children-briefing-february-2024-v1.pdf

A complicating factor for father was his anxiety about losing contact with his son. He shared that (unknown to the professionals involved) he and his partner had regular, often weekly contact with his son. This also included seeing sibling D. Contact occurred in his family home and was arranged between the parents often at last minute and focussed Child J's mother's needs. He had not had overnight stays but hoped to work towards this with his partner's support. Father and his partner shared that it was a difficult relationship to manage with Child J's mother, and he remained anxious that she would stop contact, as she had done before.

Father and his partner shared they had concerns about the care of his son, and on occasions, Sibling D, for example, she had not been fed or was taking some care responsibilities for Child J. They said they had not come forward with their concerns because they were anxious about contact being stopped and how this could complicate matters for their family.

2. The partnership needs to consider how it promotes information to communities about safeguarding being everyone's responsibility, recognising that for some separated families, contact may be used to control access to children. Information, advice, and guidance should be accessible to extended family members who have worries about children's wellbeing.

The father reported he was not aware of professional involvement during his son's life. Child J's family members were angry that they were unaware of any professional concern about Child J's care and felt they should have been contacted. The review shows several opportunities for exploring information and support from wider family members (father). Records show there was information during the pre-birth period where efforts were made to contact him and learn about his role in his son's life, but in discussion, the father did not recall this. Records stated that the father did not want to be involved then, which led to any assessment work reasonably not involving him. There was, however, an opportunity, given the number of professionals having contact with the family over time and responding to requests for help and support, to revisit and show curiosity about who was involved /could be involved. Instead, the mother's narrative remained the overriding one.

The child protection investigation following a possible non-accidental injury in May 2023 should have led to contact being made with Child J's father. This response, as detailed in the report, was not thorough enough, although now, with hindsight, the information that the family shared about their worries may have contributed to the assessment being undertaken.