Norfolk Safeguarding Children Partnership

Child Safeguarding Practice Review

AL

December 2022

FINAL FOR PUBLICATION

1 Introduction

1.1 The death of any child or young person is tragic. The Norfolk Safeguarding Children Partnership offers its condolences to AL's Family and thanks them for assisting in this Review.

1.2 It appeared that AL took his own life, age 17. He had experienced several years of poor mental health and was in acute grief. The Inquest is awaited. *The Partnership will consider any additional learning that comes from the Inquest.*

1.3 Norfolk Safeguarding Children Partnership commissioned this Child Safeguarding Practice Review (CSPR)[1] to learn from the circumstances of AL's death. At the Rapid Review[2] shortly after AL's death the complex inter-play between mental health, for either a child or a parent, and safeguarding children was noted as a key area for this CSPR to consider.

1.4 The Purpose of a CSPR is to seek to understand what happened, and why, to assess the effectiveness of local multi-disciplinary child safeguarding systems, and to identify any improvements which may be required in those systems. The principle is to use a systems approach to analyse interventions in the context of the multi-disciplinary system rather than the actions of any one individual or agency. Analysing a single case may indicate the effectiveness of the system as a whole. It is not the purpose of a CSPR to seek to identify whether a critical incident could have been prevented, nor whether anyone is to blame.

1.5 Members of AL's Family were consulted and gave their views about the family's needs and the agency responses. AL's Father was unwell and died before he was able to contribute his views.

1.6 Some of the practitioners or managers who were directly involved met individually with the independent Lead Reviewer and Review Panel Chair. There were also conversations with agency representatives who had not been involved to understand agency systems, responses and structures. A Reflective Practice Learning Event was held for practitioners and managers involved to share their own learning and their responses to the emerging learning that the Panel had identified. Their views are incorporated into the Analysis and Learning in section 5. The Norfolk Safeguarding Children Partnership thanks them for their reflective contributions and acknowledges that the practitioners were also deeply affected by AL's death. The Review also had access to relevant agency records about the case and local policies and procedures.

1.7 The Review was undertaken by an Independent Panel of senior managers from the agencies involved. It was led by the Head of NSCP Business Delivery and the independent Lead Reviewer.

1.8 The scope of this Review was to understand the multi-agency work with the family between January 2019 and January 2022, when AL died. It was agreed that the work with the whole family, including AL's older sister and younger brother, and with the parents in their own right should also be considered. The review has also considered relevant family history and agency involvement before 2019 to understand the complexity of the mental health issues in this family.

[1] CSPR – a statutory multi-disciplinary and independent review after a child dies or is seriously harmed. Its primary purpose is to learn and identify any changes which may be required in local or national safeguarding systems.
See **Working Together to Safeguard Children**, 2018, Chapter 4 Working together to safeguard children - GOV.UK (www.gov.uk)

[2] Rapid Review – a Rapid Review is held quickly after a child's death or a critical incident in which a child has been harmed to learn about the immediate circumstances, decide if safeguarding actions need to be taken and identity any early lessons and/or actions which may be required. It is parallel to any criminal or coroner's enquiry and may recommend a CSPR if a fuller review indicated. Rapid Reviews are also governed by **Working Together to Safeguard Children**, 2018, Chapter 4.

1.9 The key lines of enquiry set from the Rapid Review were:

- Agency responses to mental health / safeguarding,
- Family approach to multi-agency safeguarding and mental health,
- Bereavement and trauma,
- Older children and young people living with neglect,
- Recognition of the needs of young carers,
- Multi-agency arrangements for risk management, service provision and children and young people in specialist education,
- The impact of COVID on support to the Family, and
- Embedding learning from previous local CSPRs.

1.10 In parallel to this Review the Mental Health Trust conducted a Serious Incident Investigation. This Review has benefitted from learning from the Trust Investigation.

2 Family circumstances and relevant background

2.1 In January 2019, the Family comprised Mother, Father, AL's Sister (16 years), AL (14 years) and AL's Brother (8 years). These titles will be used to refer to them in this report. The Family is white British.

2.2 Father had a separate accommodation address, until Mother's death in November 2021, but was at the house several days and nights each week and played a key role in caring for Mother and supporting the children, particularly AL's Brother. It was not always clear to agencies that Father played such a significant role prior to Mother's death. Sometimes Father was known to leave the home when practitioners visited as he believed his presence inhibited AL engaging in work with practitioners. Father was involved in some actions, alongside Mother with some agencies. After Mother's death Father was the primary carer for AL and his Brother.

2.3 **Mother** was described, by Family, as academically high achieving but having serious mental health difficulties from childhood, including serious self-harm and suicidal ideation and actions. She had several years as a psychiatric in-patient and later had community-based treatment. Family say that Mother continued to self-harm, witnessed by the two older children when they were younger, which they found distressing. Concern about self-harm and suicidal ideation or actions were not evident after 2014. She was treated for depression throughout the period under review. Mother was visually impaired from birth and was registered blind in 2014, following an accident to an eye. From that point, according to Family, difficulties in the family seemed to intensify. Her mother (AL's Grandmother) became her main carer until the Pandemic and difficulties with her own mobility. Grandmother helped Mother to manage her medication, necessary reading and organisation of any correspondence, including about the three children. Mother was diagnosed with Chronic Fatigue Syndrome in 2015.

2.4 **Father** had a long-term diagnosis of bipolar disorder and anxiety. He also had alcohol dependency.

2.5 The parents separated shortly after AL's Brother was born but Father continued as a key adult in the household and was described by Family as AL Brother's main carer. He became Mother's Carer when Grandmother was no longer able to fulfil this role. AL's Sister moved out of the family home in 2021. Mother's death in November 2021 was sudden and unexpected, from natural causes.

3. Work of agencies supporting the Family and key events

2013 to 2016	There were concerns about Mother's mental health, suicidal actions (in 2014) and alcohol use, and the impact on the children. Assessments by children's services in 2013 / 14 led to a period of Child in Need[3] support that resulted in some improvements.
Late 2014 to 2015	**Psychiatric and Psycho-therapeutic Support for AL** AL (age 10) showed signs of anxiety and withdrawing from social contacts. He was helped by Child and Adolescent Mental Health Services (CAMHS) in 2015
From 2017 *to 2021*	**Psychiatric and Psycho-therapeutic Support for AL** CAMHS worked with AL continuously until summer 2021 (age 16), providing therapy, often at home when he was too anxious to attend clinic and later in 2021 sessions to help him learn to manage his anxiety. When AL was too anxious to join sessions, Mother was advised about managing AL's anxiety. He was also prescribed medication. There were regular Medical Reviews of his mental state and medication. Progress was gradual and intermittent. There were no reported thoughts of self-harm to professionals. A family member has now said that he did occasionally harm himself.
November 2017	**AL** (13) was educated at home with support from his secondary school. He was unable to attend because of his anxiety.
December 2018	**AL's Sister** (16) started to receive support from CAMHS because of anxiety.
February 2019	**AL's Brother** (8 years) was assessed because of ongoing headaches and nausea. No physical causes were found but the symptoms continued.
April 2019	Police were called to undertake welfare check on the **Sister** (16) at Father's house; he was drunk and she was scared. Children's Services were informed and gave advice to the parents.
October 2019 *to January 2022*	**Change of AL's education placement (AL had not been at school from November 2017)** **AL** (15) transferred to a specialist online education placement, as part of an Education and Health Care Plan. He continued to be a remote student here, engaging from home, until his death. His education mentor visited him weekly in term time, except during the pandemic lockdowns.
November 2019	**AL's Sister** (17) **re-referred to CAMHS** - assessed to have anxiety and depression; she reported suicidal thoughts and self-harming over time.

[3] **Child in Need** - coordinated multi-agency work to support children and families under section 17 of The Children Act 1989, led by children's social care. See Norfolk Safeguarding Children Partnership Threshold Document: 1.9 Norfolk Thresholds - Norfolk Safeguarding Children Partnership (norfolklscb.org)

January & February 2020	**Refusals of parental consent for Family Support** **AL** was overwhelmed with anxiety; he was not washing or dressing. The education mentor obtained Mother's agreement to refer the family for Early Help Family Support[4]. However, Mother then declined assessment or support.
March to August 2020	**Start of the Covid-19 Pandemic Changes to delivery of services** **AL's education** continued online but his mentor had to cease weekly home visits in Lockdowns. AL's engagement with online lessons improved slightly but online engagement with his education mentor was variable. **AL and CAMHS**: Support continued by telephone. Mother said AL was progressing well with his anxiety management, learning and personal hygiene. Mother declined to proceed with plans for Family Therapy. From August, face to face therapy resumed. Plans started for AL to be transferred from the Under 14s Team to the CAMHS Youth Team. Sessions with the therapist who had worked with AL since 2017 ceased in October.
August 2020	**Parental decision to decline active CAMHS Services for AL's Brother** **AL's brother** (10) had high levels of anxiety, some were said to be Covid related but he continued with abdominal problems and nausea as noted in February 2019. He had been researching how to self-harm. A risk management plan was agreed with his parents but Mother declined active involvement with CAMHS for AL's Brother.
October 2020	**AL's** Sessions with the therapist who had worked with him since 2017 ceased.
December 2020	**AL**'s CAMHS Medical Review: AL making only limited progress.
January – July 2021	**AL** started a planned series of sessions to work on managing his anxiety, with a different CAMHS practitioner. Some sessions were delayed as AL was often too anxious or unwell. At Medical Reviews in June and July Mother said that AL was continuing his education; but he was not, in fact, engaging. **AL** was to be discharged from the CAMHS Under 14s Service (he was now nearly 17). He was understood to be on the Youth Team waiting list.
June 2021	**Parental refusal for mental health crisis support for AL** AL's mental health was declining. He was not allowing anyone into his room, was not eating and had developed a nocturnal pattern. AL's sister had moved out. The Education Mentor spoke with the GP who contacted CAMHS but AL was now too old for the Under 14s service. He was said to be on the waiting list for the Youth Service. Mother declined a referral to the Mental Health Crisis Team as she did not think that they could help and as AL was not a danger to himself or others.
July 2021	**Parental Agreement and later Refusal for Family Support Referral** Mother and AL agreed to a referral for Family Support. Mother later declined saying that AL was better.

[4] **Early Help** Early Help is provided to families when a child is seen to have additional needs or vulnerability, perhaps as a parent needs assistance, but where the family does not meet a level which requires social work involvement. Early Help can be provided by a single agency or by several agencies coordinated by a Lead Professional. Norfolk also has a Family Support Team which provides support at this early stage and can coordinate across other agencies involved. See Norfolk Safeguarding Children Partnership Threshold Document: 1.9 Norfolk Thresholds - Norfolk Safeguarding Children Partnership (norfolklscb.org)

From September 2021	**Referral for Family Support with parental consent** – **concerns about AL and AL's Brother** **AL's Brother** had transferred to secondary school and had attendance problems. He had been diagnosed with abdominal migraine and referred to CAMHS for anxiety. He was prescribed medication for anxiety. **AL** had poor sleep and personal hygiene. Following the Family Support Assessment AL was referred to another social support service; but he later declined this as he did not want to meet new people.
October 2021	**AL'**s engagement with learning deteriorated. He had not been taking his medication. Mother was advised to supervise him because of the risk of suicide if he stored it. Mother pushed for an assessment of whether AL had Autistic Spectrum Disorders.
November 2021	**Mother's unexpected death – from natural causes** Father was now the sole carer for AL (17) and his Brother (11), both of whom were vulnerable. Children's Services immediately provided Family Support, visiting regularly. AL was severely affected by his Mother's death and there were concerns about Father's alcohol use. The Police were concerned about the home conditions and there was evidence of poor diet. AL's Sister (19) was struggling to support the Boys; she had moved out of the home in the summer and lived some distance away.
November 2021	**AL's acutely distressed after his Mother's death** Father contacted AL's previous Lead Professional at CAMHS. Father and AL were provided with advice, but Father declined a referral for AL to the mental health crisis team as AL was returning to education. Father had given AL some of his own anti-psychosis medication to help AL sleep at night. Family Support visited the home often to monitor and support the family and advise Father. AL told the Family GP that he was not having thoughts about suicide or self-harm.
December 2021	**Family Meeting with Father, Sister and the Boys and Family Support Team**. Sister (19) was trying to visit each week and stay over one or two nights to support the Family. Wider Family members were in frequent contact offering advice and emotional support to Father and the Boys, but they were unable to visit at that time.
December 2021	Emergency services were called to the house on occasions by Family members to check on the Boys as Father was drinking. There were accumulations of rubbish and food waste after New Year. Children's services continued to visit to support Father in making improvements. A neighbour was offering some support.
January 2022	**The Family Support Assessment** noted the Family's social isolation, Father's poor mental health (exacerbated by grief) and ongoing mental health concerns for both AL and his Brother, with poor hygiene and diet. There were inconsistent household routines and different accounts about how meals were provided. Father did not think that there was a problem. Sister was trying to support the household routines. AL's Brother had school attendance problems which were thought to be as a result of anxiety. The Boys feared Father's drinking. Father said he was reducing this.
January 2022	Referrals were made for both boys to three different health services: CAMHS, 0-19 Healthy Child Programme health assessments and separately for bereavement support work. The

	Intensive Support Team were to visit twice a week for practical support with household tasks and a contingency plan was agreed whereby contact would be made with Family Support or the Children's Advice and Duty Service if there was a marked deterioration. Plans were in place for the boys to resume their education, which would have also given additional monitoring and support. A referral was made to help Father manage his drinking, which he was using to numb the pain of his loss. He was also referred for bereavement support work. Father and the Boys were advised to use emergency counselling and advice lines if they needed additional support in emotional crises.
January 2022	A further **Family Meeting**, with extended Family members online, the education mentor and the Family Support Practitioner noted Father's own grief and drinking, AL's grief and mental health and isolation, and AL's Brother's anxiety and school attendance problems.
January 2022	AL's education mentor was concerned about the state of the home and AL's emotional and poor physical state. The mentor signposted AL to counselling and advice services with whom he could talk by phone or online, but later it was not clear that AL's phone was working. Father was asked to check this.
January 2022	The referral to CAMHS Youth Team for AL was triaged by the Youth Team and he was placed on the waiting list for assessment.
Second week of January 2022	AL died. *It appears that he had acted to take his own life*. *Inquest awaited.*

4. Views of the Family on key issues and on the services received

4.1 Family members were still grieving for AL and for his Mother when they met with the Lead Reviewer and Chair of the Panel. They shared their views before the sudden and unexpected death of AL's Father. They wanted to support learning to prevent other families experiencing such tragic loss. The Family members felt disloyal for sharing their thoughts but believed that it was important to do so to ensure that there was understanding and to honour AL.

4.2 Given three deaths in this family in a brief period it is not appropriate to attribute all the statements to specific individuals, nor to include all the information and views given. What follows is a summary of the key information and views which have informed this report. Some of the family's information has been included in the family background section at 2 above.

4.3 Mother started self-harming from adolescence and had no understanding of how it affected family, friends or later her children. She was proud of her scarring.

4.4 By the time AL's Brother was born Mother was regularly drinking and self-harming or attempting suicide, resulting in psychiatric treatment. This impacted on the children; it was often the Sister who found Mother on these occasions. Mother's appearance as a result of the self-harm led to bullying at school.

4.5 Mother would keep irregular hours, if she wanted to sleep all day, she would take night medication in the day. She initially hid her drinking from Family and professionals. Family felt that Mother could be hugely devious and confronting her about her behaviour did not feel possible.

4.6 The older children shared a bed with Mother well into their primary school years.

4.7 Mother "put on a good spin" for the mental health professionals. Family felt that they showed no interest in the children's wellbeing or Mother as a Mother.

4.8 After Mother lost her sight, she could not see the mess, so housework was an issue. She would do the laundry but was controlling and prevented the children having the clean clothes. After Mother died a relative and family friend helped clean the house.

4.9 Mother did not want AL's Sister to be recognised as a Young Carer (2014).

4.10 Family members thought that both parents would lie to social services and that Mother would tell professionals that she would take AL to school, but Family thought that she did not try.

4.11 Mother blocked care coming into the Family. She did not welcome anyone – including family members at times. Mother had to have control, had to be at the centre of things, needed to "control the narrative." She would not accept help for the children. If Family visited AL was always upstairs under his duvet. Mother would refuse to help persuade him to come downstairs. Mother appeared to encourage AL to stay in his room, not go out, or to have a normal life.

4.12 The parents sometimes shared their different prescribed medications between them.

4.13 After Mother's death the physical state of the home became much worse. Mealtimes were non-existent. Father would give the boys chocolate saying that they would not eat what he cooked. The Family ate takeaways. Father would wait for the Sister to be there to look after the Boys. Father would drink but might pull himself together if he was expecting someone to call.

AL's experience as seen by Family members (in retrospect)

4.14 AL thought that Mother's behaviour was normal. "Mother was his world." "He was so dependent on her that he couldn't live a normal life without her." He slept in her bed every night until he became ill shortly after he started High School. He worried about what he would do if Mother died. Mother would tell AL that he was too anxious to go to school and that he was too ill to go out. Mother did not act on what she had agreed with professionals.

4.15 A Family member said that AL self-harmed a little when he was younger, just scratches. He had seen his Mother do it and thought this was a normal thing to do when you were upset.

4.16 Family described AL's anxiety as AL being withdrawn and uncommunicative. He had unwashed hair and slept in unwashed bed linen.

4.17 After Mother died, AL had frequent phone contact with his Family members. AL would say how much he missed his "mummy" and he would ask Grandmother what Mother was like when she was younger. Grandmother believed that AL was a suicide risk. "He was a complicated young man. He had a lot to say, he just couldn't say it. He was kind, gentle, sweet…" She hoped that he had never seen any of mother's suicide attempts. He shared some of his feelings with his Sister and was desperately unhappy. He would sometimes go out with her; he enjoyed going out.

The Family's views on the services provided

4.18 AL's education mentor returned every week: Grandmother said, "I can't fault the education placement."

4.19 Professionals believing adults who make things seem normal when they were not. Sister thought children should be listened to.

4.20 Just before AL died, AL's Sister understood that part of the support plan was for her to go to the house, but she did not think that the plan was specific about what to do when she was there or how she could afford to travel, as she lived a long way away. Between November and January, she would aim to go fortnightly but sometimes she managed to go as often as twice a week. However, she was unable to go in the days before AL died.

4.21 After Mother's death there was concern about Father's drinking. Grandmother phoned the house every day to see what was happening and tried to ring children's workers but they did not always respond. She feared for the safety of the boys; she would phone the police or paramedics for welfare checks. An Aunt was also in regular contact with the Family and services but was living abroad and was unable to return to the UK because of Covid restrictions.

4.22 In a Family Group Meeting, via Zoom, with professionals in early January, the Family members were all asked individually to score how the Father and the Boys were 'coping.' Most gave low scores, but the Family felt that their opinions were disregarded and that nothing changed.

4.23 AL's Sister now believes that she should have been taken in to care when she was younger. She had some help from therapists at school but it was only when she could not manage sixth form that she was assessed by CAMHS. She felt the CAMHS crisis team "was amazing" in helping her.

5 Analysis and Learning

*In this section **Practice notes** have been included where there has been recognition of valuable learning but where this is not new learning but a recognition from this case of the need to support and reinforce good practice in frontline work and its management more widely but where a specific recommendation is not required.*

5.1 In analysing the work undertaken we clearly have the benefit of hindsight. We must be careful not to use it to unfairly judge the work done but must seek to understand what systems dynamics may have prevented things being known or actions being taken, and why that was so.

5.2 **Assessing and responding to AL's mental health needs over time and in the acute period after his Mother's death**

5.2.1 AL was identified as having difficulties with generalised and social anxiety over several years. His school, educational psychology services, CAMHS, the alternative education provider and children's services took these seriously. The commitment and continuity by individual practitioners to meeting AL's needs is noted.

5.2.2 A question has arisen as to whether sufficient attention was given to whether he was also depressed. AL was provided with psychotherapy and medical support from CAMHS over three years and was also prescribed medication to assist him.

5.2.3 **Transition of services** The CAMHS Under 14s Services provided good support to AL for more than three years and he was assessed to be making slow and occasional progress, although he had not yet reached a level where he was functioning well. Originally it was planned that he would be transferred to the Youth Team but there was confusion about this and he was later discharged from the CAMHS service, after

5.2.4 receiving behavioural therapy to help him manage his anxiety better. This meant that for a few months AL was without additional psychological support. It was during this time that his Mother died.

5.2.5 **Medication** Medication was a key part of the treatment for managing AL's anxiety, especially after his therapy ceased. It was not clear that AL was always consistent with taking his medication and when this was reviewed in intermittent Medical Reviews it was sometimes AL's Mother who responded on his behalf, Mother also told CAMHS that she was giving him his medication, but later evidence suggests she was not supervising him taking his medication. The responsibility for prescribing AL's medication was transferred to his GP when AL ceased to be the responsibility of the CAMHS service. AL was assessed to be stable at that time. He was provided with repeat prescriptions but it is not clear if they were collected, or if he was taking them. Nor is it clear if his Father was aware of the need to supervise AL's medications. It is known that Father gave AL some of his own medication to AL. It is acknowledged that monitoring the use of AL's medication by professionals was a challenge during the Pandemic as he could not be seen easily.

Recommendation 1 Medication supervision
The Norfolk Safeguarding Children Partnership should seek assurance from health commissioners and partners that protocols and guidance are in place to ensure the safe management of medication for young people known to have mental health problems, including monitoring use, and advice to carers on storage and administration.

5.2.6 **Assessing the risk of self-harm or suicide** Throughout most of the period reviewed, up to Mother's death, AL was seen as at low risk of self-harm or suicide, although he had at times expressed suicidal thoughts. These were seen in the context of his diagnosis of anxiety and there was inconsistent reporting by Mother who did not believe him to be a risk to himself. AL's education placement was conscious of a generalised possible risk of suicide and advised Mother about this when she revealed that AL had not been taking his medication.

5.2.7 After Mother's death there was appropriate concern about AL's mental state and it was clear that AL was in acute distress and was withdrawing further from family life, but this was also a known pattern of his anxiety. AL denied any suicidal thinking to his GP. He said to the Family Support Practitioner "I want to get better." His education mentor noted that "AL wants to feel better;" the mentor provided him with information about emergency counselling helplines, although later it was not clear that his phone was working. The education placement also alerted the Children's Advice and Duty Service (CADS) to a possible risk of suicide. AL, encouraged and supported by his Father, also spoke to his previous CAMHS practitioner; when the practitioner rang him on a later occasion, he said he was feeling better. The CAMHS practitioner advised Father to call the GP if AL were to become worse. Family have said that they were concerned about the risk of AL harming himself because of the level of his grief and that they raised this with services, who were monitoring him. AL was referred for bereavement counselling and to CAMHS because of his acute distress but these services had not started for him when he died.

Practice note: Bereavement is known to increase risk of self-harm or suicidal ideation or actions. When a child or young person who is already showing signs of emotional vulnerability experiences a bereavement they should be offered additional supports and closely monitored.

5.2.8 It would have been useful for non-mental health practitioners to have had access to psychiatric consultation given AL's vulnerability. Father and AL did speak with one of his previous CAMHS practitioners and were advised to consider a referral to the Crisis Mental Health Team, but Father declined this. A referral was made in early January 2022 to the CAMHS Youth Team and AL was placed on the waiting list for a 28-day assessment. A systemic problem in the service meant that such routine assessments could then take 26 weeks or more. The Family Support Service was not made aware of this possible delay. The level of acute concern about AL was not clear to CAMHS nor was his recent bereavement highlighted as an escalating need. Good practice would be for there to be a conversation between the referrer and the CAMHS service to ensure that full information on which to prioritise the referral is available. The Trust has noted that given AL's long involvement with the Under 14s team until July 2021 it may have been good practice for them to assess him.

Practice note: When there are acute concerns about a young person's current mental state consideration should be given to seeking a formal crisis mental health assessment, taking into account the young person's or the parent's wishes but making the welfare of the child paramount. There should be active consideration about whether the young person may harm themselves. Full information should be made available to assist the prioritising of such assessments.

5.2.9 This Review notes that the Mental Health Trust is currently undertaking a review of referral and assessment pathways.

Recommendation 2 - Referral Pathways for Child Mental Health Services
The learning from this Review should be taken into account in the NSFT Review of referral and care pathways and the development of any associated training package for staff. Referral processes and forms should seek relevant information about family history, any relevant history of trauma and any concerns about current parental mental health or substance misuse. Within the Trust, appropriate checks should be made to see if parents are known to adult mental health services, when children are being referred.

5.2.10 This Review has considered more widely whether agencies and frontline practitioners across services, not just in specialist mental health or GP services, have awareness and skills in this area of openness to recognise self-harm or suicidal ideation. Feedback from the practitioners and managers was that there has been increasing awareness of the mental health needs and risks for young people over the past few years and that this has been heightened by the higher incidence of mental health problems in young people in

response to the Pandemic. **Working Together 2018**[5] and the annual national guidance **Keeping Children Safe in Education**[6] has also raised awareness of this area.

5.2.11 The school and alternative education placement involved in this case have systems in place so that they can recognise and respond to cases where young people show such risks. Norfolk Schools have access to mental health training and appoint mental health champions and can seek advice from crisis specialists when needed. In the Early Help/Family Support Service there is confidence that the mix of skills and competences across staff teams, with the addition of clinical supervision and group supervision, means that practitioners are well able to consider and respond to risk of suicidal thinking. Mental Health First Aid Training is also available.

5.2.12 Evidence here is that AL's mental health and suicide risk was certainly considered by practitioners working with him after his Mother's death and steps were taken to support him but there was no evidence found that he was thinking about steps or actively planning to end his life. It is not clear whether it was considered that AL may be concealing his feelings and thoughts from family and professionals as he may not have wanted them to know what he was thinking. It should also be noted that suicidal acts can be impulsive. Evidence available after his death suggests that AL was thinking about ending his life.

> **Practice note:** When there are concerns about a person's mental well-being or that they may harm themself or may be thinking about ending their life care should be taken not to rely solely on the individual's own statements or the reassurances of those close to them who may be unaware of the person's intent.

5.2.13 The Norfolk Safeguarding Children Partnership has useful practice guidance on **Children at Risk of Suicide**[7]**,** which was updated in 2018.

> **Recommendation 3** - **Practice Guidance to Professionals on Children at Risk of Suicide**
> Norfolk Safeguarding Children Partnership should review this practice guidance to ensure that it is up-to-date and promote it with the dissemination of learning from this Review.

5.2.14 The Norfolk Suicide Prevention Strategy[8] and Action Plan 2016-21 is currently being refreshed. The Norfolk Suicide Prevention Group continues to monitor and analyse patterns of suicides in the County and learn from them. The Suicide Prevention Group will take into account the learning from this Review when reviewing the Strategy and Action Plan from 2023.

[5] **Working Together to Safeguard Children 2018** – statutory guidance Working together to safeguard children - GOV.UK (www.gov.uk)
[6] **Keeping Children Safe in Education 2022** – statutory guidance to schools and educational institutions - Keeping children safe in education - GOV.UK (www.gov.uk)
[7] 5.22 Children at risk of suicide - Norfolk Safeguarding Children Partnership (norfolklscb.org)
[8] Norfolk Suicide Prevention Strategy Full Summary Interactive 2016 2021.pdf

5.3 Use of safeguarding children thresholds

5.3.1 During the period under review work with AL's Family was undertaken by Universal Services at the Tier 3 level of need as agreed within the **Norfolk Safeguarding Children Threshold Guide 2019**[9]**.** The guide is a useful resource for local agencies working with children or parents (or carers) to understand the local agreed processes for how to assess and seek help for families with different levels of need. **Tier 3** is for Children with complex multiple needs who may need targeted or specialist services. A referral to the Early Help Hub or conversations with the Children's Advice and Duty Service may be required. **Tier 4** is for children in acute need when a referral to Children's Advice and Duty Service is indicated or direct to the police where there is imminent danger.

5.3.2 At times, when there was concern about AL and later about AL and his Brother, CAMHS or the alternative education placement made referrals for additional coordinated support to the CADS with a view to seeking Early Help or Family Support, at Tier 3, in addition to the services being provided. The referrals were not made on the explicit grounds that AL or his Brother were being harmed or neglected and referrals were generally seeking support, such as supporting AL to go out of the home, rather than a formal child protection response.

5.3.3 Referrals at Tiers 1, 2 and 3 require the consent of one or both parents or of a young person who is of capacity to give informed consent. As can be seen from the summary timeline above (in section 3) in 2020 and 2021 Mother gave consent for the referral to children's services on several occasions and then withdrew it. It was not until shortly before Mother died in October 2021 that an assessment for Family Support was completed and following that AL was referred to another agency for additional support, which he later declined. After Mother's death a Family Support Practitioner was allocated to support the Family and a period of intensive work followed.

5.3.4 **Should the work with AL's Family have been under a child protection threshold? Were the children being neglected or emotionally abused?** The review team have considered whether at any point the level of need had moved to Tier 4 and should have been assessed as **child protection** on the grounds that the children were possibly being harmed.

5.3.5 Workers visiting the home prior to Mother's death did not identify **physical neglect** by adults, although there were concerns about self-neglect by AL who at times was not washing or looking after himself; this was associated with his chronic anxiety. Other possible causes of his self-neglect were not explored. After Mother's death there were increasing concerns about physical neglect, including in the provision of meals. See paragraphs 5.3.10 and 5.3.11 for further discussion of the situation after Mother's death.

5.3.6 **Was non-engagement considered sufficiently?** Prior to Mother's death there was a pattern of AL missing therapy or anxiety management sessions at CAMHS and Mother's excuse was often given that he was "unwell". A pattern of avoiding contact with professionals was already part of AL's response to his anxiety. It is not clear that enough thought was given to whether Mother may have been colluding with AL in not attending his appointments. The outcome for AL was that he was not accessing all the help offered or that he needed. This could have been assessed as a possible form of neglect. However, Mother gave the impression of being concerned and committed to AL's care and improvement. The lack of monitoring of AL's medication may also have been an issue here.

[9] The Norfolk Threshold Guide 2019 - FINAL 200319.pdf - Google Drive

5.3.7 Mother agreeing to referrals to other services and then withdrawing consent may also be considered as a form of neglect, by denying a child access to services or health care that they need. Yet these were seen in a context of Mother working closely with CAMHS, the alternative education placement and Brother's school and to be cooperating with suggestions and plans for improvement. She was seen to be committed and involved. Workers were, however, concerned that AL was only improving slowly despite a lot of support: "two steps forward, one step back." It is not clear that it was explored further with Mother why she would agree to referrals for Family Support Services and then later withdraw her consent.

Practice note: Engaging reluctant families A question arises about the skills required by practitioners for seeking genuine consent for referral on to children's safeguarding agencies and advising on the possible consequences of not consenting.

Practitioners need skills:

- in building trusting relationships to make families feel that they are not being judged and are willing to accept support,
- that families are finding help through the people who already know them,
- that the people who know them and who they trust are introducing other people
- and that those people have additional skills and roles to support them to meet their children's needs.

Experience has shown that this is when consent and engagement rise, with better outcomes.

It would not always be appropriate to resort to child protection processes to override parental consent as it is likely to alienate and lead to difficulty in meaningful engagement. However, persistent failure to engage with necessary services may require a child protection approach.

5.3.8 A possible systems barrier noted by practitioners was that when seeking to refer families to CADS a question is often asked about what the identifiable *immediate* risk to a child is. It is not clear that this was the case in the referrals for AL's Family but was seen by practitioners as a possible systems issue. Such an approach may mitigate against considering the longer-term and more amorphous nature of neglect where there may not be a clearly identifiable and anticipated harmful event but there is a need to identify a pattern where parenting may not be good enough to meet children's needs, including siblings' needs, over time. This may require greater information gathering and analysis at the edge of the child protection threshold to assess the probability of harm if action is not taken. This has implication for the interaction between referrers and the CADS service and the possible need for challenge between agencies and or escalation to consider a wider range of possibly harmful behaviours, omissions or patterns and not just single harmful events.

Practice note: Repeated refusals by parents for access to needed help should be considered as possible neglect and referring agencies should consider the reasons behind such refusals of referrals. If these are found to result in the child's needs not being met practitioners should escalate the concerns, including refusal to be assessed for help, for consideration at a child protection threshold which would allow wider gathering and sharing of information between services. This would serve to support decision-making about whether the threshold for Tier 4 is being met. It is noted that use of an Early Help Action Plan or other multi-agency forums to support families would also be able to share information, however, these would require parental or young person consent.

Recommendation 4
Recognising the longer term nature of neglect; and parental non-cooperation

The Norfolk Safeguarding Children Partnership should review its guidance on Thresholds in order to support practitioners' understanding of neglect, the long term and cumulative impact of neglect and how to identify non-cooperation of care givers, as possible evidence of neglect. As well as highlighting examples of single significantly harmful events examples can be provided to help practitioners recognise that neglect includes not being brought to appointments, repeated refusal of services, not complying with advice or not administering or monitoring a child's medication.

5.3.9 **Parental alcohol misuse** can be a child safeguarding issue leading to either neglect or emotional abuse. There is no evidence that Mother's drinking was observed or known about by practitioners. Family members have informed this Review about it. Father's alcohol misuse was known about by some agencies but not by all until after Mother's death when it became a matter of concern as it was impairing his ability to care for the boys and was not improving. It could be argued that the child protection threshold of neglect was being crossed but in the context of his acute grief and his, albeit reluctant, agreement to work on his alcohol misuse that a child protection framework may not be needed. However, he was ambivalent and despite agreeing to cut down his drinking was not doing so. He was himself in acute grief and self-medicating with alcohol. It may therefore have been unrealistic to expect him to reduce his alcohol use at that time.

5.3.10 The Review Panel have considered whether there was evidence that the threshold for child protection had been crossed, after Mother's death. The Panel was considering this in retrospect. There was disagreement; some Panel members felt that the Boys were at risk of significant harm, others that work was being done to improve the situation at home. The practitioners, at the time, were working with the Family to seek to affect change, by offering support and advice. Father, although ambivalent, was seen to be cooperating on some important issues, including agreeing to referrals for the Boys to bereavement services and to CAMHS, getting AL's brother back into school and to undertake bereavement work for himself. It was known that it was a fragile situation as he was not coping well and continued to rely on alcohol. However, the Boys were distressed and fearful of Father's drinking, which was emotionally abusive. However, progress was slow and there were incidents of concern when father was possibly not in a fit state to care for the Boys. The Boys were not being fed properly. On one occasion when the police were called they were concerned about the situation and the impact on the Boys but assessed that Father was in a mental state to be able to provide care and that there was no need to remove the Boys. A multi-agency strategy meeting under section 47 of the Children Act, after this incident, would have been an occasion to consider the situation with a different lens given the ongoing concerns. The Family Meeting held just after the New Year recognised the concerns and agreed a plan to achieve better outcomes.

5.3.11 It is not clear to the Lead Reviewer that a move to a child protection approach, with changes of workers, **at that point** would have achieved more than the agreed Family Support Plan was seeking to put in place. It may also have served to heighten anxiety for the Boys. Clear and short deadlines to Father would have tested his ability to change and if not, then a child protection approach or even considering care for the Boys would have been required. It is not clear if Father was warned that if he did not cooperate more fully, including with reducing his alcohol use, and things did not change quickly then it may be necessary to convene a child protection conference. AL died before these planned services could be achieved.

5.4 Understanding the importance of family history and family dynamics in assessments and interventions

5.4.1 Feedback from the practitioners to this Review has shown that not all of them were aware of the possible trauma that the older children had witnessed when they were younger, in relation to Mother's self-harm and suicidal behaviour, or later, the impact of parental drinking. They were unable, therefore, to reflect on how this may have impacted the children and take this into account in their plans and assessments of need. Practitioners told us that if they had known about these issues, they would have taken them into account in their work with the children as part of **Trauma Informed Practice**[10] and the importance of understanding and responding to **Adverse Childhood Experiences**[11]**.** The CAMHS practitioners held in mind that AL's anxiety and behaviour may have had a traumatic cause but the cause did not become clear in the clinical work. They were clear that they would have taken this into account had they been aware.

5.4.2 A question therefore arises about how practitioners can become aware of such traumatic family psycho-social histories and what information is within agency records or can be shared between agencies if the information cannot be gained from or is not shared by families themselves. This clearly raises an issue of consent or authority to share such private information when a family is being assessed below a child protection threshold.

5.4.3 Practitioners are reliant on the information provided by parents and children, or wider family, when compiling a psycho-social history. They are also aware of rights to privacy and that individuals may only share what they want to be known, in the way that they want it to be known.

5.4.4 CADS was clear that in assessing referrals senior and experienced workers analysed the family history available in records in order to decide on appropriate levels of intervention.

5.4.5 This Review has questioned whether within CAMHS there was sufficient recognition that at times different parts of the service were working with different Family members without there being a join up between approaches and a Family perspective. This may have given a clearer picture of a Family where three children were showing emotional difficulties. This may have led to additional thinking about whether Mother declining Family Therapy should have been challenged more or considered as a possible safeguarding threshold matter. Practitioners noted that there are systemic difficulties marrying up records of different family members held within the Mental Health Trust.

5.4.6 For much of the period there was no holistic picture held by any agency of three children from the same Family with chronic and sometimes acute mental health needs over time. An understanding that more

[10] Trauma Informed Practice Trauma Informed Practice - Norfolk Safeguarding Children Partnership (norfolklscb.org)

[11] **Adverse Childhood Experiences ACEs** - ACEs are traumatic experiences which can have a long term effect on children's emotional health; see Adverse Childhood Experiences (ACEs) and Attachment - Royal Manchester Children's Hospital (mft.nhs.uk) and Addressing vulnerability in childhood - a public health informed approach (publishing.service.gov.uk)

than one child was affected may have led to more questioning about family dynamics and trauma. AL's education placement did recognise that two children, AL and his Brother, were having difficulties.

5.4.7 **Father and the role of Fathers**[12] Father was an important figure in this Family but key practitioners had little knowledge of him prior to Mother's death. Father's GP was unaware that Father had caring responsibilities for children as he was registered with a different GP and at a different address. Father had parental responsibility for all three children but was divorced from Mother and was thought not to be living at the house, yet there was clearly an important parental relationship and he had a significant role. This was recognised and he was involved by practitioners when he was present or on behalf of Mother when she was unable to physically take children to services. However, services saw Mother as being the primary parent.

5.4.8 Before Mother's death Father was occasionally present when practitioners visited the home and he was accepted as having a role in parenting and was involved in assessments, an Education Health Care Plan Review for AL and with taking AL's Sister to CAMHS and AL's Brother to school. His difficulties with alcohol use were not apparent on those occasions. At times he would leave the house as he was aware that his presence could inhibit AL's engagement with practitioners who were visiting.

5.4.9 Reviews into tragic incidents such as these over time have shown that agencies frequently do not fully appreciate the role of men or their significance to children as they are often not seen or known about by professionals. This is particularly noticeable when fathers are considered to be non-resident. The extent of Father's role was not clear in this case and it was not fully taken into account until after Mother's death. A key question was then testing his capacity to change and take full responsibility for the children. This was underway in the period up to AL's death.

Recommendation 5
Understanding the Importance of and Working with Fathers and Father Figures

The Norfolk Safeguarding Children Partnership should produce and promote sector specific good practice guides on understanding the importance of fathers and father figures and good practice in working with them, highlighting the expectations of all partner organisations around professional curiosity, engaging, assessing, recording and information sharing when working with all families.
This recommendation recognises the positive work already undertaken by the Norfolk Safeguarding Children Partnership to support understanding and improving work with fathers and father figures and seeks to build on and embed the work achieved to date.

5.4.10 **Involvement of wider Family** Prior to Mother's death there was little contact between services and wider Family members. This was appropriate as Mother (and Father) appeared to be cooperating with services and the need for a Family Networking Approach had not yet been identified. It was noted that Family members did on occasion contact services when there were concerns prior to the period under review.

5.4.11 From November 2021, after Mother's death the wider Family were in shock, compounded by the exact cause of her death not being understood for some time. Key relatives were unable to physically get to the house because of distance and personal health or Covid restraints but maintained frequent contact

[12] This Review has benefited from the direct involvement in the Review Panel of the Safeguarding Children Partnership's Officer who is leading the Partnership's work to increase understanding of the importance of involving fathers and father figures in safeguarding work. The Partnership's work to improve practice in this area is commended.

remotely to support and monitor and there was some reliance on AL's Sister who, although now an adult, was herself still young, vulnerable and grieving. Some support was offered by a neighbour.

5.4.12 Wider Family members were involved in the second Family Meeting remotely and expressed their worries and hopes for more support. Grandmother also called emergency services on occasion. The Plan was that AL, his Brother and Father should be supported in the family home, if possible. The Family have expressed concern that not as much was done as they would have hoped.

5.4.13 **How is "Think Family"[13] used in services throughout Norfolk?** The importance of families is recognised in Norfolk services when parents need additional support. The **Family Networking Project**[14] of One Norfolk and the **Stronger Families Project**[15] recognise the importance of families and that sometimes they may need additional help. In the work with AL's Family after Mother's death Family Meetings were used to involved wider Family members. Mother and Father were both vulnerable in their own right, particularly Father. The concept of "Think family, think parent, think child" was introduced by the Social Care Institute of Excellence from 2009 to raise awareness of the need for practitioners working with parents who have mental health difficulties to consider the possible impact on children. It is referenced on the Norfolk Safeguarding Children Partnership's website under the guidance **Children at risk where a parent has a mental health problem**[16]. A question remains, however, how services working primarily with adults, including fathers, who have their own difficulties hold in mind and make assessments when those adults have caring responsibilities for others or for vulnerable children?

Recommendation 6 - Understanding Families in their wider context : **Think Family**

The Norfolk Safeguarding Children Partnership should seek assurance from Partner Agencies, including those working primarily with adults, that there are processes in place to identify and note when vulnerable adults, including men, have parenting or caring roles. Services should have systems in place to recognise the importance of seeing a family in its wider context, including assessing key relationships and obtaining a holistic view of any difficulties in the family, and not focusing solely on individual family members. Systems should ensure that where possible and appropriate family members, including fathers, and other key relatives, should be heard in order to capture important historical information or to understand key dynamics.

5.5 Multi-agency response and coordination

5.5.1 To safeguard children (in both preventative and protective senses) agencies must work singly and jointly to understand family and individual problems and work with them to provide solutions or, if necessary, take other action to protect children from harm, or if suspected self-harm. Joint working of course raises the issue of authority to share private individual and family information, subject to consent or if at a protection threshold dispensing with consent and sharing information proportionately.

[13] SCIE Think Family https://www.bing.com/ck/a?!&&p=fa0daf77e9b959aeJmltdHM9MTY2MjMzNjAwMCZpZ3VpZD0wNzkwYjMzMC1jMTE5LTY5YzYtM2QwNi1hMTI0YzBhMjY4ZjAmaW5zaWQ9NTE4Ng&ptn=3&hsh=3&fclid=0790b330-c119-69c6-3d06-a124c0a268f0&u=a1aHR0cHM6Ly93d3cuc2NpZS5vcmcudWsvcHVibGljYXRpb25zL2d1aWRlcy9ndWlkZTMwL2ludHJvZHVjdGlvbi90aGlua2NoaWxkLmFzcA&ntb=1 (Need to tidy up this hyperlink!)

[14] Family Networking (justonenorfolk.nhs.uk)

[15] Home | Stronger Families Norfolk

[16] 7.2 Children At Risk Where A Parent Has A Mental Health Problem - Norfolk Safeguarding Children Partnership (norfolklscb.org)

5.5.2 At Tier 2 or Tier 3 of the Norfolk Safeguarding Threshold a Lead Worker may be needed where there is more than one children's agency in place supporting a family to coordinate the work of several agencies, perhaps through an Early Help Assessment and Plan; this would require agreement and cooperation of a parent.

5.5.3 We have noted that work for the children was done in parallel rather than as one family system, until after Mother's death. Schools worked independently with Mother, and later Mother and Father; and then Father. As AL came to be provided with CAMHS services it is not clear that there was liaison with AL's school which continued to offer him an online and home tuition service when he was unable to attend because of his severe anxiety. A Lead Worker to coordinate work across agencies, would have been useful. This would have been possible if an Early Help and Assessment Plan had been initiated but Mother did not consent to this.

5.5.4 When AL's Sister started work with CAMHS in 2018 there was no family coordination within CAMHS of the work across the siblings with the same parents. This was perhaps a missed opportunity to take a more holistic view. Also, in 2018 AL's Brother's abdominal symptoms were first noted and referred to hospital for assessment and found to have no physical cause but as there was no cross agency coordination to consider the possibility that these may have a psychological cause and the parallel with his Sister and Brother having emotional problems was not recognised. A Think Family approach should also lead to consideration as to what may be happening across siblings, when there are similar difficulties and how the difficulties for one child impacts on the others and the complexity for parents dealing with three parallel issues and different services.

5.5.5 A positive opportunity for coordinated leadership came at the assessment for the Education and Health Care Plan in 2019. This was led by the educational psychology services and the relevant agencies were able to contribute their different views about AL, and Mother and AL also contributed so that his educational needs could be identified. There is no evidence however that Father was consulted or thought about at that stage. Father was fully involved in the review of the EHCP shortly before Mother's death and was able to express his views about his hopes for AL as AL faced his future and needs as a 17-year-old.

5.5.6 From October 2019 there is good evidence of coordination across education and CAMHS for AL with sharing of information and some joint thinking and planning. It appears as if the education mentor took on a de facto lead professional role across these two services. However, AL's Brother's school was working alone with Mother and Father to support him not fully aware of the work being done with AL and his Sister.

5.5.7 CAMHS and the education placement worked very well together, sharing information and making referrals to CADS for Family Support. As noted above Mother declined this on several occasions and although further referrals were later made there was not escalation to seek consideration of whether a child protection threshold was met. It is notable that at the referral just before Mother died AL's mentor also raised concerns about AL's brother, bringing concerns about the two boys together, for what appears to be the first time.

5.5.8 From Mother's death the leadership of the multi-agency work was held in one place.

5.5.9 **Responding in a family crisis** Mother died in early November 2021. The Family Support Service started to work with the Family to complete an assessment of need and the Family Support Practitioner was visiting within two weeks. The Family Support Practitioner had to establish relationships with AL and his Brother and Father, other Family members and the other services involved in order to bring together an

overview and assessment – including of Father's ability to parent. AL was initially reluctant to engage, given his anxiety with strangers and his grief.

5.5.10 Intensive work was undertaken and the view was formed that it was better to work with Father to support him as the carer in the Family. He did not fully accept that he had a problem with alcohol, and contingency plans were put in place.

5.5.11 There is a question about whether some services which came to be identified as being needed to support the Family could have been fast-tracked given the circumstances, this includes a service to support Father and his alcohol misuse, although this was unlikely to be a short term solution, and the re-referral to the CAMHS Team. This would require greater flexibility and the ability to make a resource available quickly. It was noted that the Mental Health Crisis Team was available if AL should come to need this but he was not seen to be at such a level of risk.

5.5.12 The situation was compounded by seasonal holidays when services were reduced.

5.6 Engagement on the terms of the adult? The need to keep a child focus and professional curiosity

5.6.1 As noted above there were times when Mother appeared to be controlling the way in which work was done. In retrospect, it is wondered by practitioners whether Mother agreed to referrals for Family Support in order to appease workers but with no intention of proceeding with it. We cannot be sure. Family have noted that Mother could be controlling and have stated in retrospect that she was not always truthful and that she was hard to challenge.

5.6.2 There was often reliance on mother's accounts of what was happening for AL and his progress with regard to following suggestions for his treatment; especially when AL would not himself engage directly with practitioners. It has been noted above that she often said that AL was too unwell to attend sessions. There was possibly a pattern of both AL and Mother not cooperating with his treatment. It would have been helpful to have explored this more fully to understand whether there was more behind it. The Family has suggested that Mother did not genuinely cooperate with AL's treatment.

5.6.3 **How do we hold curiosity in mind when we see no evidence of progress and reflect on whether there may be other dynamics at work and whether parents are being truthful?** There is evidence that Mother was cooperative in a number of areas. She worked with AL's Brother's schools on his emotional and physical difficulties leading to attendance issues and appeared committed to addressing these, sometimes suggesting that it may have suited Father for AL's Brother not to attend as Father liked the company of AL's Brother. She supported AL in his CAMHS treatment and pushed for him to have an Education Health Care Plan and an ASD assessment. Skilled practitioners when asked about this have said that they believed her to be committed to the children and genuine in her responses. One service noted that when challenged about an incorrect statement Mother became quite angry. In retrospect, however, Family have raised observations about her often misleading professionals and not supporting AL's treatment as fully as she stated and perhaps even undermining it. We are unable to explore this further given the deaths.

5.6.4 Practitioners across services need to engage with and form professional relationships with children and their parents to assess and provide interventions, particularly interventions which require human interactions and rely on information shared by the individuals concerned. We must assume that parents usually provide honest responses unless there is clear evidence to the contrary but we must also hold in mind that at times parents may not be fully open and may mislead us, either deliberately or unconsciously.

A manager feeding back to this Review questioned, in retrospect, whether there had been disguised compliance which had gone unnoticed.

5.6.5 The term "disguised compliance" has come into analyses of serious case reviews over recent years to describe such behaviour. Recent analysis the use of the term suggests that it is possibly unhelpful and blaming[17]. Practitioners need to think more analytically about when parents do not cooperate or cooperate on their own terms and in ways which may not support change or improvement. There is evidence here of Mother seeming to cooperate, which practitioners thought was genuine, but also evidence that AL was not progressing as expected.

5.6.6 This Review suggests that there may have been a need to get further behind what was happening and why and what the underlying problems for AL and his siblings may have been.

Practice note: Professional curiosity A number of case reviews into significant harm have identified the need for practitioners across services to be respectfully curious and think more deeply about information received and to ask "why" questions. In busy work environments it can be easier for professional curiosity to be lost.

Practitioners must always reflect on information given and whether it is evidence based or if there may be grounds to suspect it and be prepared to seek additional information, to question or to challenge it through respectful working relationships. What is important is reflective thinking about what is happening and whether there may be more than meets the eye.

Key aspects of professional curiosity include among other things:

- seeking information from a range of sources, including the child, family history and the extended family, including what help may have been tried before,
- thinking about the child's lived experience, and whether it is good enough *(See Norfolk's FLOURISH Materials)**
- asking if the information received is evidenced,
- looking for patterns,
- thinking and asking about why this is happening and whether there are other possible explanations
- identifying gaps in information,
- using reflective thinking through supervision or consultation
- and being prepared to change one's point of view.

**Norfolk FLOURISH* [18]

[17] Disguised compliance or undisguised nonsense? A critical discourse analysis of compliance and resistance in social work practice in: Families, Relationships and Societies Volume 9 Issue 2 (2020) (bristoluniversitypressdigital.com)
[18] Flourish - Norfolk County Council

5.7 Reflective thinking, consultation and clinical supervision

5.7.1 As the analysis above shows this was a complex family. The different and parallel needs of the three children, each with mental health problems, and the longer-term mental health problems of parents and how they affected their parenting were a lot for practitioners to think about. There were a number of good interventions that showed that systems were in place to respond but progress for the children, especially AL, was intermittent and slow. There was no holistic view of the children and family.

5.7.2 This shows the importance of clinical reflection for practitioners. As well as their own analysis there is a need for frontline practitioners to have access to experienced colleagues and specialists who are not caught up in the immediate dynamics of the family interactions. This provides support in thinking in different ways about what behaviours might mean, what further assessments may be needed, or to help confirm that they are on the right track. This is especially important when progress in work seems to be too slow or not moving forward.

5.7.3 Evidence provided to the Review shows that the alternative education placement had consultation available to support the mentor in their thinking about AL and his needs. When the situation seemed to be stuck they were also able to use other external systems for support, for example discussion with CADS to get additional advice. On one occasion this was able to help thinking through that a supplementary referral to youth services was not realistic for AL.

5.7.4 School practitioners have access to advice and reflection from their Designated Safeguarding Lead (DSL) and in this case there is evidence that this worked well. DSLs are themselves supported by The County Education Safeguarding Team which works with networks of DSLs to provide consultation and advice.

5.7.5 Within Children's Services, CADS has experienced consultant social workers and managers to support triage and analyses of family history . The Family Support Service had supervision in place for the Family Support Practitioner and there are a range of specialists available for co-consultation and through reflective group supervision to support workers. The Family Support Assessment and Plan was overseen and endorsed by a manager.

5.7.6 There was clearly good information exchange and co-consultation between the education mentor and the CAMHS practitioner for AL.

5.7.7 A challenge was that until Mother's death this was not all brought together in one place for coordination across services to provide a holistic response. In Norfolk there is an agreed and valuable Joint Agency Group Supervision procedure (JAGS)[19]. Its purpose is to provide a mechanism to reflect on cases which are very complex, feel 'stuck', or are drifting. It can be used in work at Tiers 3 and 4 of the Safeguarding Threshold. It provides a reflective space for joint analysis of information, an opportunity to explore what professionals know about the lived experience of the child and should help strengthen the relationship between professionals who are working together with families to secure the best outcomes for children. It had not yet been triggered for practitioners working with AL's family after Mother's death. It would have been a useful place for the agencies working with the different members of the family, including Father, to come together with multi-agency supervisory support to analyse the levels of need or risk, the rate of progress and whether different interventions were required.

[19] 3.16 Joint Agency Group Supervision Procedure - Norfolk Safeguarding Children Partnership (norfolklscb.org)

5.7.8 As noted above it would have been useful to have had specialist psychiatric or psychological consultation for the assessment and formulation of the Family Support Plan when Father, AL and AL's Brother, and other Family members, were all in acute shock and grief and there was still uncertainty about the cause of Mother's death. This may have assisted additional thinking about what kind of responses were likely to be effective given AL's heightened anxiety and grief, for example, he was perhaps unlikely to have accepted bereavement support from a stranger, yet he would talk with his wider Family members. Specialist psychological advice may also have been useful with regard to Father's ability to manage his alcohol dependence.

Practice note: in work where there is a high or complex component of mental ill health, for a child or parent, consideration should be given to accessing consultation from a psychiatrist or psychologist to advise the network of professionals on analysis and decision-making about possible interventions and timing.

Recommendation 7 - Supporting Reflective Thinking in Complex Work

The Norfolk Safeguarding Children Partnership should review how Joint Agency Group Supervision process is working across services, including awareness of it among practitioners and supervisors and further promote it, if necessary.

The Partnership should also review with Commissioners and Providers how psychiatric or psychological consultation can be made available to multi-agency networking in cases where there is a mental health component but mental health services are not directly involved.

5.8 Bereavement support

5.8.1 Father, AL and AL's Brother were all seriously impacted by Mother's unexpected death. In December 2021 AL's Brother was referred to Nelson's Journey[20] a bereavement support service. AL would have had to make a self-referral to a bereavement service, given his age. Father was signposted to Cruse[21] for bereavement support but would also have had to have made a self-referral. A practitioner who knew AL thought that there was a possible gap in bereavement services for a young person like him as he acted emotionally and mentally much younger than the 17-year-old that he was and would have needed a service to meet that. He was also unlikely to self-refer.

5.8.2 AL was processing his emotions and thoughts by talking from time to time to his Family members by phone, which can be a positive way to mourn in the early stages of grief. A useful approach can be to provide those close to children with information about how to support them in the initial phases of shock and grief until they are stronger and later able to consider using a bereavement or counselling service if it is necessary. The Nelson's Journey materials are a useful resource. Given his reluctance to speak with strangers, including online or by phone, it was considered unlikely that AL would use more formal bereavement counselling. AL was reluctant at first to speak with the new Family Support Practitioner but started to do so briefly during their visits in December. He did speak briefly on the phone to his Previous CAMHS practitioner and in January to his education mentor about his feelings.

[20] Information and Guidance | Nelson's Journey | Child Bereavement Help for Norfolk (nelsonsjourney.org.uk)
[21] Cruse Bereavement Support (Norwich and Central Norfolk) | Norfolk Community Directory

5.8.3 As noted above (5.7.8) given AL's complex mental health, specialist advice on how to support him in this acute bereavement may have been useful.

5.9 Recognition of the needs of young carers

5.9.1 Given Mother and Father's physical and mental health problems and their possible impact on parenting, a question for this Review was whether consideration was given to the possibility that any of the children should have been considered as Young Carers. This could also have applied to whether the children were caring for each other, given the difficulties the children had. Records show that this was considered in 2014 for the Sister (age 12) but Mother declined a referral.

5.9.2 Father was recognised formally as the Carer for Mother. Given the children's own difficulties they were not seen to be providing care to their parents, because of their own needs. Practitioners did not think , in retrospect, that AL would have been able to use a Young Carer's service as he was so anxious about strangers; however, this possibility was not explored at the time.

5.9.3 Practitioners noted a learning point that it is important to consider the question of whether a child is a carer even if it may not be realistic to refer them on to a Young Carer's service. This would encourage reflective thinking about the possible impact of the disability or health of parents or siblings on children and young people, even if they are not then referred on to a Young Carer's service. As noted above, there is a caveat that agencies working with the children were not fully aware of the full nature of the parents' health problems and their possible impact. Services working with Mother in her own right did not refer any of the children for Young Carer's services.

5.9.4 As part of the review to understand the wider systemic context of provision for Young Carers the reviewers met with leading commissioners and providers of carers services in Norfolk. It was confirmed that the Family had not been referred for services.

> **Practice note:** Experience from Young Carer's services has shown that being labelled a "carer" can be a stigma for a child and that young carers often do not see themselves as carers, they see what they do as normal.
>
> Another barrier can sometimes be that families feel that there are already too many services to relate to take on another one. It is important to note that a young person can self-refer and has access to the carers' helpline.

5.9.5 A lot of work has been done in Norfolk to raise awareness of the needs of Young Carers with Adult Services and in Schools. Young Carers are being recognised through the school census. There is no strategic lead for planning for Carers across Health Services. Some Primary Care Networks have worked to raise awareness of Young Carers and GPs can now recognise Young Carers in patient coding. Young Carers services have working links with hospitals.

5.10 The impact of Covid on work with AL's Family

5.10.1 From March 2020 services to the Family could not be delivered face to face during periods of lockdowns, especially when services had to reduce to essentials. AL was used to working only online with his education placement. However, he was still anxious and reluctant to do so when this involved talking or face to face

contact on screen in real time rather than being able to use text chat systems where he had more control. The main change for him was that the weekly visits from his education mentor shifted to online in the first lockdown period and he initially had some difficulty engaging with the mentor in this way. Later the mentor was able to have contact with him in the family garden.

5.10.2 AL's CAMHS therapy stopped suddenly and shifted to monthly phone calls and visits when later possible. The calls were with Mother as AL would not speak on the phone because of his anxiety, Mother reported AL as being "fine." AL's therapist thought that Covid may have stalled AL's recovery and integration back into the wider world.

5.10.3 As Mother was clinically vulnerable, AL's Brother's primary school offered him a school place in March 2020 and from January 2021, but this was not taken up. Mother was engaging with the school by phone and Father collected and returned packs of work for AL's Brother. Occasionally school staff visited in the garden. The school put in place remote monitoring and reporting processes for all the pupils. AL's Brother was not noted as of additional concern in these periods. Covid meant that AL's Brother was out of school from March to September 2020 and, after that, he had school attendance problems because of increasing anxiety. It was also reported that he was anxious "because of Covid".

5.10.4 Practitioners also noted that Father was present more during Covid and AL's Brother was said to like having his father there.

5.10.5 None of the key workers working with the Family reported that they had been prevented from working remotely with the Family because of their own isolation or ill-health. However, agencies were clearly under additional pressure.

5.10.6 Agencies were asked to comment on arrangements put in place generally from a strategic and systemic point of view for this Review to gain a wider picture of how the pandemic affected systems as well as this family. The responses provided are rich with learning about organisational planning and responding in a pandemic which goes beyond the scop[e of this CSPR. The Norfolk Safeguarding Children Partnership may wish to use these to inform any future strategic contingency planning for safeguarding systems.

5.10.7 The responses provided show that agencies responded and adapted strategically as the pandemic progressed and occasionally there were staffing problems which required flexibility. A point noted by AL's Brother's school was that it was much harder to monitor children who required safeguarding (not AL's Brother) but this was always prioritised, and reporting systems were developed to manage this. It was also noted that multi-agency work and contact with other key agencies was harder in this period. For agencies which were not used to working remotely this was an important shift. The Mental Health Trust noted that for vulnerable children account also had to be taken of the possible impact that a child's usual supports and monitoring systems, such as schools or other services, were not available to them in the same way. Systems for prioritising, emergencies and prescribing were put in place.

5.10.8 A useful account of planning and response for safeguarding children by local agencies to the lockdowns and pandemic is included in the NSCP Annual Report 2021.[22]

[22] NSCP-Annual-Report-2020-21_FINAL-for-publication.pdf (norfolklscb.org)

5.11 Implementing learning from case reviews – measuring the impact of lessons learned

5.11.1 In September 2020, the Norfolk Safeguarding Children Partnership published a Serious Case Review into the death by suicide of a young person. This was a review into work with a different family with different dynamics. The NSCP delivered briefings to staff groups and agencies were asked to take this learning forward into practice as well as work on specific recommendations.

5.11.2 As there were some similar issues to AL's circumstances the Review Panel sought to ascertain whether the practitioners involved with AL's Family had been aware of that SCR or the lessons from it and whether they had influenced practice. Few were aware specifically about the case and the lessons. Some were aware that there were occasionally agency or team briefings and some had attended such briefings but did not remember if they had been for this case. Others were unaware. It is noted that it was published and learning was disseminated during the pandemic when practitioners and services were under great strain.

5.11.3 Recommendations from Safeguarding Practice Reviews and other scrutiny is shared and disseminated through the Norfolk Safeguarding Children Partnership Group for all partner organisations to act upon the learning. Multi-agency roadshow workshops are held following the publication of a review. Multi-agency Local Safeguarding Children Groups discuss the learning from SPRs and members feedback to the following meeting on how this learning has been discussed within their organisation. The Multi-Agency Audit Group monitors progress against all scrutiny recommendations and only when there is sufficient evidence will the recommendations be considered as completed.

5.11.4 The Review Panel noted that the Partnership is aware of the challenges of ensuring that practice learning from case reviews and from audits reaches and becomes embedded in frontline practice and is working to improve this all the time.

6 Conclusion

6.1 AL was a child and then young person who was, at times, overwhelmed by anxiety. He seemed to be making some slow improvements but became overwhelmed with grief at the unexpected death of his Mother. Practitioners were concerned about his emotional well-being at the time and steps were being taken to support him and the Family.

6.2 Practitioners worked hard to support him over several years. This Review suggests that AL's difficulties, and those of his siblings, who also had problems may have been more rooted in family trauma than was understood at the time. Like other reviews before it, it has raised questions about the importance of understanding families, and their history and dynamics including the role of father figures. Father was a key person who played an important caring role but who had his own chronic mental health difficulties which also impacted on the children. It is also important to be curious and to take a holistic view when several children in the same family are showing problems.

6.3 The Review notes the need for interventions to understand as fully as possible significant family history, including any history of trauma and its possible impact (Section 5.4). It is also important to identify key individuals who have a role in the family, including fathers and father figures plus other key relatives. (Section 5.4.7).

6.4 Section 5.3 explores the complexity of balancing working to engage and support families with the need to hold in mind whether children's care is good enough, over time. The learning shows the need to hold in mind a wider and longer term view of neglect, beyond incident based or physical neglect but considering if parenting is not meeting children's needs, including their health or mental health needs. This includes assessing possible behaviours such as unwillingness to cooperate, withholding consent for services, providing misleading information or not taking children to treatment.

6.5 Questions have been raised, in retrospect, about whether the parents were always honest with practitioners, although they seemed to be so at the time. The Review has shown, again, the need for practitioners and their clinical supervisors to hold in mind the need for curiosity and to have an open mind to the possibility that all may not be as it seems, especially when there is no apparent, or only slow, progress.

6.6 Challenges in engaging parents and the need for curiosity beyond the apparent have been noted in case reviews in the UK over several years. Sections 5.3 and 5.6 explore how this may have manifested itself in this case. This is not new learning but is repeated here as a reminder of how important it is to hold it in mind in practice and how challenging it can be for practitioners.

6.7 Section 5.7 reminds services of the need for frontline practitioners to have access to reflective supervision and consultation to aid reflective thinking. The value of multi-disciplinary supervision is noted, for which there is already a valuable model in Norfolk. The importance of having access to specialist mental health advice for children with complex mental health needs or in acute bereavement is noted in paragraph 5.7.8 and section 5.8.

6.8 The work with AL's family, given the complex and longer term mental health needs of both parents, including alcohol use, serves to remind practitioners in both children's and adults' services of the need to think about how an adult's difficulties can impact on their children or those that they have responsibility for. It is important therefore that services working with adults identity if a vulnerable adult has responsibility for caring for others and what the impact of their difficulties may be. (Section 5.9)

6.9 Family members felt disloyal to AL and the parents in contributing to this Review and wanted to protect AL's Brother. However, they wanted to ensure that something positive would come from his tragic death and that learning from this Review would be used to improve responses to families with children like AL.

6.10 Leaders and practitioners are asked to review their systems and practice considering the practice learning identified here and to strengthen or change approaches in light of the recommendations made.

Malcolm Ward
Independent Reviewer
December 2022

7. Recommendations

1	**Medication supervision** *(see paragraph 5.24)* The Norfolk Safeguarding Children Partnership should seek assurance from health commissioners and partners that protocols and guidance are in place to ensure the safe management of medication for young people known to have mental health problems, including monitoring use, and advice to carers on storage and administration.
2	**Referral Pathways for Child Mental Health Services** *(see section 5.2)* The learning from this Review should be taken into account in the NSFT Review of referral and care pathways and the development of any associated training package for staff. Referral processes and forms should seek relevant information about family history, any relevant history of trauma and any concerns about current parental mental health or substance misuse. Within the Trust, appropriate checks should be made to see if parents are known to adult mental health services, when children are being referred.
3	**Practice Guidance to Professionals on Children at Risk of Suicide** *(see paragraphs 5.2.5 – 5.2.12)* The Norfolk Safeguarding Children Partnership should review this practice guidance to ensure that it is up-to-date and promote it with the dissemination of learning from this Review.
4	**Recognising the longer term nature of neglect; and parental non-cooperation** *(see section 5.3)* The Norfolk Safeguarding Children Partnership should review its guidance on Thresholds in order to support practitioners' understanding of neglect, the long term and cumulative impact of neglect and how to identify non-cooperation of care givers, as possible evidence of neglect. As well as highlighting examples of single significantly harmful events examples can be provided to help practitioners recognise that neglect includes not being brought to appointments, repeated refusal of services, not complying with advice or not administering or monitoring a child's medication.
5	**Understanding the Importance of and Working with Fathers and Father Figures** *(see paragraphs 5.4.7 – 5.4.9)* The Norfolk Safeguarding Children Partnership should produce and promote sector specific good practice guides on understanding the importance of fathers and father figures and good practice in working with them, highlighting the expectations of all partner organisations around professional curiosity, engaging, assessing, recording and information sharing when working with all families.
6	**Understanding Families in their wider context Think Family** *(see section 5.4)* The Norfolk Safeguarding Children Partnership should seek assurance from Partner Agencies, including those working primarily with adults, that there are processes in place to identify and note when vulnerable adults, including men, have parenting or caring roles. Services should have systems in place to recognise the importance of seeing a family in its wider context, including assessing key relationships and obtaining a holistic view of any difficulties in the family, and not focusing solely on individual family members. Systems should ensure that where possible and appropriate family members, including fathers, and other key relatives, should be heard in order to capture important historical information or to understand key dynamics.

7	**Supporting Reflective Thinking in Complex Work** (see section 5.7) The Norfolk Safeguarding Children Partnership should review how the Joint Agency Group Supervision process is working across services, including awareness of it among practitioners and supervisors and further promote it, if necessary. The Partnership should also review with Commissioners and Providers how psychiatric or psychological consultation can be made available to multi-agency working in cases where there is a mental health component but mental health services are not directly involved.