

**THURROCK LOCAL  
SAFEGUARDING  
CHILDREN  
PARTNERSHIP**

**SERIOUS CASE REVIEW  
SAM AND KYLE  
OVERVIEW REPORT**

**Report by David Ashcroft, Independent Overview Author**

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## **Introduction**

1. This is the Overview Report for the Serious Case Review commissioned on behalf of Thurrock Safeguarding Children Partnership in respect of two children, known for this review as Sam (born January 2016 and died January 2018) and Kyle (born October 2012). The death of Sam was the initial trigger for undertaking a Serious Case Review, but it was agreed that more useful learning would be generated by extending the scope of the review to consider both children and their experiences over a longer period.
2. The case concerns the circumstances and agency responses to this family from before the birth of Kyle in October 2012 through to after the death of Sam, who died at home of unascertained causes in January 2018, aged just under two years old. There had been a number of concerns about the family relating to neglect, domestic violence and the parenting of the children, and a number of different agencies had been working with them to support around these issues/challenges. For the first 18 months of life Kyle was a Looked after Child and then under a Supervision Order. Kyle was then supported through a variety of family support services including as a Child in Need, through an Early Offer of Help (EOH) and through the Prevention and Support Service which replaced the EOH, until a decision to consider a further Child Protection Plan was made just before Sam's death. A Child Protection Plan for Kyle was agreed three weeks after Sam's death, and Care Proceedings resulting in a Full Care Order for Kyle were completed in April 2019. The family also accessed universal services including health visiting, their General Practitioner, the hospital Emergency Department, and Kyle attended nursery and then school. In particular, the midwifery service was an important point of contact around the births of both children, and practitioners were alert to safeguarding and parenting issues when mother was using maternity services.
3. It was agreed, following meetings to review and agree the scope of the enquiry that the case should be recommended as a Serious Case Review, and this was approved by the Independent Chair of the Local Safeguarding Children Board, as the decision was taken before the adoption of new multi-agency safeguarding arrangements in Thurrock under the provisions of the Children and Social Work Act (2017). This is therefore a Serious Case Review rather than a Child Safeguarding Practice Review, although it has been undertaken in line with the revised guidance of *Working Together 2018*, and subsequent guidance from the National Child Safeguarding Practice Review Panel. An Independent Panel Chair and Author were appointed. It was agreed that the review should concentrate on specific lines of enquiry focused on the learning to be gained. This was supported by a Practitioner Event where staff and managers involved in the case were invited to contribute perspectives on the case and help draw out key conclusions. This provided a wider forum to review working relationships between agencies and to reflect on how these could be strengthened. It was

considered important that the review process should be proportionate, timely and address areas of learning and practice rather than construct an exhaustive narrative account of the work undertaken with this family over a period of up to eight years. The Review has taken longer than anticipated due to delays in meeting with the family and seeking their input to the process and their comments on the report. Arrangements were made to speak to the family and to understand their points of view. The final report has been shared with mother and with the support of an advocate she has made a number of comments and suggestions. Other family members (father and paternal grandmother) were also provided with the opportunity to comment on the report.

4. The Key Lines of Enquiry for this review were agreed as follows

- Family had multiple contacts with a range of agencies - what can be learnt about how well these were coordinated?
- Did thresholds/categories and allocation to different teams inhibit responses?
- Examine the sharing and use of information with partners – who knew what when?
- Review the sharing of information and gathering of evidence pre and post death of Sam
- What were the barriers/inhibitions for practitioners in dealing with neglect?
- Examine whether previous tools, training and recommendations for dealing with neglect have been effective, and if not, why?
- What were the levels of professional curiosity and confidence in dealing with this family?
- How were concerns escalated - both where there were differences of opinion and where greater expertise and direction was sought
- What were the arrangements for management oversight - did they support and give confidence to practitioners appropriately?
- What does this case tell us about supporting young and vulnerable parents? Were these vulnerabilities recognised?
- How did contact with universal services inform assessment and evaluation of risk by more specialist support?

### **Outline of history and concerns**

5. Mother first came to the attention of Thurrock agencies in October 2011 aged 17 when she completed an antenatal booking with a Community Midwife at Basildon and Thurrock University Hospital and was referred to the Maternity Safeguarding Team. This was because she had disclosed that she was a looked after child, placed in foster care since the age of ten by a London Borough. She also disclosed a previous history of self-harming. The midwife sought to make contact with the relevant London Borough's Social Care, without success until December 2011, when a Social Worker informed the Community Midwife that mother had had a miscarriage and as there was no ongoing pregnancy no information was shared. It was appropriate that the Community Midwife sought safeguarding advice and tried to ascertain more information from the London Borough about mother.
6. In April 2012 mother self-referred for antenatal care. A scan in May showed that the pregnancy was more advanced than mother had thought, and the expected date of delivery was mid-October. Mother's partner was identified as the father of the baby. Mother was now a care leaver but was not in education or employment. She did not appear to have an allocated Social Worker from the London Borough, although she did have a Leaving Care Personal Advisor who remained in touch with her.
7. In June 2012 the midwife referred again to the Maternity Safeguarding Team, who checked with Thurrock Social Care who had mother on their system, but she was not an open case. There was some confusion as to which London Borough mother was known to – due to different addresses – but eventually the correct London Borough agreed that a pre-birth assessment would be completed at twenty weeks. The Maternity Safeguarding Team suggested that contact should be made with Thurrock Children's Social Care as the baby would be born in Thurrock. The Maternity Safeguarding Team made the proactive and appropriate decision to continue to oversee this case and liaised with community midwife colleagues and health visitors.
8. The Maternity Safeguarding Team continued to seek clarity from the London Borough and Thurrock Social Care into September 2012 about what plan was in place and whether a pre-birth assessment was to be completed and by which agency. There was concern that mother was vulnerable, inexperienced in childcare and unprepared for caring for a new baby. A planned assessment visit was cancelled at short notice by the London Borough Social Worker. The Maternity Safeguarding Team attempted to escalate their concerns with both Thurrock and the London Borough Social Care with little success. At one stage a Child Protection Conference was proposed by the London Borough for immediately after the due delivery date, but this did not take place and the case was transferred to Thurrock at the beginning of October 2012, with a plan for a discharge planning meeting post-delivery. The Community Midwife was concerned that "this case was not going to be sorted before the expected date of delivery".
9. Mother had been in the London Borough's care following sexual abuse by her father who was a schedule 1 offender and she had had a troubled upbringing. The Health

Visitor was also concerned about the home conditions following a visit in early September 2012, and about the maturity of mother, and had concerns about her partner around his offending, alcohol misuse and incidents of domestic violence. A referral was not made but contact was made with Thurrock Social Care to seek information. Father had been known to Thurrock Social Care since 1995, with concerns about neglect, poor school attendance, ADHD and violent behaviour at school. There had been incidents recorded of domestic violence and misuse of alcohol.

10. Thurrock Children's Social Care completed a pre-birth assessment which proposed that the case should progress to an Initial Child Protection Conference. However, this was overtaken by Kyle's birth and subsequently the decision was taken to place mother and baby in a foster placement on their discharge from hospital. This took place on 26<sup>th</sup> October 2012 under Section 20 of the Children Act, and an Interim Care Order was granted at the beginning of November, pending final decisions about care arrangements.
11. Professionals were concerned that mother was a vulnerable young person who had suffered considerable trauma, poor care and negative parenting as a child. There were concerns about whether she would be able to demonstrate the engagement with support that was likely to be required; about the dynamics of the relationship with father who had acted violently towards her; and his alcohol use and anger issues. There were concerns about inadequate family support and risks posed by members of both the maternal and paternal extended families. All these factors led to a conclusion that there were significant concerns about the parenting ability of Kyle's parents, and that statutory intervention in some form was appropriate.
12. Kyle was born in the bathroom at home on 24<sup>th</sup> October 2012 and taken by ambulance to hospital. Although the birth took place before professionals arrived there were no immediate concerns about Kyle's or mother's health, and it was noted by maternity ward staff that mother was meeting the baby's needs and there was good interaction between them.
13. It was agreed that mother and baby would be discharged to a foster placement for further assessment under an Interim Care Order, so Kyle was at this point a Looked after Child placed with his mother in a foster placement. There were subsequent concerns about the suitability of the foster placement and a need for further assessment, so in December 2012 mother and Kyle moved to a residential assessment unit in Kent, and father joined them at the beginning of February 2013. There was a Court Order for an independent parenting assessment on the basis that previous assessments and psychological reports for the Interim Care Order had raised questions about the parents' parenting and capacity. In May 2013 mother, father and Kyle moved to temporary accommodation and from August were awarded a council tenancy in Thurrock. The independent parenting assessment was completed in July 2013, which recommended that Kyle remain in parental care under a Supervision Order. This was granted in September 2013 for twelve months.

14. Although Kyle did not become subject to a Child Protection Plan at birth, he was on an Interim Care Order from November 2012 and then with a Supervision Order through to September 2014. The concerns were sufficient for a high level of oversight and protection to be felt necessary – with psychological and parenting assessments required by Court and regular Looked after Child Reviews in November 2012, and February and August 2013. This assessment correctly reflected the range of issues that confronted Kyle’s parents, and which suggested that they would require considerable assistance to provide consistent and stable parenting for Kyle.
15. There was contact with both GP and Health Visitor during this period – although their records do not make it clear that either were fully aware of the reasons for moves or for the on-going supervision by Social Care, or of the complexity of the issues. There is not a clear record in the GP notes that this was a child who was Looked After or under a Supervision Order – and Kyle was seen by GPs for a variety of appointments including immunisations during 2013 and 2014. These included cellulitis of the pinna (ear) due to a piercing. Kyle’s parents had been advised that it was inappropriate for this to be done at such a young age.
16. In April 2013 mother disclosed to her Health Visitor the historical sexual abuse by her father and stepfather, and that her mother had not been able to protect her due to her alcohol use. This had already been identified as part of the Social Care assessment and was part of the life history available from the London Borough. Mother had only occasional contact with her family, and her siblings were Looked after Children. This information reinforced the picture that mother had little positive experience of parenthood and was likely to need considerable support to flourish as a new mother.
17. Mother’s family were not allowed unsupervised contact with Kyle. Mother also reported that she has mild learning difficulties and dyslexia. It was highlighted that mother could be easily manipulated and could present as though all is well when this was not the case, and that as a result of previous experience she had difficulty trusting agencies and professionals and could be extremely secretive. The assessments also recorded that both mother and father might have learning needs, and that their cognitive ages were not in line with their chronological ages. Both parents had experienced challenges and a lack of stable parenting in their own childhoods and had mixed experience of how to provide this for their own child.
18. The psychological report had suggested that both parents needed ongoing counselling/therapy due to childhood trauma and father’s lack of insight into his misuse of alcohol and anger leading to domestic violence. There was concern about unresolved issues within the parent’s relationship that could lead to further domestic violence. An incident was recorded when father hit mother in the back of the head in September 2013. He had previously thrown a bicycle at her when she was pregnant in 2011 and was reported to have assaulted his mother.
19. In May 2013, Core Group meeting notes record that the parents were due to see their GP to arrange couples counselling regarding domestic abuse. It also appears that mother was seeking independent counselling support through her GP. Mother was

recorded then as planning to start a childcare course at college in the autumn, and that father would be the main carer for Kyle, although by August 2013 both were expecting to start courses and would be sharing care responsibilities. Social Care records report in August that mother had had a termination in July 2013 - she reported that she did not feel that she could cope with two children. In fact, it was the father who started at college and mother was then left with the primary caring responsibilities. Several professionals observed that father was much less engaged with Kyle and prioritised his own needs and wishes.

20. A Social Care assessment completed by July 2014, prior to the discharge of the Supervision Order in September, summarised both strengths and weaknesses in the parents' capacity to keep Kyle safe and recommended further support with a number of services, and with practical help and financial assistance in terms of accessing nursery and swimming for Kyle. The recommended outcome was to continue to provide support to Kyle as a Child in Need under section 17 of the Children Act which continued after the end of the Supervision Order in September 2014.
21. A Child in Need planning meeting took place in October 2014 which identified the need for continuing support to build parenting skills and to improve home conditions and avoid hazards in the home for Kyle. Regular visits by the Family Support Worker continued through 2015. However, there do not appear to have been any other multi-agency meetings to support or to share information with and about the family during this period. A planned meeting in March 2015 was cancelled as Kyle was unwell. Mother reported to the Health Visitor in May 2014 that Kyle was seen being rough with the kitten and pulling its tail. Pet safety with young children was discussed.
22. In September 2014 Kyle had started attending nursery, and there were concerns noted by the Health Visitor during this period. In August 2014 the Health Visitor was concerned about poor conditions in the home, and about a bump to Kyle's head. Later that month the Health Visitor again recorded poor conditions and hygiene at home, with food on the floor. The Health Visitor was also concerned after observing Kyle being rough with pets. Although there was little evidence to confirm that Kyle was aggressive towards the pets this became a background assumption which reinforced professional concerns about his disruptive or aggressive behaviour. In September 2014 there were concerns about the supervision of Kyle, who was observed to have scratches, although home conditions were noted to have improved toward the end of the month. The nursery was concerned about Kyle's behaviour, including swearing and use of age-inappropriate language and a lack of boundaries. In a discussion in September 2014 the social workers raised with the Health Visitor concerns about the state of the home and that kittens and a hamster had died. There continued to be a range of issues. It is also clear that mother felt that the involvement of professionals was an intrusion and she was not always willing to accept offered help and guidance.
23. During the early part of 2015 mother attended a parenting course, although she experienced some challenges in what she chose to disclose to the course members about her own history.

24. In May 2015 the case was agreed to be closed to Children's Social Care and stepped down to Early Offer of Help. There were not seen to be risks of immediate significant harm, although there were a number of factors which suggested that continuing support was important to ensure Kyle's positive development and to support both parents. Mother stated at the time that she felt she had been given her child back when the Social Care case was closed. There is little recording of what Kyle's own feelings might have been or to assess the need for safeguards from Kyle's point of view.
25. Kyle was recorded in the multi-agency meetings as a boisterous, accident-prone child, who had been slow in language development, and who could be aggressive towards other children. This may have minimised the professional concerns regarding the repeated examples of minor injuries that Kyle experienced which were not individually concerning, but perhaps indicated a lack of care and attention in the supervision Kyle received from parents. Where these were observed by different professionals there was not a cumulative picture of the frequency or seriousness of these incidents. For example, in March 2014 Kyle was observed by the Health Visitor on a home visit to have a bruise and lacerations. These were mapped on forehead and bridge of nose. Mother told the Health Visitor that no medical treatment was needed and that these were the result of a fall. 12 days later Kyle was seen at the GP practice. It may be that the injuries had healed, but there was no observation recorded of these injuries. The GP was not aware of the observations by the Health Visitor.
26. There were several occasions when Kyle was not brought to appointments, or presented sometime after an illness or injury, suggesting that parents were not consistently prioritising the child's welfare. Again, this was noted by each separate agency, but the cumulative picture was not apparent. There are indications that mother was finding it difficult to manage Kyle's behaviour, to create consistent boundaries or to recognise Kyle's developmental needs.
27. At the time of the change in May 2015 from Social Care supervision as a Child in Need to an Early Offer of Help with a Team Around the Child, there were still a range of concerns identified. Although a number of factors were captured in the social work report that recommended closure to direct social work involvement and a step down to early help, and the supervision discussions which endorsed this decision, it could be challenged whether there was sufficient evaluation of the perspectives of all the professionals working with the family. Concerns had persisted for a considerable period and had not significantly changed. The Early Offer of Help involvement did not carry the same level of oversight as being assessed as a Child in Need although both fell within the support defined under section 17 of the Children Act, and Early Offer of Help was dependent on the consent and co-operation of the parents - and their engagement varied and had already been identified as one of the risks to providing consistent and stable care for Kyle. There are also instances when parents' reporting on Kyle differed from the observations of professionals. For example, at the meeting in May 2015 the Health Visitor identified that although Kyle was generally doing well, there were still concerns about speech and language development. Mother said that at home Kyle did not stop talking and that the Social Worker had observed this – this



was not corroborated by the Social Worker. However, at the same meeting the nursery reported that Kyle was doing well overall and that language skills were developing. It is not clear how this difference of views was resolved into an agreed plan or how the different perspectives and observations were balanced.

28. Although the nursery reported at the Team Around the Child meeting in late May 2015 six occasions when Kyle was observed with bruising this was not seen as evidence of intentional harm. Mother had provided explanations, but it is of concern that there were a series of injuries within a short period. It is not clear that any of these injuries required or received any medical treatment; there is no record of GP attendance for them although Kyle was taken to the GP for mumps (for which Kyle attended hospital to have a lump drained), a ring worm rash and coughs and colds during the same period. At least two of the injuries were to Kyle's ear – such injuries can be indicative of non-accidental injury and there was no referral to consider whether this might require further investigation. Both were attributed to being hit by a gate when playing in the garden. There is no detail on how Kyle was being supervised on these occasions.
29. At the Team Around the Child meeting at the end of May 2015 mother shared that she and father were “on a break” and had split up. She hoped that they could sort things out but at present father was staying with his parents and had Kyle with him for some periods. Mother was obviously affected by this and professionals were concerned about how this might affect her capacity to parent – she had struggled to manage household tasks and childcare when father had started college and had not been available to support her. She was encouraged to restart the counselling support – although it is unclear whether she did so immediately.
30. The transfer from Social Care to Early Offer of Help in May 2015 was a significant point of change. It also marked the end of the involvement from the Leaving Care Personal Advisor from the London Borough.
31. However, there were regular Team Around the Child meetings held through the following months (from May 2015 to February 2016) and these involved those professionals who were working with the family. It is not clear what sharing of information there was with the GP practice.
32. This (May 2015) was clearly a point when parents were under some stress and there were concerns about the care Kyle was receiving. Mother was now also pregnant again. While it was appropriate to move to an Early Offer of Help in line with Thurrock threshold guidance for families at Tier 2 of need, as there were no explicit signs of significant harm or risk, there was still a complicated set of factors affecting Kyle's welfare which certainly warranted the offer of early help support. The prospect of a new arrival should have increased the oversight rather than reduced it.
33. At the next Team Around the Child meeting in June 2015 there remained a number of concerns. Mother and father were back together, but it appeared that he was providing limited support for mother and did not get involved regularly with Kyle's care. The worker from Coram who was supporting mother was concerned that Kyle

was very heavy handed and could be aggressive. She was concerned that Kyle could cause harm to the new baby and would require constant supervision. The nursery confirmed that Kyle could unintentionally hurt other children and seemed to have no understanding that this was doing something wrong. The Health Visitor shared that she was concerned about the way Kyle had treated the kittens previously owned by the family.

34. The issue of whether Kyle did or did not show rough or harming behaviour towards the pets is not documented clearly in case records but appears to have been a concern that was shared by professionals and was seen as an example of the risks Kyle presented. It is an example of a narrative or explanation that became current in the management of the case, but which was not clearly evidenced or tested.
35. A range of concerns were noted again at the July 2015 Team Around the Child meeting. For the third meeting in a row father did not attend (he did not attend any of the six Team Around the Child meetings between May and December 2015), and professionals were unsure how much support he was providing. These concerns, and particularly father's lack of engagement or support for mother, continued through the remainder of the year. Mother appeared to be struggling with Kyle's behaviour and her engagement with services was becoming more sporadic. She was not attending the Speech and Language Therapy session despite several reminders and had declined support from Parents First and did not feel she needed further counselling support.
36. Although she was excited about her pregnancy and seeking to involve Kyle in anticipation of the birth of the baby, it was feared that this could be a source of stress for Kyle and that she was losing sight of Kyle's needs. The nursery reported that Kyle was unsettled recently. This would not be surprising for a young child with a new sibling about to arrive, but it is not clear what proactive steps were taken to help manage Kyle's behaviour, or to support mother with this.
37. Mother's pregnancy was referred appropriately to the Maternity Safeguarding Team when she completed her antenatal booking in June 2015. Following up on their previous concerns from her first pregnancy, the Maternity Safeguarding Team were aware that there was a Team Around the Child process in place. The emphasis of the communication between the teams that is recorded is on the vulnerabilities of the parents and especially father's inability to recognise risk. It is not clear that the continuing issues affecting Kyle's lived experience and the issues of behaviour were noted as prominently as the issues around parenting capacity, which were felt to have improved. It was noted that mother had stopped taking her antidepressant medication when she became pregnant (in consultation with her GP), and that she was feeling well but with occasional low moods. She was advised to seek help from the GP if she felt it was needed.
38. Mother consistently attended her antenatal appointments and there were no concerns about her pregnancy itself. There was continuing liaison between the Early Offer of Help team and Maternity Safeguarding Team who still had concerns about home conditions, supervision and the prospects for Kyle and the unborn baby.

39. The September and November Team Around the Child meetings covered similar ground – with intermittent engagement with services from mother, a lack of involvement by father and continuing issues for Kyle in terms of behaviour and roughness with younger children, speech and language development, and a lack of routine. Kyle had been discharged from Speech and Language Therapy as parents had not taken Kyle to appointments. It is not clear that the failure to bring Kyle to appointments was escalated or referred back to other professionals working with the family. Some improvements were noted by nursery and from home visits, but the concerns outweighed the positives. Reviewing the records of the Team Around the Child meetings it is of note that positives are often recorded in general terms (“doing well.... things are better”) and that specific instances are given of what is not working well. It is not always clear how the multi-agency group shared and reconciled this mix of evidence to form a clear statement of risks and what was needed to address them. The application of the Signs of Safety approach, now in use in Thurrock, should encourage this clarity of thinking and recording which is less evident at the time of this case. Explicit danger statements and definite plans to deal with these risks would have been much clearer for both the family and professionals.
40. At the end of the Team Around the Child meeting on 4<sup>th</sup> November 2015, Paternal Grandmother informed professionals of an incident that had occurred at her address the previous weekend to which police had been called. At a Hallowe’en Party Paternal Grandmother’s ex-partner had attended, had become aggressive and assaulted father, Paternal Grandmother, her husband, and also mother – punching her in the stomach. Father had also been injured and attended A&E the following day for an injury to his little finger. Mother attended for a scan on 6<sup>th</sup> November and there were no concerns about the wellbeing of the unborn child. There was concern that the couple were putting both Kyle and the unborn baby at risk by their contact with the perpetrator of the assault, and that they had not informed professionals of the incident in a timely manner. Nursery had not been told when Kyle attended on the Monday following, and checks with the police showed that it was ambulance services that called police, not family members. It is not clear that Kyle’s whereabouts and wellbeing were checked as a result of this incident.
41. In summary, at the November 2015 Team Around the Child meeting it was noted that parents had not taken steps to safeguard Kyle and unborn baby, despite known concerns about Paternal Grandmother’s ex-partner; that they were beginning to disengage with services (e.g. Parents First had been declined, Speech and Language Therapy had discharged Kyle due to non-attendance and father was unwilling to work with Coram) and that Kyle’s behaviour and the lack of routine were still of concern. The emphasis of professional concerns was on the extent of parental compliance rather than of the on-going risks, problematic development and safety of the children.
42. At the December 2015 Team Around the Child meeting there were some improvements in attendance at services and home conditions were reported as improved. However, Kyle had been observed by the Children’s Centre worker on a home visit being rough with the new pet kitten and throwing a sharp knife. Mother was urged by all professionals to engage with the outreach support offered by the

Children's Centre and to accept support from Parents First once the new baby was born. Kyle had been absent from nursery with chicken pox, although mother had kept Kyle off longer than advised so that more sessions were missed than necessary.

43. The Early Offer of Help manager advised professionals and the family at the December Team Around the Child meeting that she was planning to close the case to Early Offer of Help – stating that while there were still concerns these were not at a level to justify a re-referral to Social Care at this time. The Early Offer of Help could only be kept open with parental consent. Father had been very reluctant to accept any support through Early Offer of Help involvement and mother's engagement with services had deteriorated over the previous two-three months. Alternative strategies for sustaining parental engagement were not explored and overtook the continuing concerns for the children. Universal services (Health Visitor and Children's Centre) would remain in place and did not require Early Offer of Help involvement. Professionals were concerned that the situation could deteriorate once the new baby was born. Although mother was reluctant Paternal Grandmother suggested that there was no harm in another meeting once the baby had arrived. Mother agreed that the case could be kept open and that another Team Around the Child would take place in February 2016. This was a positive step and should have been used as the basis for exploring how better engagement with parents could be sustained.
44. The Maternity Safeguarding Team prepared a detailed plan for the birth of the new baby which appropriately recognised the previous history. A pre-birth assessment by Social Care does not appear to have been considered as necessary to reassess the risks and issues facing this family with the arrival of a new baby and when previous concerns persisted. There is no record of a request for a pre-birth assessment to be undertaken. This was a missed opportunity both for Social Care to respond to the concerns expressed by other agencies, and for a formal request to be made to Social Care. No one took responsibility for ensuring action or escalation despite the level of concerns.
45. Mother continued to attend her antenatal appointments and Sam was born at home in January 2016 and then admitted to hospital by ambulance. After checks mother and baby Sam were discharged home. No concerns were highlighted in hospital and interaction between mother, baby and Kyle were noted as good while they were in maternity care.
46. At the February 2016 Team Around the Child meeting both mother and father attended, and progress was reviewed. Kyle had had an accident a couple of days before with cuts to the forehead from glass shelves. Mother gave different versions to workers of how this had occurred which were not picked up as an issue for clarification or further probing. This accident was another example of mother not taking sufficient care to remove or avoid risks. There was positive feedback at the Team Around the Child meeting from nursery and the outreach worker from the Children's Centre about mother's handling of the children, but concerns remained that parenting was reactive. Kyle continued to have a lot of time off nursery, as had been the case in the previous year. It was felt that the frequent absences could be

due to the parents struggling to organise themselves and get Kyle ready for nursery on time. This made it difficult to establish regular routines for Kyle.

47. Although concerns remained, the parents made it clear that they did not want or felt they needed further support and the case was closed to Early Offer of Help. All professionals at the meeting (midwife, nursery, Parental Outreach Worker; Health Visitor gave apologies) were content for this to happen and did not offer any professional challenge to this decision despite the fact that concerns were still current. This was despite a continuing range of incidents and concerns over the previous few months about Kyle's behaviour and wellbeing and parents' capacity to keep Kyle safe – and the arrival of a new baby which added new strains on the family. Mother stated that she felt she was establishing a routine with Sam, but that Kyle was disruptive. All these factors challenge, in hindsight, whether the decision to close the case was appropriate. Without parental consent to continue with the Early Offer of Help, this presented a dilemma, but a more risk-aware decision would have been to try to maintain involvement, as the substance of the concerns and risks had not changed, or to refer for Social Care assessment in order to establish a refreshed and comprehensive picture of the strengths and challenges facing this family. The advice of Parental Grandmother not to close the case in December, but to see how things were, once Sam had been born, could have been built upon as a means of sustaining continued active support. There may have been a level of compliance from other agencies with the view from Early Offer of Help that the case had to be closed because parental engagement was failing – rather than a championing of the safety of the children where risks continued to be evident and an attempt to rebuild an effective working relationship with parents.
48. Kyle attended the GP practice for treatment for infections and for immunisations in March and April 2016. In September 2016 Kyle was brought in with a history of behaviour problems, being destructive and in October a request was made for a referral to a Community Paediatrician for a possible diagnosis of ADHD. Father was reported to have ADHD and mother told the review Author that she felt this might be a reason for Kyle's behaviour and her difficulties in managing Kyle. She felt that securing a diagnosis might help explain Kyle's behaviour and help manage Kyle better. It is not clear what action was taken about this by the GP other than to refer her back to the Health Visitor. The GP did not initiate contact at this point with the other agencies who had been working with the family. Mother attended again in May and July 2017 stating that Kyle had ADHD and requesting a referral. She reported that there had been previous referrals and that she could not cope with Kyle's behaviour. Despite the decision to close the Early Offer of Help in February the same issues were persisting, and mother continued to find these difficult to deal with.
49. At several appointments from September 2016 into 2017 mother raised concerns with the Health Visitor that they were having difficulty managing Kyle's behaviour and questioning whether Kyle had ADHD like their father and uncle. Several referrals were made to paediatrics but were not accepted as Kyle was too young for a diagnosis to be given. The nursery nurse observed at a home visit in December 2016 that Kyle's interaction was loud and rough. Much of Kyle's behaviour was seen to be aggressive

and destructive, consistently reported as frequently and repeatedly swearing and using inappropriate language. This was an issue both at nursery and school. There should have been more acknowledgment that Kyle must have copied or learnt this behaviour from somewhere and that this therefore raised questions about parenting and environment.

50. Given Kyle's behaviour and lack of boundaries had been a feature of professional concerns for some time and given the amount of work that had been undertaken or attempted with the family around these issues, the consideration of ADHD should have been identified as an issue that was not resolved and should have been escalated sooner. This was a missed opportunity to escalate concerns by the GP and to ask other professionals about help for this family, even if a possible ADHD diagnosis was not itself a sufficient justification for a community paediatric referral. However, the GP was not aware of the extended history of concerns and the persistent risks that had been evident over the previous five years. Sam was also seen by the GP for oral thrush, which was treated, but a possible common factor of poor hygiene at home and a lack of sterilisation of bottles was not picked up, although the Health Visitor urged care in preparing feeds and gave appropriate advice.
51. In October 2016 Kyle was injured in a road traffic accident when running out alone into the path of a car. Kyle was taken to, and seen at A&E, and minor injuries were recorded and treated. However, this indicates a further occasion when Kyle's safety was compromised by a lack of supervision at home.
52. In May 2017 the Health Visitor was still concerned about the unsanitary home conditions. Multiple bags of rubbish were seen in the home, and Sam was able to access and eat dirt from the floor. Mother did not try to stop Sam until the Health Visitor pointed this out. Mother acknowledged that she needed help in managing Kyle's behaviour. There was a strong smell of cat faeces and a full litter tray and spilled food and ground-in dirt on the carpet and table. A Common Assessment Framework referral was made by the Health Visitor to Children's Services through the Prevention and Support Service<sup>1</sup>.
53. Already significant work had been attempted with parents around managing behaviour and advice about the home environment, but none of this seems to have been consistently effective. In June 2017 the Health Visitor observed during a home visit that Kyle continued to be aggressive towards both parents and sibling. During the visit Kyle threw a guinea pig to the Health Visitor, telling her to hold it – this behaviour was not challenged by parents.
54. At this point (May 2017) the case was opened to the Prevention and Support Service which had replaced the Early Offer of Help arrangements. A Prevention and Support

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<sup>1</sup> Prevention and Support Services provide integrated support to children, young people and their families. The key objective of the service is to offer advice, support and direct work to families to prevent issues escalating and requiring statutory intervention. The Prevention and Support Service considers all referrals which fall within Level 2 of this Threshold Document. At the time referrals could be made direct to the Prevention and Support Services or via the Multi-Agency Safeguarding Hub.

Manager visited the family following the Common Assessment Framework referral from Health Visitor to arrange a Team Around the Family meeting. Team Around the Family meetings were recorded in July, August, October and November 2017. The Health Visitor, who was named as the Lead Professional, was not able to attend until the October meeting. Her early engagement and contribution to the meetings in person would have been an opportunity to collate the information and assessments from different professionals and her earlier work with the family. There is a mismatch between the Prevention and Support Service recording (which identifies the Health Visitor as the named Lead Professional) and the actual roles undertaken. The Health Visitor continued to visit and raise concerns, but the lead role does not appear in practice to have meant more than a box completed on the Prevention and Support Service records.

55. During this time both school (in preparation for Kyle's start in September) and the Health Visitor were concerned that the Prevention and Support Service work was not effective and that the current plan for support was not working. A Parental Outreach Worker, based at the Children's Centre, was allocated to work with the parents and undertook a number of home visits and also saw the family at the Children's Centre, but the outcomes from her work appear limited. The records of the Team Around the Family meetings do not suggest close and regular collaboration between the Prevention and Support Service on one hand and the Health Visitor, nursery and school who all remained concerned about progress. In September the Health Visitor suggested escalating for more intensive input as parents were not meeting the necessary actions to ensure Kyle's needs were being met. The Health Visitor discussed this with the Prevention and Support Service Team Manager and was told that it did not meet the need for escalation as the family were engaging. This was an optimistic view, not borne out by the persistent and recurring concerns that professionals were observing. It may reflect a degree of professional deference toward children's services, which because of the statutory responsibilities of social work functions, were felt to carry extra weight even when the family was been supported outside the social care arena. The Health Visitor might have raised this in supervision or sought the support of the designated safeguarding team in health in order to challenge the Prevention and Support Service response.
56. The Health Visitor was significantly concerned by the on-going issues. In the notes of the October 2017 Team Around the Family meeting, following her own home visit the previous month, she records

"...I am of the view that this case needs to be escalated as I do not feel that the family are achieving the actions set out.,,,Kyle's behaviour appears to be consistently poor in the school environment with frequent soiling incidents. Mother has informed me that Kyle is progressing well with toilet training at home however this does not appear to be the case at school....I am concerned that Kyle's voice in not being heard and parents are telling professionals that improvement are happening, however on observation this is not the case."

57. In October the Health Visitor and school again requested escalation to the Children and Families Assessment Team, but the Prevention and Support worker wanted to complete eight sessions with a Family Support Worker with the family first. These sessions were not undertaken, and this merely delayed any serious engagement with the family. It is not clear what purpose these visits would have served when the Parental Outreach Worker from the Children's Centre had already been trying to work with the family during the previous months. Both the school and Health Visitor could have made a direct referral to Children's Social Care, which they did not do, choosing to work through the Prevention and Support Service team.
58. School and health continued to be concerned about home conditions, Kyle's behaviour, a lack of adequate school clothing that fitted, and the possible risks for Sam. The Health Visitor emailed children's services with a significant list of concerns following a home visit on 21<sup>st</sup> November 2017. The home was in an unsanitary and dangerous condition, Kyle was sleeping on a dirty floor (had previously been sleeping on a sofa). There was supposed to be twice weekly contact with the family from a Family Support Worker, but the parents reported that this was not happening, and the Prevention and Support Service have subsequently confirmed that these visits did not take place. The Health Visitor did then make a referral into the Multi-Agency Safeguarding Hub. It was her professional opinion that these children were at risk of significant harm due to unsanitary home conditions which were detrimental to their health and development.
59. The Prevention and Support Service undertook a home visit on 24<sup>th</sup> November 2017 to verify the information provided by the Health Visitor and to explain to the family that the case was now to be considered for escalation to Children's Social Care. The observations on this visit corroborated the concerns and conditions previously reported by the Health Visitor and as a result the case was referred for a Children and Families social care assessment and a Social Worker allocated. The Prevention and Support Service referral noted that they had been involved for six months but gives no detail of the work undertaken, commenting that the situation had deteriorated rather than improved
60. On the same day an anonymous call was taken by the Prevention and Support Service Manager which reported that about a month ago Sam had been pushed out of the buggy by Kyle, hitting Sam's head and causing a large ("golf ball sized") bump. Mother had reportedly explained that she had not taken Sam to hospital but cut the baby's fringe to disguise the injury. The caller also said that the living conditions were disgusting and filthy.
61. The Social Worker was not able to make contact with the family and therefore did not make a home visit until 8<sup>th</sup> December 2017. The Health Visitor was proactive in seeking to contact the Social Worker to provide an update and communicate her and the school's concerns.
62. At this time Kyle was treated for an infection. Mother misunderstood the description and details of this, and shared inappropriate details and photos of Kyle with other



parents at the school. She did not always seem to know where the boundaries about confidentiality should be.

63. At the initial assessment visit by the Social Worker on 8<sup>th</sup> December 2017 it was noted that the family had made some attempts to clear up. The Social Worker observed Sam, but Kyle was in school. The assessment states that both parents wanted to work with professionals but there is no reference to the sporadic history of engagement and support demonstrated over the previous involvement with both Kyle and Sam.
64. Following this visit the social work plan was to hold a professionals meeting at the school, to progress a Children and Families Plan and to see Kyle in school. There was no further contact over the Christmas holiday period and a meeting was arranged for 8<sup>th</sup> January 2018 at the school. Mother agreed to attend with Father and Paternal Grandmother.
65. On 6<sup>th</sup> January 2018 Sam was found dead in bed and was taken by ambulance to hospital. The family were appropriately cared for at the hospital.
66. Post-mortem investigations did not establish a cause of death, which was recorded as unascertained at inquest. There was no presumption of non-accidental injury or harm. The police took no further action in relation to Sam's death.
67. Following a strategy discussion and the sharing of information from those working with the family an Initial Child Protection Conference was held on 26<sup>th</sup> January 2018 and Kyle was placed on a Child Protection Plan under the category of neglect. Kyle has subsequently been placed on a Full Care Order in foster care.

### **Key Lines of Enquiry**

68. **Family had multiple contacts with a range of agencies - what can be learnt about how well these were coordinated? Did thresholds/categories and allocation to different teams inhibit responses?**
69. The family was supported at different times by a range of individual practitioners and under different legal and service frameworks. Both mother and father were understood to have a degree of learning difficulties, and it is not clear how well these different arrangements, and their different requirements and expectations, were explained to the family.
70. Kyle was variously a Child in Need, under an Interim Care Order, a Supervision Order, and supported with an Early Offer of Help which involved several different agencies supporting Kyle and mother. Kyle was provided with a nursery place through the Troubled Families scheme, supported by the Prevention and Support Services, and then referred for a further social care assessment of the family. Mother was offered at least four different services to help with practical parenting, her depression and confidence, and counselling support. Father was offered similar help as a parent and

also help with his anger management and substance misuse. The engagement with these services was patchy – and it is difficult to assess what overall benefits were provided. The family also accessed universal services (GP, health visiting, A&E, maternity and school and nursery). There are few indications that the behaviour of parents and their capacity to provide consistent and safe supervision changed significantly during the period in which they were offered and took up services. Some positive changes were noted, but these were rarely sustained, and the same issues came up again within a few months. As each different worker came into contact with the family it seems that they were optimistic and hopeful for a positive change – and did not exercise sufficient professional skepticism as to whether the lives of initially Kyle, and then both children, would be demonstrably improved. Families function differently at different times, and this case shows both better periods as well as periods of greater concern. This volatility should itself have been an issue to be addressed, to help the parents through more difficult times and to build consistency and routine into the lives of the children. If there was not improvement in the overall situation of the children, and a reduction of the risks of harm or neglect to which they might be subject, then should earlier escalation have been considered? It is not clear that the situation at the end of the Supervision Order in September 2014 was significantly improved from when the concerns had prompted the Interim Care Order when Kyle was born in October 2012. Similarly, there is little evidence of significant change for the children during 2016-17 and when the Prevention and Support Services replaced the earlier Early Offer of Help.

71. Sam was never formally subject to an assessment or care framework, except for the period when the Prevention and Support Service was offering support to the family and in the very few weeks before Sam's unexpected death. However, the risks from the parents' chaotic parenting, and the possibility of Kyle presenting risks through his rough behavior were significant. Sam lived for very nearly two years in a household where there were continued challenges, periods of intervention and support and inconsistent engagement and involvement from the parents. Kyle was observed both to be affectionate and caring, but also rough and violent towards other younger children, and to be verbally aggressive. There should have been consideration as to whether Kyle's behaviour presented any risk to a baby sibling.
72. Although Kyle and then Sam were very young, and were not able to express their own views, the various interventions and assessments do not provide a clear sense of how they might be experiencing life. The education staff at nursery and school and the Health Visitor did make attempts to understand the voice of the children – the school shared with the Health Visitor a log of Kyle's behaviour between September and November 2017 to seek to get a view of his life. The Health Visitor also urged the completion of Graded Care Profile 2 assessment. Although training and rollout of this tool was at an early stage at this time, it would have been possible for the Health Visitor to initiate this assessment herself. It is only with the final plan for an assessment in December 2017 that the Social Worker is asked to undertake any wishes and feelings work, in line with the newly introduced Signs of Safety approach.

73. It is probable that this variety was confusing for the family and failed to provide the consistent and persistent framework for assessing and supporting their needs and delivering wider support for the family. Mother felt that Social Care involvement was a threat to her parenting – the subsequent decision to take Kyle into care has only reinforced her feelings that she risked losing care of her child. This explains her reluctance to engage more positively and consistently with the help offered from children’s services. At times the emphasis was on support for the parents – at other times on the children. There is no evidence that this in itself inhibited or restricted the services offered, but it did mean that the opportunities and mechanisms for good multi-agency working changed.
74. For two critical periods – from the final months of the Supervision Order in September 2014 through to May 2015 – and from the closure of Early Offer of Help in February 2016 through to at least May and possibly September 2017 - there was little coordinated oversight of how well this family was doing, what help they might be offered, and what their engagement or lack of it, meant for the risks to the children. When Health Visitor and educational staff began to raise concerns in 2017 it took a total of six months before these were comprehensively assessed, with the eventual conclusion that Social Care intervention was appropriate.
75. As noted above a variety of threshold were applied to the family over a period of nearly seven years. Some were formal categories of care – reflecting a high level of concern about the children’s welfare and their parent’s capacity and resilience, while others were less formal and depended on the consent, engagement and co-operation of the parents. When managed under Early Offer of Help and the Prevention and Support Service arrangements these services maintained that the issues did not warrant intervention by Social Care at Tier 3 or 4, as set out in the Thurrock Threshold guide, while nursery, school and health visiting felt that the impact on the children was significant and concerning. The Early Offer of Help period worked more effectively, but the referral to the Prevention and Support Service failed to identify and collate the concerns or recognise the severity of the risks faced for both Kyle and Sam. This referral was made directly into the Prevention and Support Service– the system now requires all referrals to go via the Multi-Agency Safeguarding Hub, which would provide a better opportunity to ensure that all previous history was identified and were available to inform work with the family. As noted above there was a degree of deference to the Local Authority services because of the formal responsibilities of Children’s Social Care – this “rubbed off” into the way that universal services handled their relationships with other parts of the children’s services function.
76. From May 2017 until the referral to children’s social care in November 2017 there was a reliance on the Prevention and Support Service programme that was over-optimistic about progress. It was a missed opportunity to rely on this programme when there was little evidence that it was delivering any change or establishing any relationship with the parents or children.
- 77. Examine the sharing and use of information – who knew what when?**

78. There are a number of instances when information was not shared or was available between agencies and professionals working with the family. There was little linkage between the GPs and health visiting or other agencies, so GP when they saw mother and children, were not fully aware of the history of concerns, or of the vulnerability of mother. It is only through collating the information provided for this review that the various strands of contact with services becomes clear. The GPs had little context (of home conditions, concerns from agencies, periods of statutory oversight) in which to assess the presenting issues they saw in surgery.
79. During 2014, 2015 and 2016 the council's housing service records that the parents were having repeated problems both clearing rent arrears and making regular payments. There were several attempts to set up repayment plans which were not adhered to. There is no mention of any financial difficulties in the records of other agencies working with the family – although it is likely that this was another factor in the pressure under which the family was living and could be expected to have a bearing on their parenting capacity and wellbeing.
80. When the Prevention and Support Service programme set up the Team Around the Family meetings from May 2017 the Health Visitor was named as the Lead Professional. This was appropriate given the existing relationship and work that the Health Visitor had undertaken. However, the Health Visitor was not able to attend any of the multi-agency meetings until October, which compromised her in fulfilling the Lead Professional role effectively. Both the Health Visitor, the nursery and school were left anticipating a positive outcome from the Prevention and Support Service work, which did not materialise. They raised concerns during this time but could have made a direct referral to Social Care. It appears that the Prevention and Support Service programme was perceived as the gatekeeper to further escalation which mitigated against a robust evaluation of the concerns.
81. **What were the barriers/inhibitions for practitioners in dealing with neglect? Examine whether previous tools, training and recommendations for dealing with neglect have been effective, and if not, why?**
82. Neglect is the on-going failure to meet a child's basic needs, and it is the most common form of child abuse. There are broadly considered to be four types of neglect. *Physical neglect* - where a child's basic needs for food, clothing and a safe home environment are not met or where they are not properly supervised and kept safe. *Educational neglect* – where a parent does not ensure that their child receives an education. *Emotional neglect* - where the child does not get the nurture and stimulation they need, and *medical neglect* - where a child is not given proper health care. Neglect can be very difficult to identify but it is widely recognised that the cumulative effect of these signs can cause serious problems, both at the time and as adverse childhood experiences which may have lasting impact.
83. Research studies conducted over the past decades involving maltreating families confirms that the vast majority of parents who are neglectful lack competence in their

role because of inadequate availability of resources, poor preparation and support in their role as parents, and impairment in coping due to overwhelming sources of stress present in the family and community. All these factors applied to mother and father.

84. Practitioners need to be supported by a system that allows them to make good relationships with children and parents and supports them in managing the risks of harm that stem from maltreatment. This includes both the harm from neglect and the way that neglect can conceal other risks and dangers.
85. There is a need to improve practitioners' understanding of the prevalence of neglect, to improve the identification of this, and to optimise responses to the problem. Neglect has been a feature of previous Serious Case Reviews conducted by the Safeguarding Partnership in Thurrock, and there has been training and workshops on the topic. It is not clear why this knowledge has not been applied more consistently.
86. Ensuring that practitioners and their managers have access to high-quality, specialist training on the recognition and management of neglect could be an important means to move towards better responses. Part of this could focus on appreciation of the definition of child neglect and, most importantly, the application of this in relation to casework. Completing child neglect assessment using a tool such as the Graded Care Profile 2 could ensure that the Department of Health definition of child neglect is not used in isolation, and such tools could assist with decision-making in difficult circumstances. Thurrock has now adopted this tool but it was not fully implemented during the timescale of this case and training on using the tool was not available to all practitioners. Although the Health Visitor correctly identified that it might help establish a baseline for the concerns about neglect and home conditions, she had not yet been trained to conduct such an assessment. A shared record of what were the concerns around neglect, and more robust tracking of whether there was any substantial improvement would have provided different professionals with a common point of reference and also made it easier to set clear expectations for the family – and also identified those issues with which they might need help – such as rent arrears, damp and maintenance problems, untidiness, clutter and domestic hygiene. Specific and practical objectives were not set clearly in this case, which made it difficult for the parents to improve or for professionals to evaluate progress and assess whether risks were reduced.
87. The description of neglect set out in *Working Together 2015* makes it very clear that action can and should be taken to safeguard and promote the welfare of the child in circumstances where the evidence suggests that serious impairment to the child's health and development is likely. This is important to highlight and reminds professionals that the aim should be to prevent impairment rather than only acting after it has occurred.
88. Neglect is often characterised as acts of 'omission' rather than 'commission', but the distinction is not always that clear cut because neglect and abuse often coexist and acts such as leaving the child in the care of someone unable to look after them

properly can be seen both as commission and omission.

**89. How were concerns escalated - both where there were differences of opinion and where greater expertise and direction was sought?**

90. When working with a family in different situations and setting it is inevitable the different impression and assessment will be made. Open and frequent communication between professionals is essential to ensure that these interpretations are checked out, confirmed or modified, and that a consistent and common plan of advice, care and support is agreed with the family. Even when there were regular multi-agency meetings in this case, it is not always clear that there was a shared and agreed plan – either with the family or with other professionals. Meeting notes record actions and follow-up, but do not reflect clear goals, constraints or consequences if things do not go to plan. This was especially true during 2017. This made it difficult for the family to own and complete the goals for themselves and led to confusion over responsibilities and options for professionals. Setting out a clear care plan – at whatever Tier or level of intervention – which was shared and accepted by all agencies - would have provided a more robust framework for this family and enabled a more consistent judgement to be made as to whether things were improving for Kyle and Sam.

91. Contributions at the Practitioners' Event illustrated that there had been, and remained, differences of view about the severity of the concerns about the family, and a strong sense from other agencies that children's services, and particularly the Prevention and Support Service, had been reluctant to accept the level of possible harm for Kyle and Sam or the need to escalate the case for a Social Care assessment. This may not have been entirely reflective of the true position, but it appeared, in hindsight, to have coloured the expectations that professionals had of each other. This is critical in ensuring there is a joint understanding of who holds risks and at what level. Against the threshold criteria then in place, the view from children's services that this was a Tier 2 case was reasonable – and therefore that statutory social care intervention was not justified. However, for periods, especially when Kyle was very young, a higher level of scrutiny and support **was** considered appropriate (Interim Care Order, Supervision Order and Child in Need) and the fundamental concerns which were apparent in 2012/13 were not different when support was offered as Early Offer of Help or the Prevention and Support Service in 2016 and 2017, and when the family were coping again with a new baby.

92. One of the key learning points from this Review is the continuing need for different agencies and practitioners to keep checking out their understanding of the formal responsibilities of each other – and to keep refreshed their understanding of how this works in practice through the application of thresholds and referral processes. All parties share a responsibility to keep this dialogue open and positive.

**93. What were the arrangements for management oversight - did they support and give**

**confidence to practitioners appropriately?**

94. There is evidence of appropriate supervision and management oversight in the work of the Maternity Safeguarding Team through both of mother's pregnancies. Appropriate professional advice was sought by community midwives on a family which had a range of challenges – and the focus on the wellbeing of both mother and the children was maintained.
95. There is evidence of supervision by managers when the decision to step down from Child in Need to Early Offer of Help was made in May 2014, The management oversight of the Prevention and Support Service programme is less clear – and concerns raised by other professionals do not appear to have been reflected in the direction given during this period.
96. Arrangements for supervision of health visiting cases are not clear, especially as there is a high caseload of universal cases – many of which do not present safeguarding issues.
97. It appears that there was no written policy in 2017 with regard to recording management oversight of the Prevention and Support Service cases. The record keeping shown to the review is patchy and does not always align with information recorded by other agencies in terms of visits, contact with parents, and exchanges of information between professionals.
98. **What does this case tell us about supporting young and vulnerable parents? Were these vulnerabilities recognised?**
99. The vulnerabilities of both mother and father were identified before the birth of Kyle and led to prompt and decisive action by Children's Social Care to intervene and place Kyle under an Interim Care Order. This oversight by statutory agencies was sustained through the subsequent Supervision Order granted for twelve months in September 2013. The Looked after Child review process through to August 2013 ensured that relevant agencies were included in the support and care offered to Kyle. It was recognised that both parents would require considerable assistance if they were to provide consistent and stable parenting for Kyle.
100. It is clear that the engagement of both mother and father varied, and at times both of them resisted the offer of services or chose not to take up services. They had some suspicion of statutory intervention in their lives – understandable given their previous histories. It is less clear that this was recognised as part of the dynamic of working with them, and that professionals adopted strategies which sought to overcome this.
101. Several professionals involved in the case have commented on the lack of services specifically to support young and vulnerable parents. Both mother and father were offered a number of contacts and sessions to address parenting issues, but it is not clear whether these had the necessary expertise to help with their previous trauma

and the difficulties they experienced in implementing consistent parenting practice.

102. In retrospect mother has asked why there was not continuing support for her from Adult Social Care when she left children's services herself. She feels strongly that there could have been more support for her to support her children, if offered with the right encouragement and guidance within the family home.

**103. How did contact with universal services inform assessment and evaluation of risk by more specialist support?**

104. Nursery, school education and health visiting were universal services that kept in touch with this family and were concerned about their welfare and noted the impact of neglect on the children. During the periods when there were regular Looked after Child reviews or Team Around the Child meetings it was easier to co-ordinate the work between universal, targeted and specialist services. When these meetings lapsed, or there were long gaps, this became more difficult and led to frustration between partner agencies. Clear escalation arrangements need both to be in place and to be used to allow concerns to be aired in a timely and professional way, with suitable access to managers across agencies to resolve differences of view. Although there were differences of view about how to work with this family, and on the severity of the concerns, these were not raised formally by universal services through any escalation process, although these processes were in place. As I have commented earlier, this may reflect a level of uncertainty between agencies and professionals about respective remits. This is not unusual, or unique to Thurrock. In the complex world of services for children all parts of the Local Authority Children's Services function are often seen as "Social Care" – just as the diverse services across health are all regarded as "health". Better awareness of the responsibilities and scope of each agency needs to be refreshed.

105. Since autumn 2017 the Local Authority Children's Services have undertaken a review of its services and early support offer, resulting in a refreshed approach through its "Brighter Futures" programme and the development of its Prevention and Support Service, incorporating the Troubled Families programme creating a greater joined up approach to early intervention which also includes NELFT 0-19 Healthy Families Programme, Children's Centres, Disabled Children's Short Break and Outreach Service (formerly the Sunshine Centre) and a range of commissioned services that tackle the root causes of demand i.e. Domestic Abuse, Substance Misuse, Parenting Support and Sexual Violence.

106. Tier 2 needs (early help interventions) are those where there are indications that without the provision of additional services this may escalate, or circumstances deteriorate to the detriment of the children or families concerned. Services provided within Tier 2 are designed so that they can be activated as early as possible, sometimes even where need is predicted rather than presenting. For example, there may be services and interventions that could assist parents where there are known to



be specific vulnerabilities or risk factors. Within Tier 2, participation is now most likely to be on a voluntary basis where parents and children or young people, alongside supportive professionals, have identified a need and are willing and able to access appropriate services. In general children who require early intervention and preventative services are those with 'additional needs'.

107. The role of the Case Manager within the Prevention and Support Service is now to offer advice, guidance and support to professionals working alongside children and their families. They will also provide direct intervention with families, based on their individual specialisms within PASS. The role is pivotal in offering consultation, signposting and allocation of the most appropriate services which will, include multi agency service provision. This role was underdeveloped in 2017 when PASS worked with this family and this led to a lack of clarity in who was leading work and what direct work was intended to take place. Mother has said that more immediate and practical help would have been helpful, which was not provided during the PASS involvement in 2017.
108. The Prevention and Support Service now has social work trained Case Managers who will also intervene and have oversight of those cases that have been stepped down from Children's Social Care or whose needs are subject to safeguarding concerns and require to be stepped up. They also provide initial visits to families where it is unclear whether the case should progress to Statutory Social Care Team.
109. The most recent Ofsted report on the current operation of the Prevention and Support Service indicates that many of the issues that arose for this case have now been addressed.

“Judicious, targeted investment in the newly reconfigured locality-based preventative and support service (PASS) as part of Thurrock's Brighter Futures strategy means that early help is carefully prioritised for the most vulnerable families. The pathway into PASS is clear: a 'team around the family' and well-being model takes a holistic, multi-agency perspective in addressing families' needs. As a result, children and families get the right level of help and protection at the right time, delivered by caring and skilled professionals, and this is making a difference to their day-to-day lives and protecting them from harm. Actions by managers to align performance monitoring, as well as audit programmes with children's social care, are positive developments. “

Ofsted Inspection Report (December 2019)

### **Equality and Diversity**

110. There is no evidence that any of the nine protected characteristics under the Equality Act 2010 were exceptionally relevant to the circumstances of this case or affected access to services or their delivery. The family identified as white British.

## Learning Points

111. The challenges for this family and the concerns articulated by professionals did not significantly change from before Kyle's birth until Sam's death. However, the case was managed over six years in a variety of different ways and without clear overall objectives which connected each separate intervention and linked separate episodes and plans together. This did not make it easy for mother and father to appreciate professionals' concerns or to have a consistent framework within which to develop their parenting skills and confidence. At times the emphasis was on their needs – at others on the children. Both parents loved their children and wanted to care for them well but needed clear encouragement and direction in order to do so safely. Parents were inexperienced and lacked role models for positive parenting, were not able to prioritise consistently the needs of the children, were not able to provide a safe and clean home environment, were inconsistent in their approach, and found it difficult to set appropriate boundaries for the children or on their own behaviour.
112. The parents' experience of positive parenting was limited. They attempted to engage with some of the services and offers of help, but it is not clear that this resulted in sustained improvement in the conditions in which Kyle and then Sam were living. It is not clear that the purpose of different sessions and referrals was made clear – explaining how each was intended to contribute to better and more confident parenting. Monitoring focused on compliance and attendance, rather than whether it had made a difference to the family's lived experience, and how well it was possible to bring all the offered help together into a coherent package of support. Father was often less engaged in parenting or with professionals, while mother was fearful that she might lose care of her children. She has now lost Sam due to an unexplained death, and Kyle to permanent care by the Local Authority, and naturally feels angry and let down.
113. The Maternity Safeguarding Team recognised and were concerned about the trauma of mother's earlier life and her experience of abuse and her life in care and felt that she was a vulnerable mother who needed considerable support. They were not clear why there was not a more proactive intervention from Thurrock Social Care, both in 2012 and when mother was pregnant with Sam. Mother has herself asked why there was not continuing support for her as an adult when she left children's services. The strength of this view was articulated at the Practitioner Event, especially by health, nursery and school staff, and there is learning to be gained from mother's experience of a fragmented response from services about more coherent support for young people leaving care, particularly where this is remote from the placing authority.
114. The overall impression from the recording on this case is of agencies working in silos – raising concerns or asking for a response, rather than developing a shared

understanding of the complexities and challenges of the case and working out a plan together. Thresholds were seen as entry mechanisms to “get into Social Care” rather than as ‘vantage points’ from which concerns could be evaluated and joint plans put in place.

115. Professionals concentrated on their own engagement with parents and their compliance, rather than attempting to place the child at the centre, and assess the situation from Kyle’s perspective or later to assess the situation for Sam. Kyle was a young child who was provided with inconsistent boundaries, whose behaviour could be challenging, who found relationships with other children difficult, and who experienced delays in social and emotional development. There were also concerns about Kyle’s speech and language development. Kyle was also a child who was loved by their parents and could respond to support and guidance to improve their behaviour and keep them safe. When starting school Kyle was frequently soiling and swearing and aggression were problematic. Although these continued to be challenges, Kyle also made progress. There is little sense in the plans recorded of Kyle’s lived experience and what goals and objectives were being encouraged. Kyle was observed to behave differently in different settings – but there was little exploration across agencies of why this might be and how the more positive behaviours could be reinforced and supported.
116. When Sam was expected the opportunity to undertake a pre-birth assessment and establish a comprehensive picture of the family’s needs and wishes was not taken. There was a slow recognition of the complexity and potential significance of the concerns which were being observed by professionals. This might have enabled a more constructive engagement with parents and made more lasting improvements in the lives of Kyle and Sam.
117. There were several critical points at which different decisions could have been made about how to manage this case and to establish a better understanding between professionals and with parents and to explore wider networks of support. In May 2015 the decision to end the section 17 Child in Need involvement of Children’s Social Care was based on the absence of current child protection concerns, but the issues of parenting and neglect were still not resolved. In February 2016 the step down from Early Offer of Help was due to the declining engagement from parents, as the Team Manager was clear that the early offer could only continue with parental consent, but there were not significant changes in the circumstances for Kyle – and Sam was a newly arrived baby. Paternal Grandmother had suggested that the case be kept open from December to await Sam’s birth – which was a sensible and practical move. Although she was seen as a positive support with the children, there was little exploration of whether any other networks of family or friends could be part of a safety plan. The Signs of Safety approach, now adopted in Thurrock, would expect these possibilities to be actively explored. There is a contrast in the record of the Team Around the Child discussions between generalised feedback that was positive, but still specific examples of concerns. I believe there was an understandable desire

from all to hope that things would get better, despite the fact that the same concerns continued to be raised, and that parents struggled to be consistent.

118. Mother has commented in reviewing the final report that there needs to be greater advocacy for children to ensure that their voice is heard and that all are made aware of the impact of plans on their lived, day-to-day experience.
119. From May 2017 the family was supported through the Prevention and Support Service programme. There is a disjuncture between the continuing concerns raised by the Health Visitor and by nursery and school as they prepared for Kyle to attend in September 2017, and the assurance from the Prevention and Support Service programme that things were improving. In the recording there are no firm dates when visits were made (other than by the Health Visitor which are separately recorded). Several of the entries in the notes of the review meetings are repeated for succeeding meetings – making it unclear to what and when they relate. The interventions from a Family Support Worker, which were proposed in the autumn 2017 in the face of repeated requests from the other professionals for a more active engagement, did not take place. It appears that other professionals felt inhibited from escalating the case because the Prevention and Support Service were involved but were equally frustrated by the lack of progress or urgency. When the concerns resulted in a social work referral, visit and assessment in December 2017, the concerns quickly led to a recognition by Children’s Social Care that there were significant issues to be addressed. Sam’s tragic death, from unrelated and unknown causes, was unrelated to the issues that prompted a Child Protection Conference and the decision to take Kyle into care.
120. It was clear from discussions at the Practitioner Event that the level of cooperation and trust between professionals and different agencies had been less than ideal. There were different views about the level of concerns and what was the appropriate way to respond to them. There were differences of opinion around thresholds and on the impact of circumstances on the children. This illustrated that these concerns had not been escalated or resolved at the time. There was some uncertainty about whether all professionals were aware of how to escalate concerns, both within their own organisations or with partner agencies.
121. Since the time period of this case (2012-early 2018) Thurrock has extended two approaches (Signs of Safety, and the Graded Care Profile 2 for assessing the impact of neglect) which, if used more effectively might have provided common ground for assessing concerns and agreeing practical steps to meet needs. However, these were at an early stage of introduction and not all practitioners had yet received training to use these tools. Recent internal reviews and external inspection suggest that both these approaches are now much more firmly embedded.

## **Recommendations**

122. Thurrock Safeguarding Children Partnership should review within the next six months its procedure for the escalation of concerns and for resolving differences of view between professional and agencies. This should especially consider where there are challenges to the thresholds applied to cases which involve a number of agencies, and where there are persistent concerns about either neglect and/or parental engagement.
123. Thurrock Safeguarding Children Partnership should develop a series of practice workshops to be run between agencies to explore and build on better co-operation and understanding of handling complex or persistent cases. Case studies should be used – such as this Review - and the development of joint or group supervision approaches should be explored. This should be viewed as an opportunity to strengthen understanding between services and encourage wider joint working and sharing of relevant information about concerns.
124. Thurrock Safeguarding Children Partnership should, using the principles within the Signs of Safety approach, review interagency procedures for establishing agreement with families of written care plans involving all those working with a child, with shared, clear and practical objectives that can be monitored– especially in persistent cases of poor parenting and neglect.
125. Thurrock Safeguarding Children Partnership should consider auditing the operation of the Prevention and Support Service programme to establish the extent to which the positive evaluation in the 2019 Ofsted report has been sustained and strengthened.
126. Thurrock Safeguarding Children Partnership is recommended to encourage the continued development of the Signs of Safety approach, and the use of the Graded Care Profile 2 for use across agencies and professional groups.

David Ashcroft  
Independent Report Author  
June 2020

## **Appendix 1 Independence of Review Chair and Author**

David Ashcroft was appointed as the Independent Overview Author of this Review in November 2018. He has worked at a senior level in children's services for the past 20 years, including operational responsibility for all aspects of safeguarding and children's social care in a number of local authorities. Mr Ashcroft currently chairs Norfolk Safeguarding Children Board and Safeguarding Partnerships in Sheffield for both Adults and Children and has been the Chair of South Tyneside and Manchester Local Safeguarding Children Boards. He was for three years the national chairman of the Association of Independent Local Safeguarding Children Board Chairs. He is also an independent member of other Improvement and Children's Partnership Boards. He is an accredited C4EO Sector Specialist in child protection, and an associate member of the Association of Directors of Children's Services.

Mr Ashcroft has conducted, as an independent chair and/or overview author and lead reviewer, over twenty Serious Case Reviews, Domestic Homicide Reviews and other inquiry, inspection and investigation assignments. He has undertaken extensive training in review methodologies including the Home Office Domestic Homicide Review training module and has been an expert adviser to several national projects to develop training and improve standards in reviews and report writing. He has no managerial connection with the agencies involved in this case or with the Safeguarding Partnership.

David Peplow was appointed as the Independent Chair of the Serious Case Review. He is an experienced chair and reviewer who has worked with many Safeguarding Partnerships and Boards.

Both Chair and Author are independent of all agencies within Thurrock.

## References and additional reading

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