Local Child Safeguarding Practice Review Commissioned by The Bradford Partnership - Concerning Child A

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1 Introduction

1.1 This report was commissioned by The Bradford Partnership (formerly Bradford Safeguarding Children Partnership) after the death of a seven-year-old child (referred to as Child A in the report) in the summer of 2020. Child A was just shy of his eighth birthday when he was struck by a car and killed at 10pm. Immediate investigations revealed that at the time of the incident there was no one at his home address caring for him.

1.2 Child A's death was notified to the Bradford Partnership, and a rapid review meeting took place. Child A's family were known to services in Bradford and a detailed discussion took place, utilising the information known to agencies. At that time, the view of the rapid review panel was that although there was learning for the partnership, these were familiar themes that were replicated in other local learning reviews and unlikely to produce additional learning. A recommendation from the rapid review was that a single agency review should be conducted on behalf Children's Services. The National Panel however advised that, in their view, a Child Safeguarding Practice Review should be carried out and members of the partnership reviewed their decision.

1.3 This decision-making process meant a delay to the start of the review in 2020. Further delays were caused by the overview author withdrawing from the process late on in the original commission. A new author then had to be identified and commissioned to complete the review.

1.4 The single agency review by Children's Services was completed and shared with the partnership and has been used to inform some of the findings of this review, along with written submissions by all the agencies.

1.5 As a result of Child A's death, two police investigations were launched. Mother pleaded guilty to three separate charges associated with neglect and abandonment of all the children. Charges were brought for the incident in question and the months leading up to Child A's death. At the time of writing, Mother was serving a prison sentence for the offences. The taxi driver responsible for killing Child A pleaded guilty for causing death by dangerous driving.

1.6 The coronial process was ongoing and not concluded at the time of writing.

1.7 The surviving siblings (two older sisters) were made subject to care proceedings and placed with family members immediately after the death of Child A.

2 Terms of Reference

2.1 Members of The Bradford Partnership were keen to build on the learning from the rapid review and commission a proportionate review where the learning and subsequent recommendations could be shared and taken forward. The period covered is the preceding 3 years of involvement i.e., services provided between 2017 and 2020.

2.2 Agencies first became aware of the family in 2010. The panel used this early history to help build a picture of their day to day lived experience. The latter months of the review period (March – August 2020) coincide with the first of the national lockdowns imposed

by the government as the impact of the global Covid-19 pandemic hit. Agencies were therefore asked to comment on how this had influenced the quality-of-service delivery.

2.3 The report is based on the agencies' submissions and panel discussions. As significant time had lapsed between the commissioning of this report and the incident, many practitioners who knew the family had moved on. It was therefore not viable to hold a meaningful practitioner event but rather to hold thematic reflective events with current practitioners once the findings from this review and others had been finalised.

2.4 Various members of Child A's family took part in the review. His older sisters were spoken to with the help and assistance of extended family members where they now live. Child A's father and stepmother also responded to the invitation and met with the lead reviewer. Their contributions are summarised in section 7.

2.5 The broad areas included in the Terms of Reference that the panel agreed were the most important to examine are as follows.

- How were issues of neglect of Child A identified and assessed, using all available information from the family's network. This should include whether there was sufficient cognisance of identifying the cumulative impact of neglect over a number of years.
- Is there a shared understanding among agencies about thresholds for intervention for child protection enquiries (s47) and were these thresholds applied correctly in relation to these children?
- Was the impact of mother's poor mental health assessed and understood in terms of how it impacted on her parenting capacity? How was this understood by the network to have impacted on the children's emotional well-being?
- In relation to the above, how well was the children's day to day lived experience understood and assessed. If this was not understood, what were the barriers to hearing the children's voices?
- How were extended family included in assessments and interventions including assessing the support offered (or otherwise) by them. Special attention should be paid to the role of men in the lives of the children including their respective fathers, mother's partners, and male members of the extended family.
- How does the multi-agency network and partner agencies understand their role in challenge and escalation of matters where they believe a child to be suffering harm? Were there opportunities in this case to use formal routes to escalate concerns? If these were not utilised what were the barriers to this?
- Given the time lapse between the death of Child A and the publication of this review, what learning have agencies identified and what changes have occurred to practice as a result?
- The review should be cognisant of issues arising from diversity and intersectionality and how these may have influenced service delivery.
- What if any, was the impact of Covid -19 on service delivery to this family?

3 Summary of findings

3.1 The findings of the review indicate that the impact of severe neglect for these children was not sufficiently assessed or understood by the family or professional network. Work

that was carried out placed too much emphasis on the adult and not enough on the lived experience and voices of the children. The children took the opportunity to describe their home life in an articulate and thoughtful way, but their stories were not responded to with protective action. Consequently, the family were not helped to recognise and address the cumulative effects of the poor environment, lack of supervision and emotional unavailability.

3.2 Thresholds for statutory intervention i.e., joint s47 enquiries between the police and Children's Social Care were not applied and there was no multi agency approach to assisting the family on a longer-term basis or with a view to required changes being sustained. The criminal threshold for neglect was not understood and therefore not tested, by way of liaison with the police. There was limited assessment of harmful parental behaviours such as alcohol misuse, the legacy of domestic abuse and neglect of the children by leaving them home alone. The lack of understanding about the severity of the neglect and therefore the threshold for statutory intervention, meant that practitioners and managers were not sufficiently cognisant of the need to escalate concerns to a safeguarding level.

3.3 For many families, contact between fathers and their children provides a context for domestic abuse to continue. Notably in this instance, Mother had reported to mental health services that her ex-partner (father to the older sisters) was threatening and controlling, and the review notes that the oldest child also felt the impact of his behaviour. It is likely that this added to Mother's poor self-esteem and was missed by agencies. Although by no means the only issue Mother faced, it was an important one to assess to try and establish the correlation between Mother's poor mental health, the neglect of the children and the domestic abuse.

3.4 At the time of the incident, although there was a multi agency framework available to practitioners by which they could assess the risks associated with neglect over time, this was not embedded in practice and not utilised. A new tool is now in place, but this has also yet to be fully embedded.

3.5 Good practice was noted in the review by mental health services who went some way into considering the needs of the children. The Bradford District Safeguarding Children Partnership does not currently operate a strong 'think family' approach (i.e. one which requires assessments to take account of all family members and risk factors or strengths associated with them).

3.6 Adult focused agencies e.g., the GP and mental health services, did not liaise with each other sufficiently to fully discuss and highlight the possible implications for Mother and her children, as an adult with caring responsibilities. Nor were they sufficiently challenging of Children's Social Care when they did not assess the children's welfare. Mother not engaging should have been an additional 'red flag'.

3.7 Poor use of guidance, policies and procedures which would have assisted decision making also emerged as a theme from the review. Notably the continuum of need in Bradford and use of the professional disagreements process – 'Resolving Multi Agency Professional Disagreements and Escalation' were not used to apply the correct threshold and intervene robustly to improve the outcome for the children.

4 Child A Pen Picture

4.1 Before detailing the contact professionals had with Child A and his family it is important to reflect on him and his life. Child A was a seven-year-old child of mixed White and African Caribbean heritage. The following paragraphs were written by his older sisters.

Child A's sisters' words about their brother

4.2 *Child A was the bubbliest person I ever knew. He was the funniest and most caring brother I could wish for, although he was our younger brother and a little boy, he was very protective of us as his older sisters. He was so energetic, very active and on the go all the time. He often used up this energy by participating in fast, slightly aggressive full contact sports. At times this meant he was involved in watching or participating in physical contact sports such as wrestling and fighting… but this was his fun playful way to release that energy. However, Child A could also be very sassy, which made everyone laugh all the time and he was very much loved by everyone that knew him even those he often had his play fights within his sassy manner.*

4.3 *He loved watching Kindly Key TV, I remember how we would both sit down together, and we enjoyed it so much, one episode after another. I suppose he was his own character in his own TV show. He always knew how to make people laugh when they were down. He also had his way to deal with people if they were doing wrong, but in his sassy style!*

4.4 *Child A had the purest of hearts, he had the cutest smile which I miss seeing each and every day. He may have lived a relatively short life, all of us that knew him, I know for sure, that we are all left with many happy and fond memories to cherish eternally. He loved all kinds of sports and activities such as running, jogging, PE, you name it, he was into it. He especially loved sports day at school as he was the most competitive person there on the day, he was ready and eager to win every race.*

4.5 *I have so many memories of how we used to play with our cousins when we were very young and also fond memories of playing with our school friends and neighbours whilst Child A was growing older and becoming more streetwise. He was not just my brother, he was my best friend, my sidekick, and my partner in play. He (and I) liked to play out a lot every day till late. We loved being outdoors all the time as much as we could. We used to play with our next-door neighbour's son, we played lots of different outdoor games and Child A loved going to their house. He was very confident and sociable with his friends on the street.*

4.6 *Child A would often get angry and agitated very easily, he would then fight or bite people especially teachers at school which at the time would be quite funny for all of us to see. He did take his anger out on various people when he got frustrated about something. But he was a very bright child, it didn't matter if he was happy or sad, he always tried to show us his happy side, he always tried to make people laugh with the things he did.*

4.7 *I know I miss the way we used to play fight. I will always miss us playing together, both indoors and outside, alone or with others in the street. I will really miss how he used to put a smile on everyone's face, even when he could get a bit cheeky and extremely naughty.*

5 Agencies contact with Child A and his family.

5.1 The agencies' submissions as part of the review process have been briefly summarised here. Further information is provided in subsequent sections to add context where relevant. This is not intended to be an exhaustive list of day-to-day contacts but highlights the main interactions.

Background Information

5.2 Child A lived in the Bradford area with his mother. He had two older sisters, who have a different father. Records provided to the review indicate that all three children spent different amounts of time with their respective fathers, but their main address was with their mother.

5.3 Between 2010 and the start of this review period in 2017, the family came to the attention of Children's Services twice. In 2010 (before Child A was born) an assessment was completed by Children's Social Care in relation to one of his older sisters having made an allegation of physical assault. The assessment concluded that there was an injury to the child but that this had been caused accidentally when Mother threw a TV remote control. It is not clear what other enquiries were made with agencies who knew the family, but child protection enquiries were not undertaken.

5.4 In 2016, an anonymous referral was received via the National Society for the Prevention of Cruelty to Children (NSPCC) about Child A's older sister (aged 11) stating that her father was very aggressive and that he had threatened to 'beat her up'. This was responded to by Children's Social Care consulting with the child's school. They had no concerns, and the referral did not progress to an assessment.

5.5 Agency records also indicate that there was an incident in the autumn of 2016 whereby the middle child was involved in a minor road accident when she was hit by a car. She sustained superficial injuries. Mother reported the accident to the child's school and the police responded but took no further action in line with their procedure that time.

Key period of intervention: November 2017 – February 2018; Concerns emerge about Mother's poor mental health and disclosure of domestic abuse.

5.6 At the start of this review period in 2017 concerns emerged about Mother's poor mental health and suicide ideation, following an incident where she tried to drown herself in the bath, whilst under the influence of alcohol. She was taken to hospital by ambulance but left without being seen. She was returned to hospital the following day (by police) and had a full mental health assessment, where she described being overwhelmed by her circumstances. She expressed some suicide ideation and had seriously considered how she could end her life. Mother did not return home for two days and the children were left with a young relative.

5.7 Mother was offered short term, crisis related assessment and interventions from the Intensive Home Treatment Team via the adult mental health service provider - Bradford District Care NHS Foundation Trust (BDCFT). There were three attempts to engage her before she was seen on three further occasions, and she did participate in these contacts. Child A was present for one of them.

5.8 Mother was provided with information for other emergency mental health services and longer-term counselling options, but subsequent visits were unsuccessful due to her being uncontactable, i.e., not answering the door and not responding to correspondence. As such she was discharged. A notification letter should have been sent to her GP which would have outlined the details of the referral and her limited engagement. This was not sent in this instance. (NB there is now a system in place to ensure that this occurs).

5.9 Mother attended a GP appointment in December 2017 (about 2 weeks after her suicide attempt) presenting with anxiety and low mood. The GP noted the recent suicide attempts and prescribed anti-depressants. Mother stated that she was managing the children and that her partner (possibly ex-partner) was helping. The GP requested that Mother make a follow up appointment so that her mental health could be reviewed, but this was never booked. The GP was unaware that Mother had been discharged from the Intensive Home Treatment Team.

5.10 Early in 2018, concerns were reported by West Yorkshire Police to Children's Social Care in relation to the family's home conditions, further worries about Mother's alcohol misuse and her poor mental health. The police had received a phone call from a family member saying that Mother sent a message indicating that she was going to take her own life. The police visited and found Mother heavily intoxicated. The family member was also present.

5.11 The police did not consider it necessary to detain Mother under the Mental Health Act and she was left in the care of the family member. The police log records that it was believed two young children lived there but were not present. From police reports, Children's Social Care were contacted but they did not feel it was appropriate to assess Mother over the phone and the police completed an early help referral. This was not recorded on Children's Social Care's database, so it is unclear how this was followed up.

Key period of intervention: March – June 2019. Concerns arise about children being left home alone.

5.12 Between March and June 2019, there were three contacts raised with Children's Social Care in relation to Child A's oldest sister who would have been thirteen at that time. The first one was in March 2019 when she expressed to school that she found her father very aggressive and did not want to see him anymore. This was followed by a second contact a few weeks later about the same sister reporting to school that she was often left as the sole carer for her younger siblings overnight (aged 9 and 7). Both these contacts were logged as 'information only'.

5.13 A third contact of a similar nature was made by school to Children's Social Care in June 2019 when the same sister again reported that she was regularly left to care for her younger siblings overnight. It was a credible account, and this was accepted as a referral requiring assessment which was undertaken by Children's Social Care. It is recorded in the assessment that the sister retracted the allegation and said that she had been mistaken and Mother was in fact in the house (we know now this was because Mother told her to). Mother did however admit to leaving them whilst she went shopping but not overnight. The assessment concluded that there was no evidence that the children were left home alone, and no further intervention was taken. Child A was not spoken to alone as part of the assessment as he was reluctant to speak to the social worker. Mother

declined the offer of early help, and the family were closed to Children's Social Care.

Key period of intervention: March – May 2020. Allegations by the children that Mother was emotionally and physically abusive towards them

5.14 In March 2020 the middle sister in the family (aged 10) made allegations to the school that their mother was emotionally abusive to them. Mother was allegedly swearing at them and using abusive and threatening language towards them. School spoke to Mother who said that she was 'joking'. Nevertheless, good practice was seen, and school appropriately made a referral to Children's Social Care. NB this referral and period of intervention coincides with the first national lockdown, imposed by the government to prevent the spread of Covid-19.

5.15 The following day the child presented at school with a bruise stating that it had been caused by Mother. A Child and Family assessment was undertaken, but there was no strategy discussion, s47 (child protection) enquiries or child protection medical. The assessment did however raise concerns about the poor home conditions. It was reported that there were rubbish bags overflowing out of the kitchen to the stairs, one of the children's beds was broken and they had been sleeping on a filthy mattress for the last month.

5.16 From Children's Social Care records, some work on the conditions of the home was carried out. For example, a new bed for the older sister and benefit applications were made, but the family were closed at the end of the assessment period in early May. Information from the review suggests that some of the material in the assessment was copied from the one undertaken the previous year and was not relevant to the current situation. N.B. the sisters do not recall receiving new furniture or the conditions in the home improving.

5.17 There were no further significant contacts with the family until the events that led to this CSPR in August 2020. The younger children attended school during the initial lockdown of the same year. The older sister had weekly telephone contact with school and no issues were reported at this time.

6 Findings

Recognition, identification, and assessment of neglect

Information from the review

6.1 The review has highlighted that Child A and his sisters were subject to several years of chronic neglect. Although referrals were made to Children's Social Care and assessments undertaken, these were superficial and opportunities to intervene in a robust manner were not taken by agencies.

6.2 At the start of this review period in the latter half of 2017 and early 2018, information about the children's mother, her mental health and possible alcohol misuse was very concerning. There was no formal multi agency response to a very serious mental health crisis in an adult with caring responsibilities. The cumulation of concerns i.e. Mother's

attempted suicide, concerns about alcohol misuse, her worries about domestic abuse and the poor home conditions should have triggered a formal multi agency assessment led by Children's Social Care. Her subsequent limited engagement with services to address her mental health was also a concern.

6.3 Two agencies (police and ambulance service) made referrals to Children's Social Care in relation to this incident, but these were logged as 'Information only'. It is difficult to understand the rationale for this given the seriousness of the situation. Further opportunities for adult focused services to share more detail did not happen i.e., the mental health practitioner in the hospital, the Intensive Home Treatment Team worker, and the GP. There is strong practice noted when they did consider the whole family but there is no evidence that the needs of the children in this scenario were communicated separately to Children's Social Care. This was likely to be because they believed that the referrals that had already been made would have resulted in intervention. Children's Social Care's position in not providing intervention was not challenged. More is said about Mother's mental health and the impact of this on the children in paras 6.18-6.27. Suffice to say here that the multi-agency response to the concerns about the home environment, assessing the children's needs and the impact of parental mental ill health was inadequate.

6.4 The mental health assessment in the hospital was thorough and recognised that it was important to understand the children's home conditions. They recommended that the Intensive Home Treatment Team visit the home, which they did, but there was no clear plan about how this should be managed. Improvements to the home had been made by the time they did visit, and this lessened concerns. Barriers to escalating concerns further seemed to be that when the Intensive Home Treatment Team contacted Children's Social Care, they were told by an administrator that the family were closed (in fact they were never opened).

6.5 It is not clear what further information was shared, but Children's Social Care took no further action. After discussing the family with the trust's safeguarding team, they, (Intensive Home Treatment Team), checked with school and the school nursing team who also had no concerns. The available information within the safeguarding system was gathered in a piecemeal way and would have benefitted from a more formal mechanism e.g., assessment and multi-agency meeting led by Children's Social Care to link historical information with the mounting concerns. Children's Social Care made decisions without discussions with mental health practitioners, and this meant that key information was missed.

6.6 The further referrals in 2019 and 2020 as discussed in the narrative section of the report were not dealt with in a child centred way. Information from the review tells us that the children made (and repeated) allegations in a consistent and detailed way which were corroborated (at least in part) by Mother herself. Further, the allegations were backed by the history of previous worries and concerns available to key agencies.

6.7 Despite the history and the context provided by the children, especially in relation to disclosures to school about being home alone, the conclusion reached was that the family did not need intervention and there were no safeguarding concerns. The assessment undertaken in 2020 was another missed opportunity to gather information from all sources

and intervene more robustly. Understanding of the children's day to day experience and hearing their voices was extremely limited. More is said about this in paras 6.28-6.34.

6.8 Given the tragic circumstances for Child A that have led to this review, it is necessary to look at the issues that created this practice shortfall in relation to identifying and addressing neglect. As in many multi agency reviews there were number of contributory factors that acted as a barrier to good practice. These were;

- The context of working in Bradford was challenging for practitioners at that time. In 2018 Bradford Children's Social Care Services received an inadequate judgement from OFSTED[1]. The inspection identified widespread systemic failures to identify risk and protect children. Inspectors put this down to increased demand for services and difficulties recruiting experienced workers.

- As identified in the Children's Social Care single agency review, caseloads were high at this time and therefore did not necessarily give practitioners opportunity to devote the requisite time to assess families adequately. These have slowly reduced in the last year.

- The lack of a clear multi agency response that required detailed information sharing and analysis of the findings.

- The available framework by which to identify and assess neglect over time was not embedded in everyday practice. (This has now been rectified and an updated tool has been in use since May 2022).

- The family were designated as 'Early Help' from an early point in their history. This seemed to be a 'fixed' idea that was hard to shift despite evidence to the contrary. There was a reluctance to identify the children's needs through the lens of safeguarding concerns. In 2018 Ofsted identified a culture of identifying all cases of neglect as Early Help which may have been a feature for this family.

- On the occasions that Mother was offered Early Help services, she declined. As these are consent based services, she was not obliged to accept them and there was no follow up. Non engagement with support services was not viewed as a safeguarding concern.

- Despite the children being very clear in their disclosures, preference was given to the voice of the adult (Mother). This is especially pertinent in relation to Child A's father as she told workers that he was not involved, and this was misleading.

- Management oversight was not robust in challenging the view held.

- History was not used well to inform current risk to the children and assess the cumulative harm that long term neglect causes.

- Key agencies who made referrals did not follow these up and challenge the status quo when Children's Social Care did not act.

- Changes to the structure of teams in Children's Social Care in spring 2020 meant

[1] [1] https://files.ofsted.gov.uk/v1/file/50035108

added pressure for social workers to provide assessment *and* intervention within the same service. This was in place for a short period of time and a new structure is now in place that separates out these two functions.

Learning and Implications for improving practice

6.9 Neglect is a prevailing issue in multi-agency child protection work. Nationally, the numbers of children subject to Child Protection Plans under the category of neglect has significantly increased year on year. Bradford is no exception and along with increasing numbers of children subject to Child Protection Plans generally, there has been an increase in the numbers of children categorised under neglect. The latest figures from 2022 place neglect in Bradford as the second highest category of Child Protection Plans, second to emotional abuse.

6.10 It is crucial therefore that practitioners across the key partners including adult services, are skilled and confident in identifying and assessing child neglect. Recognition that it is not a single event, and that early intervention is necessary to mitigate against children suffering the worst consequences of long-term neglect should be a priority. Children who suffer long term physical and emotional neglect are those with some of the worst outcomes in terms of their mental health and well-being, as they transition to adulthood, so it is important that agencies respond effectively. For Child A and his sisters, responses from Children's Social Care and other agencies were incident led and failed to take account of their ongoing experiences. Opportunities were missed to assess the children's needs over time. As a result, the children did not receive the help they needed in a timely fashion.

6.11 The multi-agency chronology and written submissions prepared for this review give a clear overview of the concerns for the children in this family and are invaluable documents in gaining an understanding of the children's journey. To this end, the formulation of chronologies is a helpful tool to plot risks over time. The Bradford Partnership have introduced a neglect tool kit to enable practitioners from all agencies to better identify and assess neglect. It is not clear what the expectation is in relation to the formulation of chronologies in this piece of work, and this may be a useful addition. The panel were of the view that this may be an area of practice to explore, particularly in relation to cases where there may be some inter-agency challenge about decision-making or thresholds for intervention.

6.12 The current Neglect Strategy is due to be updated and a recommendation is made to that effect. In addition, The Bradford Partnership have promoted multi agency training opportunities in relation to neglect to improve understanding and practice in this area.

6.13 The Bradford Partnership have developed and updated their practice tool to assist with identification and intervention when children are subject of neglect. This is a strong tool but is yet to be embedded across the network which limits its effectiveness. It would be beneficial to track the use of this tool and encourage its inclusion in planning for children across the range of interventions.

Thresholds for child protection (s47) enquiries

Information from the review

6.14 None of the concerns raised in the review period led to multi agency child protection enquires. There is no evidence of multi-agency meetings taking place and little indication that there was meaningful collaboration between agencies who knew the family. This is surprising given professionals' and latterly the children's own descriptions of their experiences, which tells a concerning story. Between 2017 and 2020 when Child A died, there are strong examples of the children potentially suffering significant harm where strategy discussions should have been convened to consider single or joint child protection enquiries. These are,

- In 2017 Mother had a serious mental health crisis where she considered taking her own life whilst under the influence of alcohol. The impact of this on the children was not assessed by any agency.

- At least two allegations of physical assault. In 2019 the oldest sister alleged that she had had an altercation with her father which had resulted in him hitting her in the stomach. This was in the context of her disclosing to school how aggressive her father was and that she did not feel safe with him. In 2020 the middle sister alleged being kicked in the stomach by Mother and had a bruise.

- Two separate occasions in 2019 and again in 2020 where the children alleged that they were left home alone overnight. They were left at times without electricity, and this made them feel scared. They also alleged that they only had food in the evenings (which was take away food) and no breakfast or lunch. There is also a reference to mice eating the children's breakfast cereal.

- Allegations to the school in 2020 that Mother was verbally abusive and aggressive towards them. This was also in the context of a chronology of the previous concerns detailed above.

Learning and Implications for improving practice

6.15 The concerns that were known about covered a spectrum of child abuse – e.g., physical, emotional abuse and neglect. Neglect of the children's need for safety, emotional warmth and security were apparent in all the concerns. Information provided to the review suggests that the thresholds for intervention were misunderstood by all agencies and that available tools to assist with this were not utilised. Bradford's Continuum of Need and Risk Identification tool (dated April 2019) gives a comprehensive overview of thresholds for intervention which would have placed the concerns raised in 2017 at least level 3. With the latter referrals in 2019 and 2020 (considering the cumulative history at this point) at level 4. There is learning for the partnership about how practitioners use policies and procedures to support their practice. Use of the available documents would have been a helpful tool to recognise the risks associated with Mother's concerning behaviour towards her children.

6.16 Decisions about threshold appear to have been made by Children's Social Care in isolation. The lack of multi-agency strategy discussions to determine a threshold for s47 enquiries was also problematic. It negated the opportunity for the police to consider (and

investigate if necessary) allegations that might have reached a criminal threshold and did not allow information from other agencies (particularly mental health services) to contribute to the decision making. Consideration of child protection medicals for the children was also missed.

6.17 Lack of clarity about thresholds aside, all levels of work required to protect children or promote their welfare requires a co-ordinated multi agency approach which was also lacking. Local protocols and national guidance all place an emphasis on the importance of this.

The impact of parental mental ill health

Information from the review

6.18 Mother suffered a serious mental health crisis in 2017. As described in the narrative section of the report she received some short-term crisis intervention after trying to drown herself in the bath but was mainly avoidant of on-going services. There was no multi agency response to this event and no agency explored the impact of this on the children. Mental health services did consider Mother's capacity to adequately care for them, but their assessment would have benefitted from including and considering all the available information. E.g. from those agencies who knew the children. After this point, material received as part of this review suggests that Mother did not come to the attention of mental health services again. There are a few references to her anxiety in the school's submissions but subsequent referrals and assessments by agencies such as Children's Social Care did not identify this as a concern.

6.19 Given the serious nature of this crisis and the multiple missed opportunities to explore further, the panel were keen to explore the practice around this and understand what the barriers were. During this episode Mother was in contact with various practitioners who were aware that she had caring responsibilities. This includes the police, the ambulance service, the emergency department at the hospital, the Intensive Home Treatment Team and the GP. During the initial contact, the police struggled to identify who was caring for the children and then were further concerned when the person was found to be under the influence of alcohol.

6.20 The police and ambulance service made referrals to Bradford's Integrated Front Door, but a decision was made to log these for information only. Whilst it is difficult to understand the rationale for this, the decision may have been reconsidered had other referrals also been made by other services, thereby adding weight to the original concerns. This is especially pertinent when Mother failed to really engage with mental health services and did not follow up with her GP appointment. From research as part of this review, the organisation of front door services at that time was problematic and this was noted in OFSTED reports around the same period.

Learning and Implications for improving practice

6.21 The impact of parental mental health on capacity to provide good enough parenting has been well researched. It is widely accepted that parents often need support to manage family life both in times of crisis but also with any ongoing conditions. The review has highlighted that agencies encountering Mother did not seek to collaborate effectively with

children's services and in turn, children's services did not seek further information from referrals that were made. There was some liaison between these services (ED, Intensive Home Treatment Team and the GP) but these did not result in a co-ordinated multi agency response that considered everyone in the family.

6.22 It is possible that the Psychiatric Liaison Nurse who assessed Mother in hospital was reassured, knowing that the police had made a referral to Children's Social Care in respect of the children. Similarly, the GP was reassured by the involvement of the Intensive Home Treatment Team. Neither sought clarification of what those services were doing or expressed their concerns about Mother's ability to manage her symptoms in their contact with Children's Social Care. Staff from BDCFT did have an awareness of Mother as a carer and contacted other agencies to enquire about the children which was positive in trying to gain an understanding of the family. These practitioners were tenacious in their efforts to engage Mother, but their involvement was short lived. The lack of challenge to Children's Social Care is discussed further in section 6.37.

6.23 Multi agency contribution to meetings, assessments and plans are important. More professional curiosity was needed when agencies noted that Children's Social Care had not planned any interventions. Each agency will have their own information and unique view, and this adds to the overall analysis application of critical thinking with which front door services can plan a course of action. This resonates with other reviews in Bradford. In this case, a referral from BDCFT would have illuminated issues with domestic abuse that were also impacting mother's mental health and were likely to be affecting the children. These concerns were unknown to Children's Social Care at that time.

6.24 Information provided to the review from BTHFT makes the point that their internal procedures were not followed, and it would have been best practice for staff to have referred to their children's safeguarding team as per their trust policy for 'children behind the adult'. The paediatric liaison form is another mechanism which would have generated an opportunity to refer to Children's Social Care, highlighting the concerns around poor mental health and alcohol misuse.

6.25 In addition, the intervention by mental health services also identified issues of alcohol misuse and a history of domestic abuse from the older children's father who had recently made contact and was back in the family's life. Mother directly attributed her anxiety to his reappearance and described that she also thought her older daughter had been affected negatively by his presence. Mother described her ex-partner as 'threatening and controlling' and she had noticed the impact of that on her oldest child. She spoke of other debilitating features of her current lifestyle, e.g., having given up her college course, and suffering some physical health problems. These factors alongside the very poor home conditions (albeit they improved at this time) were worthy of further exploration. The plan made to support Mother was appropriate in trying to support her individually but did not come into fruition on a longer-term basis when practitioners struggled to engage her.

6.26 Good practice would dictate that partnerships have a 'Think Family' policy as a joint enterprise with safeguarding adults' boards. Its purpose is to promote joint working between adult services and children's services and ensure a holistic approach to safeguarding. Whilst there is some work in development in this area of practice it is in its early stages and practitioners would benefit from guidance as to how best facilitate this

approach.

6.27 BDCFT have undertaken development work since the time of Child A's death. This includes training for adult mental health staff in domestic abuse, escalation of concerns, professional curiosity, confirmation bias and 'think family'. This work in the mandatory training programme and includes targeted work around domestic abuse and the impact on children.

6.28 Work is also currently taking place to improve the way that the Front Door in Bradford operates, to make the volume of work more manageable and ensure a more integrated, multi-agency process. The improvements are opportune and when embedded will serve to provide the correct response to children's needs in a timely and holistic fashion.

Children's day to day lived experiences

Information from the review

6.29 The children's day to day lived experience was not sufficiently explored, assessed, or understood. From the information provided to the review, the children in this family (including Child A) were articulate and able to voice their opinions. They related their concerns about their home life a number of times. Notably, in 2019, Child A's older sister (aged 13) gave a very detailed account of being at home alone with her siblings. The child's account is credible as she is able to describe her struggles, worries and fears of having to care for two younger children; that she is aware that she shouldn't be in this position and that she found it anxiety provoking. She explained her difficulties about not always knowing where the younger children were, not always realising that they had left the house and not being able to exert authority over them if they were fighting. In terms of practice, much more weight seems to have been given to her retraction of this allegation, combined with Mother's much more limited account of only leaving them for a couple of hours when she was shopping. From records it would appear that the younger children were spoken to but were not asked directly about what was happening in the family. This was a missed opportunity to corroborate the older sister's account.

6.30 At other times, the children's accounts of their inadequate home lives do corroborate each other's. They appear coherent and clear in their interactions with practitioners, the conclusions of the assessments (that there were no safeguarding concerns), therefore does not match what the children in the family were communicating.

Learning and Implications for improving practice

6.31 There is little evidence of direct work in the assessments conducted and very little sense of who these children were. There was no exploration of wider family members (including their respective fathers) and relationships that the children had, no expression of how they saw themselves, their unique identities, sense of belonging or key friendships they may have had. The assessments completed were superficial and did not have an analysis of what protective factors were in place which may have been provided by extended family members.

6.32 A genogram would have been a useful place to start some further exploration of the nuances of this family, including where they spent their time and who with. Whilst it cannot

be concluded that this would necessarily have impacted on the outcome for Child A, it would have provided a more complete picture and enabled further understanding of the children and their lived experience. This in turn would have assisted in planning and led to increased intervention that was more readily viewed through a child protection lens.

6.33 The children's fathers were a crucial piece of assessment work to have undertaken. There were worries about the older two sisters' father in relation to domestic abuse which should have been explored. The part he played in the family was unclear on the records but some of the detail has been provided by Child A's sisters. Child A's father became more involved in the latter part of his life and potentially could have assessed as a protective factor. This fact emerged in consultation with the family for this review and was previously unknown. This was a major oversight and demonstrates again how much Mother's word was accepted at face value without being clarified. School staff were also unaware of his recent involvement.

6.34 Relationship based practice and direct work with trusted adults empowers children to be able to tell their story and be part of the solution to resolving difficulties. Practitioners therefore need to be skilled in eliciting the wishes and feelings of children and using their words and stories to assess risk and plan accordingly. Children need to be spoken to alone and practitioners (with help from their managers) should apply an analytical approach and consider all the available information when children make allegations and then retract them. This is a common occurrence in multi-agency work and represents a challenge when accounts conflict. The concept that, first and foremost, practitioners should listen to children does not seem to have been applied.

6.35 Through the process of the review, these children's experiences have become clearer but there is very limited information of issues arising from their specific identities. Exploring issues of intersectionality[2] would also have been a helpful framework to aid practitioners' understanding of them. As a family they encountered multiple disadvantages, and multiple barriers to accessing services. The children were of (different) mixed heritages, were mainly brought up in a single parent household, were adversely impacted by poverty and had poor housing. It was believed that they had sporadic contact with their respective fathers about whom at least one child expressed some difficulties. This was not sufficiently explored and was incorrect in relation to Child A who we have learned through this process did have a relationship with his paternal family. The cumulative effect of these factors was not evident across the multi-agency network. Services from across the partnership in Bradford, who support children, need to be cognisant of the impact of specific factors such as race, gender, religion, and family background.

Escalation and challenge across the partnership

Information from the review

6.36 Information from partners across the network suggests that decisions made by agencies about the welfare of the children were accepted at face value and not challenged. There

[2] Intersectionality is the interconnected nature of social categorisations such as ethnicity, race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage

is no evidence of agencies contacting Children's Social Care when the family were closed, and serious incidents logged 'for information only' without further intervention. The family were not 'stepped down' to early help or other services, largely because Mother would not consent. Safeguarding supervision was rarely sought, and this could have opened a pathway to escalate concerns with the support of a manager.

Learning and Implications for improving practice

6.37 Services and organisations across the partnership all make a significant contribution to safeguarding children. A healthy learning organisation is one in which discussion and challenge between agencies is welcomed and there are formal mechanisms in place to resolve difficulties. Children's outcomes improve when agencies share information, air disagreements, and resolve these for the benefit of the child.

6.38 In the period under review, there is no evidence that agencies disputed the actions of Children's Social Care either formally or informally which is surprising given the gravity of the concerns. This may suggest a lack of confidence in agencies feeling able to challenge when necessary and have trust in a robust mechanism which has the child's interests at heart. The Partnership in Bradford has a clear resolution and escalation process, which was not used. Difficulties in professional disagreements and barriers to effective challenge is a feature of other multi agency reviews over several years. This would be worthy of further exploration by the Partnership.

6.39 There is limited evidence in the information provided to the review of robust safeguarding supervision. Designated managers and safeguarding professionals are key to providing practitioners with support and expertise and were underutilised in this case.

7 Family Contribution

Child A's sisters

7.1 The lead reviewer met with Child A's older sisters in their home with their extended family where they now live. Through notes shared by them and from speaking with both girls with their aunt and uncle (with whom they live), the following is a summary of the girls' experiences of services. The sisters were also able to fill in some of the gaps that the panel were unable to answer from information submitted by agencies. They feel that they were badly let down by services and the sisters were open and forthright about sharing their experiences. The panel and author are grateful to them for speaking so candidly. The girls were keen that the learning from their situation is shared widely so that their experience is not replicated for other families.

7.2 One of their biggest areas of concern was how professionals did not notice the terrible conditions they were living in and act protectively much sooner. In the years prior to Child A's death, they moved several times. Each property started out as fine but then quickly became unclean and uninhabitable. Although their mother would always ensure that she had nice things in her room, for them as children it was a different story. There was rubbish piled up, no furniture to speak of, no proper bedding or beds and often no food. Their mother would often get into debt with rent arrears (even though she had enough

money) and they would end up moving again. At one point they had to move in with their aunt but there was not enough space and the older sister had to sleep on the floor. Another of the properties they moved to was in a terrible state. There was no working cooker, no fridge and the toaster was contaminated with mice droppings.

7.3 The girls can see now how they were manipulated by their mother, and she made sure that they did not disclose what life was really like by threatening them with being 'taken into care' and split up. For the girls that does not explain how it was missed. They described often going into school, looking unkempt with frequent headlice (particularly Child A), and often needing food in school because they were so hungry. At times they were left for much of the weekend without food, gas, or electricity. Their mother always made sure that she was back in time to get them to school. They find it difficult to believe that this could have been missed by those that saw them regularly. They saw counsellors in school and had teachers that they spent time with, in and out of class.

7.4 On the occasions they were spoken to, perhaps by school staff or social workers, their mother always had an explanation, and the involvement did not last. They gave good descriptions of their lives, but professionals always seemed to take the adults' word rather than theirs. Mother was often physically and verbally abusive, (towards all the children) but this was also 'explained' e.g., as a joke or an accident. As a result of one of the interventions, they remember their mother going to something like parenting classes, but this did not make any difference to them. Mother remained neglectful and abusive. Even after Child A's tragic death there was no follow up from children's services to talk with the girls about their life at home.

7.5 The relationship with their father was not always easy (mostly the older sister), but they stated that he was often the one who 'rescued' them. He would provide food and sometimes they would stay with him. He took them to school and the Mosque. He always included Child A, sometimes buying clothes for him when he needed them. He also provided financial support to their mother and when this dried up, she did not manage the finances and got into debt.

7.6 Services did not know or enquire about other members of their extended family. Their mother had a big family network and some of them were also known to services, and they think that this should have been taken into account when children's services (and others) were involved with them. They don't think services knew about their respective fathers and they were not asked. Again, they think that services preferred their mother's version which was that they were not in touch with their dads.

7.7 Both girls remember the incident where their mother made a suicide attempt. They were aware of happening i.e. were witness to it and suffered the aftershock of such an event. This was also a time when their mother would leave them with people that they did not know, and she barely knew. They were aware that their mother discharged herself from hospital and went on a night out straight away. Where was the follow up from services after an attempted suicide, as well as any follow up of who was caring for the 3 children whilst Mother was in hospital?

7.8 Alcohol was becoming an ever present feature, and they were left to fend for themselves. The children being on their own was a very regular feature of their lives. They lived on

spaghetti, snacks from the local shops and sweets. If there was money (like on benefits days), prepacked food might be bought e.g., sandwiches, but they rarely ate anything nutritious. When they came into care, they were both underweight. The older sister was diagnosed with coeliac disease that previously went unnoticed and therefore untreated. The girls feel strongly that they needed help during their childhoods, but they did not receive it. Their question was; when a child goes through something terrible like that, why was there no help offered? The long-term impact for them of such severe neglect is profound.

7.9 Both girls worried about Child A. His behaviour could be difficult, and he sometimes fought to get attention. They wonder how many times Child A had been left on his own when they were not able to be there. Child A's older sister was basically the parent to her younger siblings for many years and she feels guilty that she wasn't there to look after Child A on the day of his death.

7.10 There is further learning from the girls' perspective in the aftermath of Child A's death. They have been largely left out of the police investigations into his death and this has been rectified only recently (close to three years after the death of their brother). The girls had no opportunity to liaise with anyone from the police to be able to ask any questions about what actually happened to their brother, or what was happening throughout the investigations and sentencing of their mother.

7.11 They also feel that they were not recognised sufficiently as Child A's closest family. They reported that after the event other family members were given precedence over them, even though they were the ones that had always been there for him. The consequences of this is that the older sibling struggled to attend the funeral as it was organised and attended by people she didn't know. The girls did not know who would be organising it. They were not involved and were simply informed a week before the funeral of the date, time and place. This has affected the older sibling's ability to deal with her loss and grief as well as her genuine anxiety and fear about visiting Child A's grave. Support for them after this tragic event has also been slow to be put in place, even whilst becoming children in care placed with extended family where they chose to reside.

Child A's father and stepmother

7.12 The lead reviewer met with Child A's father and stepmother towards the end of the review process. The panel and reviewer are very grateful for their contribution as the report is much richer for it, and it provides more of an understanding of the relationship Child A had with his paternal family. The meeting provided information not previously known to the review and highlights more learning for the partnership in ensuring that assessments consider all aspects of a child's life.

7.13 Despite there being a pervasive belief in the professional network that Child A's contact with his father was 'sporadic', this was untrue and towards to the end of his life (the few months preceding his death) Child A was spending more time with his father and stepmother. They stated that Child A enjoyed a close relationship with his father, and they were very similar in moods, temperament and looks. They stated that Child A loved spending time with this side of his family and was becoming increasingly close to his other

siblings especially the younger ones. He had siblings (older as well as younger) from his father's previous relationships. The couple have some very special memories of a day out with Child A and his younger siblings not long before his death.

7.14 Father and stepmother were surprised to learn after Child A's death of the involvement of services. They had not known at the time about the involvement of Children's Social Care and mental health services. They hold a strong belief that had they known the truth of the children's circumstances, Child A could have been with them and therefore would not have died. He had his own room, belongings, and clothes at their house and was comfortable there.

7.15 Father and stepmother were largely unable to comment on services as they had not been in receipt of any, but the lack of contact with them tells its own story. They are disappointed that professionals did not include them in any work that was completed and feel that services let the children down. They were unaware of them (the children) being left alone and believe they were not given the opportunity to step in and help when things were difficult. On the occasions when they had contact with Child A's mother, she would always say that the children were with her sister. Father was not involved in any assessments, nor was he invited to parents' evenings at school or given any information about Child A's progress.

7.16 In hindsight, they can now see that Child A hinted at his life at his mother's house. He would often ask for a bath as he was not allowed one at home due to there being no electricity. He would comment on how nice home cooked food was, saying that he only had takeaways at home. Stepmother would note how dirty Child A appeared to be at times and he often had headlice but did not think that he was neglected to the extent that is now clear. They were also aware of vermin in the household.

7.17 On a positive note, they did comment about how helpful the police Family Liaison Officer (FLO) had been after Child A's death. He has been consistent in supporting them and explaining the process of the criminal proceedings. He has also helped them to understand and navigate their way around the different charges that were brought against both Mother and subsequently the taxi driver.

8 Recommendations

8.1 The Bradford Partnership should update and re-launch the existing neglect strategy and associated tool kit. This should include a comms strategy about how it is rolled out – e.g., one-minute guides, six-minute briefings, lunch time sessions etc.

8.2 Bradford Partnership should update its training strategy to include the rollout of neglect strategy and tool kit on a routine basis.

8.3 Bradford partnership should oversee an audit of the effectiveness of the multi-agency response to neglect as part of their Quality Assurance Framework. Key questions should include how well the existing tool kit is used across the range of services (from Early Help to Children in Care) and how is it incorporated into multi agency plans for children where neglect is identified as an issue.

8.4 Bradford Partnership should review and relaunch the inter-agency escalation policy and provide clarity for practitioners and managers on how and when to use the policy. To facilitate this, the partnership should invite agencies to participate in a 'Task and Finish' group that allows them to explore the barriers to professional challenge and what would support good practice. As part of this work, the partnership should explore other avenues that could be developed to enable front line staff to discuss cases of concern e.g., multi-agency forums or subgroups.

8.5 In line with the above recommendation all partner agencies should ensure that their single agency training offer includes bespoke training on Bradford Partnership's escalation policy and equip all staff to confident in raising concerns and disagreements.

8.6 The Bradford Partnership should ensure through its training programme and auditing that all agencies have arrangements in place to ensure ongoing work includes the child's voice and experience (including family relationships), with this information being used to analyse the plan for the child, the difference the work is making (impact) and the level of risk.

8.7 Bradford Partnership to oversee the development of a "Think family' joint protocol with Bradford Safeguarding Adult's Board. The Bradford Partnership should share the lessons from this review with SAB and ensure that the 'think family' approach is a primary focus for all safeguarding partners.

8.8 The Bradford Partnership should review their training strategy to ensure that all partners equip their practitioners to be confident when dealing with families where domestic abuse is (or has been) a factor. This should include the importance of professional curiosity about all relationships and exploring potential ongoing risks when parents separate.

8.9 The Bradford Partnership should provide a training programme which equips practitioners with the knowledge and understanding of intersectionality for those families who experience multiple oppressions. The focus of the training should be to enable practitioners to identify and assess these factors when managing the risk to children.

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