A Local Child safeguarding Practice Review

‘The siblings’

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Lead Reviewer

Introduction

1.1 This Local Child Safeguarding Practice Review (LCSPR[1]) was commissioned by Bradford Safeguarding Children's Partnership to consider the professional response to the safeguarding and support needs of school age children whose parent have complex and enduring mental health problems including intrusive thoughts about harming their own children and people in the community. The family at the heart of this review are white/British, and one of the children is neuro diverse and communicates non-verbally. No further details are provided about the circumstances leading to the review or the family, including relationships, ages, gender, and dates for reasons of anonymity and privacy.

Process of the Review

1.2 This review has been led by Jane Wiffin, an independent person with no practice links to Bradford. The methodology used was the significant incident learning process (SILP). This process is consistent with the requirements laid out with Working Together 2018[i] for the conduct of an LCSPR.

1.3 The review process was overseen by a panel of senior managers/safeguarding professionals representing all the agencies who had contact with the siblings and the family. They have acted as critical friend to the independent reviewer, and helped with local knowledge, analysis of data and considering key lines of enquiry which form the questions at the end of this report. The independent reviewer would like to thank them for their hard work, reflections and responses to the many questions asked in seeking to understand the sibling's world.

1.4 Individual agency reports were commissioned, which provided an analysis of the services provided to the siblings and their family and within these there are single agency recommendations.

1.5 The frontline professionals who worked with the siblings were brought together as a group to reflect on the emerging learning and to review the draft report. It is not always easy to review your own practice response to a family, but professionals have done this with openness, intelligence and most of all as a commitment to wanting the best for the siblings and other children in their circumstances. The independent reviewer would like to thank them for their time and help.

Family Involvement

The extended family

[1] A Child Safeguarding Practice Review (previously known as a Serious Case Review (SCR)) is undertaken when a child dies or has been seriously harmed and there is cause for concern as to the way organisations worked together. The purpose of a child safeguarding practice review is for agencies and individuals to learn lessons that improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

1.6 The independent reviewer met with members of the extended family. They wanted professional to know that supporting parents with severe and enduring mental health needs is difficult and they had found the period being considered by this review as stressful. They felt that they were not provided with enough information to understand the parent's mental health needs or what the risks were.

The sibling

1.7 One of the children in this family (the children will be referred to as 'siblings' through the report) met with the independent reviewer at school. This child wanted professionals to know that she loves her family and they have been the main source of support. The child also said that school had been a great help, and continues to be so. Overall, the child said '*It would have made a difference if help had been there right from the start, and then when everything was chaotic and uncertain there had been someone to explain what was happening, provide support and listen. I now have the best Social Worker and that was not the case before. They changed, they did not visit and did not listen to me'. Professionals need to know that you can love your parent, but still feel scared and worried about what is happening. You need someone to say that to'. It was like a weight on my shoulders.*

2. Professional Involvement: The Review covers an eighteen-month period[2].

Early Help and mental health support: a six-month period

2.1 At the beginning of the review period the parent sought advice from their GP about worries regarding their mental health and the impact this was having on looking after the children, one of whom had taken on a young carer's role. The GP submitted a referral to adult mental health who responded immediately; The GP sought permission from the parent to liaise with schools and the extended family; contact was also made with Early Help.

2.2 A month later the parent was admitted to a mental health hospital due to having unwanted and intrusive thoughts about harming adults and own children. The children were being looked after by the extended family. The staff at the mental health unit liaised appropriately with agencies, sought safeguarding advice and it was agreed an 'Early Help[3]' referral would be made to support the family. There should have been consideration by the mental health team and Early Help of a referral to Bradford Children's Social Care (BCSC) because of the possible risk which was unknown.

2.3 An Early Help assessment was completed, and an Early Help practitioner started work to support the family. A Community Mental Health (CMHT) Care Coordinator and a Support Worker were allocated for the parent and a Psychiatrist was overseeing the care and management of their mental health needs; the GP was prescribing medication. Over the time of this review the parent saw mental health professionals regularly. School supported the children through this stressful and uncertain time. During the Early Help assessment[4], the children returned to live with their parent. The schools were unaware of the Early Help involvement. It is not clear why this was the case but meant that the school only knew about what was happening and where the children were living when the sibling spoke to them about it. The sibling reported to the lead reviewer this caused more worry, because it seemed to suggest that there was nothing happening to help the parent.

2.4 Four months into the Early Help plan the parent's mental health started to deteriorate again, with ongoing intrusive thoughts of harming their own children. The extended family provided a great deal of support. In the next month there were further concerns about intrusive thoughts and the children moved back to

[2] No dates are provided to ensure anonymity to the children and family.

[3] Early Help, also known as early intervention, is support given to a family when a problem first emerges. It can be provided at any stage in a child or young person's life.

[4] An Early Help Assessment is an initial assessment and planning tool that facilitates and coordinates multi-agency support. It assesses the situation of the child or young person and their family and helps to identify the needs of both the children and the adults in the family.

live with the extended family. There was a difference of opinion between the Care Coordinator who was concerned about ongoing risks for the children and Early Help practitioner who thought that there was no need for ongoing support. This was resolved through appropriate challenge by the care coordinator; this was good child focused practice. The parent was then admitted into hospital and a referral was made to Bradford Children's Social Care (BCSC).

Child in Need support: a seven-month period.

2.5 BCSC reviewed the referral and agreed to undertake a Child and family assessment (known in Bradford as a 'single assessment[5]). Given the level of concern, and the uncertainty about the risks that the parent posed to the children a Strategy Meeting[6] would have been appropriate and a discussion about the need for a child protection enquiry. This is discussed in the next section of the report focussed on lessons learned.

2.6 The assessment was completed over a sixteen-week period; longer than the expected timescales outlined in guidance. This was reflective of the pressures within BCSC which have clearly been outlined with the Star Hobson national review (see that publication for details[ii]). During this time the children continued to live with their extended family. The parent was admitted to hospital on four occasions because of increasing concerns about their deteriorating mental health.

2.7 There was good liaison between the Social Worker undertaking the Child and family assessment and the Care Coordinator/mental health team, but the schools the children attended were not informed about what was happening. This lack of clarity impacted because the extended family were seeking advice from school about current plans which they seemed unclear about, and the schools were also supporting the children through what was an unpredictable and worrying time.

2.8 During the period the Child and family assessment was being completed the children lived with the extended family; the parent experienced increased anxiety and intrusive thoughts about harming others which they were open about with the professionals they saw. There was a lack of clarity about family time arrangements (previously called contact arrangements[7] [iii]), how much time the children could spend with the parent, and a lack of clarity about where the children should be living safely; there were indications that the

[5] A key aim of the Single Assessment is to set out clearly the assessment plan and will: Aid relationship building with children and their families. Consider the balance between managing and reducing risks and promoting resilience • Assist in explaining to children and families why social workers are involved in their lives.
[6] Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, a strategy meeting/discussion should be held. They should involve all key professionals known to, or involved with, the child and family. Local authority children's social care, health and the police should always attend.
[7] Good quality contact can benefit children by helping them to: return home where this is in the interests of their welfare; manage issues of loss and separation; maintain family relationships; and make sense of the past.

children were sometimes living back with their parent. This lack of clarity about exactly what were the agreed safe arrangements for the children to see the parent continued across the timeline of this review and this is discussed in the next section on lessons learned.

2.9 During the assessment process information was shared by the parent about historic family tensions. These were not included, explored, or analysed in the completed Child and family assessment which focussed on the supportive nature of the family. This support was very real, but there should have a been a more balanced approach with a focus on the strengths and difficulties in family relationships. This was central to the effective working of the subsequent safety plan. This plan required the extended family to make ongoing decisions about safe Family Time and living arrangements for the children, based on the extended family's understanding of the parent mental health needs and the risks this posed. What made this more complex was that the parent wanted the children to return home and the extended family hoped this would happen. Being asked to make decisions about when children can see their parents, for how long and when put the extended family in a difficult situation, which may have played into past tensions and power dynamics; this is not known because this was not explored. There are glimpses that this was the case here. It is important to say the extended family always put the safety and wellbeing of the children first, they just felt the pressures of restricting family life as they saw it. This is discussed in the next section of the report.

2.10 The Child and Family assessment concluded that the family needed support through a Child in Need[8][9] plan. It was agreed that the children would remain living with their extended family, and they would facilitate the children's family time with the parent.

2.11 The Child in Need plan focused on support for the extended family to meet practical childcare needs, developing a safety plan regarding family time, support for the children to make sense of the parent mental health difficulties and to talk about their worries; something they said they needed. The children were being supported in school, but there was agreement specialist help was required. This specialist support was often discussed but was never put in place and this is addressed in the in the next section on lessons learned.

2.12 The first Child in Need (CIN) meeting[10] took place soon after the Child and family assessment was completed. It was attended by most of the professionals

[8] why-do-i-have-a-child-in-need-plan.pdf (proceduresonline.com)

[9] The Child in Need Plan must identify the lead professional, any resources or services that will be needed to achieve the planned outcomes within the agreed timescales and who is responsible for which action and the time-scale involved.

[10] Child in Need Planning Meetings will follow an assessment where the assessment has concluded that a package of family support is required to meet the child's needs under Section 17 of the Children Act 1989. The

involved with the family, and both the parent and members of the extended family. Practical support to manage childcare arrangements remained an ongoing task as did the need to provide individual support to the children; good support was being provided at school. One of the children had told the Social Worker that they wanted help to understand the parent mental health difficulties, but this never happened. This is discussed further in the analysis section.

2.13 In the next four weeks the parent's mental health fluctuated, with them having worries about their continued intrusive thoughts about harming people in the community and worries about acting on these thoughts. The parent sought appropriate help, which was provided, and the care plan continued.

2.14 The next Child in Needmeeting took place four weeks later. It was attended by appropriate professionals and the parent but not the extended family; the reason for their absence was not recorded, which was surprising given they were caring for the children. It was acknowledged that the parents' mental health had fluctuated since the last meeting, and concerns remained about their contact with the children. The Care Coordinator said that there were family tensions connected to the organisation and management of family time and it was agreed that a clear plan needed to be put into place. This never happened. The Social Worker reported that the children's paediatrician had queried the issue of parental responsibility when the parent was unwell and who would be able to consent to any treatment for the children; this was an important issue to raise. It was agreed that this needed to be addressed, though the extended family were reluctant because they hoped the children would return home to their parent soon. It was agreed that this required further discussion, which never happened. Individual support for the children had not been progressed, though a referral to Young Carers support had been completed. The Social Worker said there would be a transfer to a new team and a new Social Worker. The outstanding tasks were to be addressed by the new Social Worker.

2.15 The parent was then admitted to a mental health unit/hospital with an initial plan of a four week stay, which would then be reviewed. They discharged themselves after a short stay and due to continued deterioration in their mental health they had an urgent review with their psychiatrist. Increased support was provided through the Intensive Home Treatment team[11]. The Care Coordinator visited the next day and discussed long-term plans, including the possibility of a move to residential accommodation for enhanced support.

Planning Meeting provides an opportunity for a child and his or her parents/carers, together with key agencies, to identify and agree the package of services required and to develop the Child in Need Plan.

[11] Home treatment teams aim to assess all patients being considered for acute hospital admission, to offer intensive home treatment rather than hospital admission, and to facilitate early discharge from hospital.

2.16 A day later the police were called due to concerns about the parents behaviour and threats being made by them. Two days later there was an incident where the parent went to the extended family home where the children were living; they remained outside, but their behaviour was of concern and the police were called. The parent left with the support of an extended family member. This was clearly a worrying time for the children and the whole family. One of the children spoke to their school about their worries for their parent, uncertainty about the future and that there was to be a new allocated Social Worker who they had not met, and how difficult it was to start again with a new person. The child reported feeling let down. The school shared their concerns about the children with the Care Coordinator, particularly regarding family time which they believed should be supervised by a professional; this was shared with the Social Worker. The Care Coordinator recognised the severe and enduring nature of the parent's mental health needs, but the Child in Need plan did not reflect this knowledge, and over time there was a sense that through support and treatment the parent 'would get better' and would resume care of the children. There was a mismatch here between the actual mental health needs of the parent, the desire of the extended family for what they saw as 'normal family life to resume' for the children and the immediacy of the Child in Need plan. It was focussed on the here and now, not the future.

2.17 The extended family expressed concern to the new Social Worker about the parent's deteriorating mental health and asked what support could be offered. The new Social Worker asked the extended family member about formalising the living arrangements of the children, but they remained reluctant to do so because they wanted the children to return home when it was safe for them to do so.

2.18 The next Child in Need meeting was held remotely[12] and professionals, the parent and extended family joined the call. The parents' ongoing struggle with their mental health, intrusive thoughts and erratic behaviour were discussed. The Care Coordinator was undertaking a Care Act assessment[13] [iv]to see what further support could be put in place for the parent; her belief was that intensive support was necessary. The children were said to be doing well at school, but one of the children had again expressed feeling upset, worried and sad about what was happening. She had told school again that she did not feel supported by the Social Worker, was angry there had been a change and was feeling let

[12] Caused by COVID public health requirements.

[13] An assessment under the Care Act 2014 is an assessment of needs for care and support or an assessment of a carer's needs for support. The nature of the assessment will vary depending on the person and their circumstances. The assessment process should be appropriate and proportionate to the individual and their needs.

down and this was shared in the meeting. It is unclear why no action was taken to address this clear signalling by a child that they needed help. The agreed individual work was not in place, and the child with additional communication needs had not been seen to understand how they were feeling. The extended family had stopped family time because of recent worrying events. They said they would like to think about exploring formalising the children living with them; this did not happen and there was no plan to address safe family time going forward. There remained several incomplete actions from the Child in Need plan and the responsibility for organising family arrangements remained with the extended family with no focus on the future.

2.19 A week after the Child in Need meeting the Care Coordinator and Social Worker met with the parent and the extended family. The parent said that their anxiety remained difficult to manage, that they were missing the children and wanted more family time including overnight stays. The extended family said that the parent was not always appropriately behaved during family time which left the children feeling scared and uncertain; they also said they were still unsure about when and how family time should take place, and this remained a strain on family relationships. The parent was accessing support, and the pattern of ringing the Care Coordinator and support worker multiple times a day had reduced; however, this behaviour had now transferred to some members of the extended family and was causing stress. The plan continued to be consideration of some form of supported residential accommodation. The children were to remain living with the extended family until the children's services Child and family assesment had been completed and the parent's mental health had improved; it is not clear who would be making that decision. The timescales for this and what 'improvement' would look like were not made clear. The parent and extended family still wanted the children to return home and so said they did not want to pursue any legal order. This left the children in a continued situation of uncertainty about their future. This lack of permanency for the children should have been a concern for the Social Worker and addressed as part of the plan.

2.20 The final Child in Need plan took place remotely. The school and the Care Coordinator had already said they could not attend on that date and the Special Needs School Nurse tried to join but was not admitted into the meeting. This meant that this was in essence a discussion between the parent, the extended family, and the Social Worker, not a Child in Need meeting. The Social Worker told the family that there was no outstanding role for Bradford Children's Social Care, no ongoing safeguarding risks and therefore the Child in Need plan would end. The mental health team would continue to provide support to the parent, discuss the family time arrangements and consider when it might be safe for the children to return home. This was not an appropriate role for them, and this

is discussed in the next section. The extended family were to manage day to day family time arrangements, making decisions about risk and safety.

2.21 The Care Coordinator had asked prior to the meeting that a contingency plan be formulated, if the social work team decided to end the Child in Need plan, which would outline what to do if there was an escalation of concern. This did not happen and there does not appear to have been any final discussion between the Care Coordinator and the Social Worker to confirm what had been agreed. This is addressed in the lessons learned section of the report.

2.22 Over the next eight weeks there was a great deal of instability with the parent attending A&E eleven times with thoughts of harming others and themselves. The parent made many calls to the police with thoughts of harming others. There were times when an ambulance was also called. The mental health team continued to provide support and follow up after each crisis. The parent was reminded of the strategies to address these unwanted thoughts. Although there were times that the parent seemed to be struggling not to act on these intrusive thoughts, they managed to access help. There were two multi-disciplinary meetings during this time, the parent's care plan and medication were reviewed. The Care Coordinator met regularly with the parent as did the mental health support worker. There was support provided by this team to the extended family who were struggling with the chaos and uncertainty. There appears to have been no discussion about the needs and circumstances of the children at this time. The extended family were managing family time, but this was a period of instability and chaos which was extremely worrying for the children. There should have been a re-referral to BCSC.

2.23 There was then a period eight weeks without any mental health crises. The parent was becoming involved in the daily lives of the children, attending school parent evenings and having unsupervised family time. The Care Coordinator visited the parent at home, and they reported one of the children was staying with them overnight. At the end of the eight weeks there was an incident of concern which led to the parent being detained in a mental health hospital. The details are not provided for reasons of privacy. The children remain living with the extended family with a permanent legal order in place.

3. Analysis and Findings of the Review

3.3 The purpose of a local child safeguarding practice review (LSCPR) is to consider the professional response to children and their family arising out of a critical incident and consider whether this suggests that there are improvements that need to be made locally and nationally to safeguard, promote the welfare of children more generally and to seek to prevent or reduce the risk of the recurrence of similar incidents[v]. There are several themes or findings that that emerge from a review of these children and their families' circumstances which have implications for future practice.

QI: Was there a sufficient understanding of the risk of harm posed by a parent with mental health problems characterised by intrusive thoughts to harm THEIR children and were appropriate safety plans put in place?

3.4 Although there was recognition over time of the parents need for support, there was not always consistent understanding or analysis of the risks and no clear articulation of what those risks were. At the beginning of the review period the parent sought help from their GP with worries about their mental health including feeling unable cope with family life and worries about not meeting the needs of the children and ensure? that the oldest child did not have to take on young caring responsibilities; there was no evidence of risk of harm to the children at this point. An appropriate referral was made to the Community Mental Health team (CMHT) and there was a quick response from them. With consent from the parent, the GP contacted the children's schools to make them aware of concerns. This was a very helpful response.

3.5 A month later the parent's mental health started to deteriorate, with intrusive thoughts of harming the children and other people in the community. The parent was admitted to hospital and a referral to Early Help agreed. Appropriate safeguarding advice had been sought by hospital staff but given the level of concern and indications of likely risk of harm to the children, a referral to BCSC would have been the more appropriate option. The response here was about need and there was insufficient recognition of risk and therefore no safety plan was put in place.

3.6 The Early Help plan was focussed on support and not risk. Four months into the Early Help plan there was a deterioration in the parent's mental health with increased thoughts to harm the children and others. An informal plan was agreed whereby the children moved to live with the extended family and the CMHT were informed by Early Help that it was not safe for the children to live with the parent; however, they returned to the parent's care soon afterwards. It is unclear why this view of the risk had changed. It was proposed that the extended family would monitor the situation. There was a lack of a clear safety

plan which would have enabled everyone to understand what was agreed and what was not.

3.7 A pattern developed from this point onwards, whereby the risk to the children was perceived to fluctuate depending on the parent's own self-reported view of their mental health, how well they were managing their anxiety, and using techniques provided to manage intrusive thoughts. This meant that the perception was that the risk went up and down, and the children could live with the parent at times when the risk was perceived to be low. The risk to the children remained, and there was a lack of reflection on the cumulative impact of the instability and uncertainty on the children's wellbeing. The sibling reported it flet like living in 'chaos' all the time.

3.8 The Early Help practitioner proposed that there was no further need for an Early Help plan or any ongoing risk and asked the school to become the lead professional. They refused, suggesting the risks remained the same and support was still needed. Early Help support continued to be involved.

3.9 The pattern of perception of fluctuating risk continued. After a week after the Early Help practitioner had considered ending their involvement, the parent anxieties increased, and thoughts of harming the children became more intense. The parent was insistent that there was no intention to act on these thoughts; the children moved back to live with the extended family. There was a difference of opinion about next steps between the Early Help practitioner who still wanted to cease involvement because they had not recognised the continuing likely risk, and the Care Coordinator who felt that more support was needed. At this time the parent's mental health deteriorated further, the parent was admitted to hospital and a referral was appropriately made to Bradford's Children Multi-Agency Safeguarding hub (MASH)[14].

3.10 This referral was screened, and a decision that Bradford Children's Social Care (BCSC) would undertake a child and family assessment. Given the known risks and the uncertainty of the likelihood of significant harm there should have been a Strategy Discussion and Child Protection enquiries undertaken to evaluate that risk; this would have been in line with the West Yorkshire guidance 'Children at Risk where a Parent has a Mental Health Problem[15]'. The reasons why a Strategy Discussion was not considered are not known; the risk of likely significant harm was clear. One possible explanation is that the parent and extended family had always sought help and had engaged well with services.

[14] The purpose of a MASH is to bring together different agencies to enable fast information sharing with the purpose of making an efficient and fast decision to safeguard vulnerable children. The MASH setting allows professionals to efficiently and quickly gather and process information in order to assess risk.

[15] 1.4.10 Children at Risk where a Parent has a Mental Health Problem (proceduresonline.com)

This should not make any difference. The child protection process, which is not one intended to blame or stigmatise families, is there to help manage known and unknown risks in a multi-agency forum for the best interests of children. The lack of a Child Protection response also meant that the seriousness of the circumstances was not always made clear to the family.

3.11 It is good practice that at this time the Care Coordinator became aware that the parent was placed in a private hospital out of the local area. Contact was made with them; information was shared about the involvement of BCSC and the ongoing Child and Family assessment.

3.12 The Child and family assessment took place over a sixteen-week period. During this time the children had once again returned to live with the parent and there was no safety plan developed or put in place. The parent was left to self-disclose thoughts of harming the children and others, and the extended family were asked by the Social Worker to respond where necessary. This lack of social work oversight of the known risks was not appropriate and there was a lack of reflection on what this might mean for the children's wellbeing or sense of stability. During this time there were regular home visits by the Social Worker and the Care Coordinator; the parent's mental health continued to fluctuate and eight weeks into the assessment process the parent reported thoughts of harming the children to mental health services. This was communicated to the extended family and the Social Worker. Contact was made with the extended family and the children moved again to live with them.

3.13 The Child and family assessment outlined the known risks, and the unpredictable nature of the parent mental health. A safety plan was recorded within the assessment. It provided a confused picture. Initially it is made clear that the children would live with the extended family, that all family time would be supervised, and the police were to be called if there were any concerns. Later in the Child and Family assessment there was a second safety plan included. This may represent thinking at the start of the assessment and at the end (a long period). This safety plan suggested that the parent should contact the extended family and Care Coordinator if they felt unwell. If the parents had care of the children, the extended family were to collect them and inform all agencies. This suggests there was no longer a need for supervised family time. A confusing message. The extended family were critical to this safety plan, yet the Child and Family assessment alludes to tensions from the past without exploring these further and considering the impact on their ability to manage this plan.

3.14 The Child and Family assessment suggested that a lack of diagnosis from mental health services was causing the parent increased anxiety and making it more difficult for the children to return home. This was a critical issue which was

not shared with the mental health team, who were unable to respond. It is of note that the Child and Family assessment was not shared with any agency providing a service to the family, so they were unaware of the overall analysis. It is not clear if it was shared with the extended family or the parent and what their views were regarding the conclusions. This sharing of both the Child and Family assessment and the analysis is critical to effective practice to support children and their families.

3.15 At this stage there was no reference to whether there needed to be a safety plan in place for both schools. They were aware of the concerns, but there was no articulation of what they should do if the parent came to school, asking to take the children home. It is not clear if this was allowed or not. The Child and Family assessment and subsequent Child in Need plan and process did not include any discussion of the risk that the parent might pose to school staff, pupils and their families. This should have been part of the safety plan.

3.16 The broad safety plan was decided by the Social Worker and recorded in the Child and Family assessment. This safety plan should have been developed in partnership with the multi-agency group working with the children and family, including the Care Coordinator, the school, and the Special Needs School Nurse. This would have enabled the expertise of these professionals to help shape a plan that took account of the parent's mental health needs and the children's known needs including one child's disabilities.

3.17 The Child in Need plan was in place for four-months, with monthly Child in Need meetings. The safety plan remained the same, despite there being evidence that it was not working effectively. The extended family shared concerns that there were family tensions caused by managing family time and the parent's behaviour, turning up at the house and not always being appropriate within family time sessions. The Child in Need plan never tackled these tensions, and although there is no evidence that the children were ever left in an unsafe situation (thanks in large part to the extended family) there was a lack of robustness. The extended family were gradually asked to assess risk and organise safe family time arrangements without reflection if this was fair, reasonable, or possible. There is no evidence that this responsibility was fully discussed with them.

3.18 The Child in Need plan ended after four months because BCSC decided there was no role for them, no unmet need and no ongoing risk to the children; this was incorrect. There had not been a change in the level of risk; during the whole of the period of the Child in Need plan there remained fluctuating concerns about the parents' intrusive thoughts to harm the children or other adults and incidents where the behaviour of the parent caused concern that they might act

on those thoughts. This had not happened, but the concerns about acting on those thoughts remained as an unknown.

3.19 The rationale for this decision appears to be a belief that these were manageable risks; the extended family were providing good quality care to the children, they were supervising family time and were tasked with making a future decision about when it was safe for the children to return to the care of the parent. Although the extended family were providing good quality care to the children, they reported that there were family tensions. They often said they did not understand the parent's mental health and what they needed to do to support them and keep the children safe, making it hard to see how equipped they were to make decision about when the children should return home. They were also concerned about the parent being inappropriate in family time causing the children distress and this had not been addressed.

3.20 The future planning for the parent remained uncertain at this time. The mental health team were at a point of formulating a mental health diagnosis and establishing a care and treatment plan. There was still some discussion about the need for the parent to be in residential care with significant support. This was incompatible with the children returning to the parent care. The extended family did not understand this; they hoped and believed that the parent's mental health would be so improved that the children would return home. The oldest child wanted to go home. The risk could not be managed without clarity about what the plans were. The North Yorkshire guidance[16] around working in the context of parental mental ill health makes clear the importance of contingency planning including a consideration of the future management of a change in circumstances for a parent/carer and the child and how concerns will be identified and communicated. This should include what to do when there is a relapse in the parent/carer's mental health, a failure to maintain medication or a change in family dynamics/relationships.

3.21 When the Child in Need plan came to an end, there was no contingency plan developed, despite the Care Coordinator asking for this to be in place. The Care Coordinator was not aware that the Social Worker had proposed that they would have some professional oversight of the family time arrangements. This was not a reasonable ask. There should have been a stepdown process agreed by all professionals. This did not happen, and this needed to be challenged. It was not.

3.22 Over the next eight weeks there were many concerns about the parent attending A&E in a state of distress and having intrusive thoughts about harming others, including children. The police were called to the parent's home

[16] 1.4.10 Children at Risk where a Parent has a Mental Health Problem (proceduresonline.com)

as well as the ambulance service. A safety plan was put in place for the parent by the mental health team and support provided. There were two multi-disciplinary meetings to review the treatment and support plan. These all focussed on the parent as an individual, as opposed to a parent who was in contact with their children. There was no recorded discussion about the children or what the risks might be to them. There was a belief that the children were being safely looked after away from the parent. There were many agencies who could and should have considered either a discussion with their safeguarding lead and a referral back to BCSC. There was a lack of a Think Family approach[vi] at this time, with a narrow focus on the individual.

3.23 The acute hospital A&E department have a safeguarding checklist, including a question about whether the patient has responsibility for children. If the answer is 'yes' the paediatric liaison nurse would access the children's records and make contact with the Health Visitor or School Nurse as appropriate to ensure concerns were shared and children's needs considered. This question of responsibility was interpreted as 'living with' which the children were not, as opposed to having regular contact with. Recommendations have been made regarding this.

3.24 Overall, there was an inconsistent understanding of the risks that the parent posed to the children, what safety plans needed to be made and an over-reliance on an overstretched and stressed family to be able to manage the risks, despite their constant assertion that they did not fully understand it.

Why does it matter?

3.25 It is estimated that one in four of the adult population will experience mental health problems at some point in their life and a third will be parents at the time[vii]. For most children there is minimal impact of their parent's illness if the right supports are in place. However, when analysing the factors that lead to serious case reviews/local child safeguarding practice reviews or factors that led to children needing to be removed from their parents' care, mental health problems are identified in a high proportion of cases. There is good evidence about what mitigates the likelihood of harm to children where parents have mental health difficulties[viii]:

- Can the parent manage their condition well and/or committed and engaged in treatment likely to aid their recovery.
- Does the parent have insight into the difficulties caused to parenting by their mental illness and into the potential impact on the child?
- Are they able to identify the child's needs as distinct from their own? This is an important question because it indicates reflective functioning, the ability to put the child's needs first.

- It is of concern when the child is part of a delusional pattern or intrusive and unwanted thoughts.
- The child is not the focus of the parent's aggression.
- A supportive parent without a mental health problem
- A supportive wider family and friendship network
- A lack of family discord and a lack of coexisting factors such as domestic abuse and substance misuse
- Doing well in school and being supported to be in school and other pro-social activities.

3.26 Effective risk assessments based on an understanding of the factors that mitigate risk or make risk more likely are critical as is an effective safety plan which includes the parent, child and wider family and which is shared with all appropriate professionals with dynamic and regular updating to include acute episodes of mental health needs.

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What can be done about it?

Recommendation 1: West Yorkshire has a 'Children at Risk where a Parent has a Mental Health Problem[17]: Inter Agency Safeguarding and Child Protection Procedure': those working with this family were unaware of this guidance. This needs to be made more clearly Bradford specific and the content refined considering the findings of this review.

Q2: Was the impact of the parent mental health difficulties on the children understood and addressed through appropriate support?

3.27 At the start of the review period the GP recognised that the parent needed support with mental health needs, made a referral to mental health services, liaised with school and extended family and Early Help; there was a clear focus on the needs of the children. Early Help became involved a few months later. The plan they developed included individual support for the children to help them understand their parent's mental illness and to consider the need for a referral to young carers for the oldest child. Individual work was completed with the oldest child on four occasions (two face to face and two over conference call) over a sixteen-week period. The referral to young carer does not seem to have been made. There was acknowledgement that the child who was neuro-diverse and who communicated in other ways than through language also needed support, but there was no plan to address this. There should have been to consider how best to enable this child to communicate how they were feeling and what support they might need through advice and help from those who knew the child's communication style well, such as the school and speech and language team.

[17] 1.4.10 Children at Risk where a Parent has a Mental Health Problem (proceduresonline.com)

3.28 Both children were well supported by their schools. School staff were aware of the parent mental health difficulties, and the school for the oldest child provided a counsellor for them. This child reported this as being very helpful. The oldest child often spoke of her worries about her parent and that they wanted more specialist help. The school acted as an advocate for the child by raising these concerns in the Child in Need meetings. The school were concerned that the oldest sibling was often left with the responsibility of telling the school of their parents many mental health crises and that this put the child under a lot of pressure; it would have been helpful if they had raised this with the Social Worker to ensure this was addressed.

3.29 The work of the Early Help team came to an end when the parent was admitted to hospital, and the Child and family assessment was started. The children were seen at home and the oldest child consulted as part of the assessment process. It is unclear how the child who was neuro-diverse was involved as this is not mentioned. There was a tendency across many agencies to consider that different communication styles equalled not being able to communicate. There is no evidence that the assessing Social Worker spoke to either the speech and language team or that they sought information about this child's communication style from the school.

3.30 The Child in Need plan appropriately highlighted the need for specialist support for the oldest sibling to help make sense of the parent's mental illness and to address worries and anxieties. There was also a proposal for a referral to young carers; this was delayed and by the time it was discussed with the oldest sibling they said it was not necessary. The planned specialist support was never provided. It remains unclear why. The oldest sibling made clear their concerns that the monthly Child in Need visit from the Social Worker was insufficient to address their worries and that they were unhappy with the change of Social Worker mid-way through the Child in Need process. These concerns were recorded in the minutes, but no action agreed to address them. The oldest sibling must have felt asking them their views was meaningless. The help seeking behaviour of this older sibling was not responded to appropriately.

3.31 There was no plan to ensure that the child who was neurodiverse had a voice or the impact of the parent's mental illness and of the chaos and instability was understood for the siblings.

3.32 When the Child in Need plan was ended, during a school holiday, there was no step-down plan regarding how the children were to be supported. The oldest sibling had not been helped to understand the parent's mental illness and the plans for their future were extremely unclear. They had made their desire to return home clear and there was a lack of clarity about what the professional

view was of the likelihood or timescale for this. This may have been hard to predict, but it is the lack of transparency and communication with the siblings which is of concern.

3.33 At the end of the Child in Need process, there remained several unmet needs which were not acknowledged. Over the subsequent twelve weeks, characterised by constant crises, the school and the extended family supported both children.

3.34 The impact of parental mental illness was recognised by professionals, but there was a lack of support provided for the family/children. The oldest child asked for help, and this was not provided. There was no plan made to make sense of the world of the child who was neurodiverse or enable communication. Both children were seen but not always heard.

Why does it matter?

3.35 Research suggests that around 28% of school age children are living with a parent who has a mental health problem[ix]. Research suggests that for some children there can be a negative impact on their health, development, and emotional wellbeing over time if the specific impact of the parents' mental illness on the child is not well understood and the right support and help are not provided. Children benefit from age-appropriate information about their parents' mental health so they can understand it and make sense of it; they also worry that they will develop the same problems and are somehow to blame. Many children experience sadness, anxiety, depression and experience a sense of loss of the relationship with a parent and family life/relationships. Children need an opportunity to talk about those worries.

3.36 Professionals need to think carefully about how to ensure that children with disabilities and differing communication styles are supported and heard. These children often miss out on specialist support through perceived difficulties with communication. Children with disabilities will usually have a network of practitioners who know them well and understand how they are feeling and able to recognise changes in mood and behaviour; they will know a child's preferred communication style. This will also be true of family members who know children well. All professionals have a responsibility under the Children Act 1989[x], the UN Convention on the Rights of the Child[xi] to ensure that children's views and needs are known and are central to thinking in the context of child welfare decisions. The Equality Act 2010[xii] makes clear the need for all public services to make 'reasonable adjustments' to ensure that disabled people/children have the same rights and opportunities as their nondisabled peers. This is also enshrined in the Convention on the Rights of Persons with Disabilities (CRPD) section 7 states that 'children with disabilities have the right to express their views freely on all matters affecting them, their views being

given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right[18]'.

3.37 Many children also take on additional caring responsibilities; this can be both an additional pressure, impacting on their education, friendships and involvement in everyday child activities. These young caring responsibilities can also be a source of pride, with a sense for the child that they are contributing the wellbeing of the whole family. This will all depend on whether the caring responsibilities are appropriate (no personal care), consistent with age and developmental abilities, they do not interfere too much with day-to-day life and the child feels they are managing and that the caring is making a difference to family life. Many young carers have challenged professional views about their caring responsibility, reminding adults of the need for an individualised response. That is why the local authority is required to carry out an assessment of a young carer's needs[19] and consider what support is necessary.

3.38 It is the central ambition of the child safeguarding and support system that children and young people will ask professionals for help when they have worries. Research[xiii] SCRs[xiv] and the work of the Office for the Children's Commissioner[xv] suggest that there are many barriers to children talking to professionals about their worries, concerns, and experiences of abuse. As such more needs to be done to improve children and young people's help seeking behaviour by professionals.

3.39 Help seeking behaviour is a developmental skill which grows and develops through childhood and into adulthood. For this to happen, help seeking behaviour needs to be nurtured and encouraged through appropriate attachment relationships and warm and supportive parental care. For some children this does not happen; they may be ignored, dismissed or actively prevented from talking to professionals. This leads to children lacking trust in all adults and they are often concerned about the consequences of seeking help.

What needs to be done about it?

Bradford now has the Mind of My Own App which supports children in contact with Social Workers to be able to communicate about how they are feeling and to raise concerns when they feel they are not being listened to. The Mind of my Own express is aimed at children who have alternative communication needs. These applications were not available when work was being considered with the siblings. It will be

[18] Article 7 – Children with disabilities | United Nations Enable

[19] "The Young Carers' (Needs Assessment) Regulations 2015/16

important going forward that professionals are made aware of this resource and make use of it.

Recommendation 2: In Bradford there is already in place Practice expectations around direct work for children by Social Workers; this does not include the responsibilities regarding children with disabilities and the additional support they might need around communication. It is recommended that this is updated to take account of the needs for children with disabilities. This should make clear that children with disabilities will have many professionals and family members who are experts on a child's preferred communication style, such as their schools, speech and language therapists and educational psychologists, Special Needs school nurses, to name a few, and these can be a helpful resource.

Recommendation 3: The West Yorkshire 'Children at Risk where a Parent has a Mental Health Problem[20]: Inter Agency Safeguarding and Child Protection Procedures' does not talk about the needs of children specifically, the requirement about what help and support they might need, and children with disabilities are not mentioned. This guidance needs to be updated and to include the requirement for a young carers assessment and factors to consider.

Q3: Was effective and appropriate support provided to the parent who was mentally unwell and the extended family.

3.40 There was good recognition of the parents' need for support with their mental ill health. This came initially from the GP and then the Early Help plan. Over time the parent was provided with extensive mental health support which matched the need. Whilst the Child in Need plan was in place there were regular joint visits between the Care Coordinator and Social Worker to think about what help the parent needed. There were two issues that were not fully addressed within the Child in Need plan:

- how to help the parent manage their anxiety and mental health needs specifically around the children when having family time. This was an issue raised by the extended family, and addressed within the mental health care plan, but not the Child in Need plan.
- An understanding of what was the likely cause of the parents' mental health problems. There is a growing body of evidence that trauma in childhood and adulthood can be a causal factor for developing mental ill health. A trauma informed approach asks professionals to consider 'what has happened to an individual' rather than simply 'what is wrong' with an individual'. There were inferences in the Child and family assessment to the complex family relationships and mother's early life,

[20] 1.4.10 Children at Risk where a Parent has a Mental Health Problem (proceduresonline.com)

but these were not further explored and the possible influences of these factors on the parent's current mental health were therefore not known. This information was included in the mental health care plan, but not cross referenced to the Child in Need process.

3.41 The extended family were supported by their GP and they were involved in all the Child in Need meetings. Support came through regular meetings with the Social Worker and care coordinator. It is recorded that the family were happy when the Child in Need plan came to an end, though it left them without support in managing family time arrangements and dealing with the many crises. Practical help was provided regarding childcare arrangements and support regarding the needs for the child who was neuro diverse.

3.42 The outstanding issue was helping the extended family understand the parent mental health and how they could support this. They wanted a sense of the future to make plans, and this was not facilitated. The Care Coordinator was not asked to help the extended family understand the complexity of the parent's needs.

3.43 Overall, the parent was provided with an appropriate package of care and support. The extended family also told the reviewer that they did feel supported, but for them they did not understand the parent needs and how to help in the context of parenting and the children.

Why does it matter?

3.44 Parents who experience poor mental health have a right to support as individuals, but also in fulfilling their parenting role[xvi]. This is made clear in legislation and guidance[xvii]. Without the right support children's lives will be unnecessarily impacted and parenting relationships lost.

3.45 Families who support an adult/parent with mental health needs also need support. One of the mitigating factors for supporting children's safety, wellbeing and opportunity maintain positive relationships with parents with mental health difficulties is the absence of family discord; support is necessary to help with this. The extended family need the opportunity to understand a parents mental health difficulties, how best to support them and enable them to fulfil their parenting role in whatever way is safe to do so.

3.46 There is a need for all services across adults and children's services to take a Think Family approach. Something missing from the work with this family.

What needs to be done about it?

Recommendation 4: The existing West Yorkshire guidance 'Children at Risk where a Parent has a Mental Health Problem[21]: Inter Agency Safeguarding and Child Protection Procedure needs to be updated to include support to parents with an enduring and complex mental health need to successfully fulfil their parenting role and needs of the extended family.

Q4: Were the living and family time arrangements for the children clearly understood by all? Were they provided with appropriate stability during the time under review and into the future, and were appropriate arrangements in place for effective alternative caregiving?

3.47 In the first ten months of the review period the children moved regularly between their parent home, to different members of the extended family. These moves were governed by the instability in the parent mental health. It must have been unsettling for the children. There is no recorded professional discussion about the appropriateness of these constant moves for two school aged children. The extended family wanted to ensure that the children were with their parent whenever this was possible, largely influenced by the children's wishes to be at home and their parent wanting to care for them. The family wanted what was best for the children; however, there should have been a clearer professional view about what the impact on the children of this instability was likely to be over time.

3.48 During the Child in Need plan, and as a result of another mental health crisis, the children moved to live with one member of the extended family, with regular planned stays with other family members during school holidays. The extended family brought some stability to the children's circumstances.

3.49 However, there was further instability caused by the lack of clarity about where the children would be living in the longer term and who would be responsible for them. During the Child in Need process (a period of four months) there were discussions about the parent needing intensive support and this would need to be provided through some form of residential care. At the same time there were still conversations about the children moving back to live with their parent when their mental health was stabilised. These two positions were incompatible, and there needed to be a clearer discussion about what was known about likelihood of the parent mental health stabilising, over what time frame and what this would look like in practice. There was no professional view about how long between crises or what period between intrusive thoughts of harming children or others would indicate change and safety. This responsibility was left to the extended family, without there being a professional view or advice or guidance.

[21] 1.4.10 Children at Risk where a Parent has a Mental Health Problem (proceduresonline.com)

3.50 The third aspect of instability was that there was no formal legal order in place, making clear who had parental responsibility during the times the parent was unwell and formalising the living arrangements of the children. Families are of course able to make private arrangement for where children live and with whom without the state becoming involved. In this situation the local authority in the guise of the Early Help worker and then the Social Worker made clear that there were times that the children could not live with their parent. The extended family agreed, but this met the criteria for some form of legal order to be put in place. A Child Arrangements Order[22] would have been an appropriate option. This would have meant a member of the extended family would have shared parental responsibility with the parent and authority for day-to-day decision making about the child would be delegated to the nominated carer.

3.51 This was discussed with the extended family on many occasions. They were reluctant to seek a legal order, because they wanted the parent to resume the parental role; it remains unclear what family relationships and history underpinned this. However, this was evidently the extended family wanting to be supportive approach; there needed to be more discussion about the likelihood of the children returning permanently to their parent in the short term or medium term. Within the timescales of the review this did not seem a realistic possibility, with the likelihood of continued instability. Without a legal order in place the parent could have insisted the children return to live with them, even if this was not in their best interests and there was a lack of a contingency plan for when the parent was unable to provide authority for day-to-day decision making regarding the children. There should have been a clearer Local Authority view about what was in the best interests of the children and to help the extended family understand this, deal with the tensions inherent with taking over the parental role.

3.52 There was a lack of clarity regarding what were safe and appropriate family time arrangements and whether the extended family felt able to manage them. This was never appropriately addressed. There were times that it was reported that family time had always to be supervised, and other times when it was thought appropriate for the parent to see the children alone. There was no written contact plan. As has already been discussed, family tensions over time made both the practical organisation of this difficult and there was an emotional cost to family members of having to tell the children and the parents what family time could and could not take place. The family needed more support with this. They were left at the end of the Child in Need process without a clear plan in place.

[22] A child arrangement order can outline where and with whom children live as well as when and how often the children can see a parent or relative (contact). It can also outline shared living arrangements. Each Child Arrangements Order is decided on the circumstances of the individual family and on what is in the best interests of that particular child. This means that there is no such thing as a 'usual' arrangement. Child Arrangements Orders are governed by **section 8 of the Children Act 1989**.

Why does it matter?

3.53 Stability in practical living arrangements and attachment relationships is crucial for children's emotional wellbeing and healthy development. Research shows that instability in attachment relationships can have a long-term impact on children's wellbeing which lasts into adulthood[xviii]. There are additional needs for routine and stability for neuro-diverse children. This is about ensuring permanency for all children.

3.54 Family time, or contact, is critical when children are separated from their parents and family[xix]. It helps to maintain connections and attachments relationships. The Life-long links programme developed by Family Rights Group[23] has demonstrated how easy it is for contact arrangements to break down and for the negative impact of this on children's emotional wellbeing. Children also need to feel safe. Regularising contact arrangements, putting boundaries around them and addressing when they leave children feeling anxious or unhappy is important. High quality contact requires ongoing proactive efforts to make it work.

Q5: How effective were multi-agency working arrangements and information sharing?

3.53 Across the timeline there were variable multi-agency working relationships and some issues with information sharing. There was also some effective and child focussed practice. What is striking is the inconsistency in who was provided with information about Early Help plans, Child in Need minutes (these were clear and of good quality) and which professional has access to the child and family assessment. There seems a lack of challenge here about decisions which professionals were uncertain about and which they did not believe to be in the best interests of the children. The decision to step down from a Child in Need plan was not questioned by any agency who was involved. The lack of a step-down plan was not noticed. The lack of a formal safety plan was not noticed by any agency or addressed.

3.54 It is of concern that there was such inconsistent communication with the children's schools, they were providing support to the children and were a safe and predictable place for them.

3.55 The key issues were:

[23] Lifelong Links aims to ensure that a child in care has a positive support network around them to help them during their time in care and in adulthood. Lifelong Links - Family Rights Group (frg.org.uk)

- The GP liaised well with appropriate agencies and the extended family, having sought permission from the parent. Despite this proactive response, the GP practice were not made aware of the Early Help or Child in need plan, the Child and family assessment and they were not asked to contribute to any of these processes. This did not cause any major issues in these circumstances but has the capacity to undermine effective working relationships in other circumstances. GPs often have the most holistic of a child and their family's circumstances.
- The GP was made aware of the parent's period of crisis immediately after the Child in Need plan came to an end and the GP appropriately sought further information. The GP did not note these in the safeguarding node for all family members records. If this had been done there would have been a flagging of mother's mental health needs and current instability.
- The paediatrician made appropriate contact with the Social Worker to ask about parental responsibility and who was responsible for providing consent to medical issues. They were not provided with any of the Child in Need paperwork.
- The Special Needs School Nurse attended Child in Need meetings and shared information. There is no record of them having received the Child in Need minutes or have any knowledge of the child and family assessment. They were made aware of the decision to end the Child in Need plan., with no other professional being present, but no view was expressed about this, and no information requested about a step-down plan. They were not provided with the safety plan (which was never formally completed – being held in the body of the child and family assessment) and they did not ask for it
- The Early Help plan did not include either school, though this appears to have been due to an invite having been sent and not responded to. This should have been chased up.
- Overall, there was poor communication with schools across this timeline. They were not fully aware of the move from an Early Help plan to a child and family assessment, but they were then invited to meetings. It emerged that it was left to the oldest child to communicate when a crisis had occurred; this left responsibility on the child's shoulders and should have been challenged. The schools? were aware that the Child in Need plan was closed during a school holiday, without their views being considered. This did not promote effective multi-agency working practices, and the absence of a step-down plan was not noticed or challenged.
- The school was aware that the oldest child was unhappy with the lack of support provided with by the Social Worker, and the change of Social Worker and this was shared within Child in Need meetings. This led to no further action, something the school could have more robustly questioned.

- There was a good working relationship between the Child in Need Social Worker and the mental health care coordinator. Several home visits were completed, and there was regular information shared. What was missing was clarity of role; what was the purpose of the joint visits. The Social Worker recorded in the Child and family assessment that a lack of a diagnosis for the parent was hampering progress. This was not shared with the mental health team, so they were not able to explain the process of assessment and diagnosis. This assertion of a problem with one agency and the way they are working, without evidence or discussion, has the capacity to undermine working relationships.
- In the period after the Child in Need plan ended there were many crises which were managed well for the parent, but no contact was made by any agency involved to consider the needs of the children.

Why does it matter?

3.56 Communicating effectively with other professionals is more than sharing information Difficulties around information sharing have long been recognised as a characteristic of interagency and interprofessional working, and they have been persistently highlighted in the SCR periodic analyses. A crucial distinction needs to be made between information sharing, communicating effectively and understanding each agencies analysis; knowing what that means overall for the child's safety and wellbeing.

What needs to be done about it?

Recommendation 5: There needs to be clarity about when and in what circumstances child and family assessments will be shared with those agencies who will be supporting children who are subject to Child in Need plans.

Recommendation 6: The guidance regarding Child in Need meetings needs to be updated to make clear that the meeting needs to include all those agencies working with a family. Thought needs to be given to the timetabling of meeting during school holiday, where some professionals will not be able to attend. It must also make clear that the decision to end a Child in Need plan should not be made without discussion with the multi-agency group and without a clear step-down process.

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