A Joint Family Review (LSCPR and SAR)

Family B

Shropshire Safeguarding Community Partnership

Reviewers Clare Hyde and Mark Griffin

Contents

Introduction

1. This review will examine the circumstances of a family of four people, two parents and two children. It will particularly focus on the mother, Michelle who cared for her two children, Emily and Harry. The parents had divorced and the father, James lived locally and was also involved in the care of the children. Michelle and Harry had a number of physical health conditions, Harry has Down Syndrome, and Emily's mental health was also a significant factor throughout the review. Together these conditions impacted the family individually and on each other.
2. The circumstances leading to the death are that on Wednesday 10th May 2023 the Police were contacted by a member of the public reporting a young boy (Harry) running in the

street naked. Police attended and located Harry, and he was taken to his home address. On arrival, officers discovered Michelle inside the house halfway down the stairs, as she was aware that Harry had left the house. Whilst talking to officers, she had a medical episode, collapsed on the stairs, lost consciousness and it was apparent she had gone into cardiac arrest. Unfortunately, Michelle did not survive and was pronounced deceased. Police officers recorded and raised concerns about the conditions within the property,

3. The review is a joint review, commissioned by the Shropshire Safeguarding Community Partnership (SSCP) and the groups that are responsible for safeguarding adults and children in Shropshire. Whilst the review fulfils statutory obligations to adults and children, it will consider the family as a whole.
4. The involvement, response and support by agencies will be analysed to identify opportunities to improve future service provision and how agencies work together.

Independence

5. The lead reviewers Clare Hyde and Mark Griffin are independent of any service or agency in Shropshire.
6. Ms Hyde was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high-quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody. Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and in Bradford in 2021 has designed and led several Learning Reviews on behalf of local safeguarding children and adult's boards.
7. Mark Griffin has thirteen years' experience of safeguarding reviews, including Serious Case Reviews, Local Children Safeguarding Practice Reviews, Rapid Reviews, Safeguarding Adult Reviews (SAR's) and Domestic Homicide Reviews as Lead Reviewer and Author, Panel member, Chair of SAR sub-group and as a manager of Safeguarding Boards.
8. He also works as a safeguarding consultant providing strategic and operational leadership to a number of organisations and is the independent chair of the Diocesan Safeguarding Advisory Panel for the Anglican Church.
9. Prior to this he was the Head of Safeguarding in the Leeds District, West Yorkshire Police, responsible for one of the largest departments in the country as the Safeguarding lead. This involved both partnership and operational responsibilities. As a Safeguarding expert, he worked with and advised Her Majesty's Inspectorate of Constabulary (HMIC) undertaking inspections, at an operational and strategic level and within the partnership.

Methodology

Overall Approach

Initial approach and development of a Joint Family Review

10. The SSCP were clear from the beginning of the review process, that it was important that Emily's and Harry's experiences informed consideration of the way agencies support families in Shropshire. A joint family review therefore began. The family, for the purposes of this review, are known as Family B.
11. It was agreed that the Joint Review's learning should be presented in a Joint Review Overview Report that while robust, should also be high-level, accessible and focused.
12. This approach was agreed by the Adult's and Children's Statutory Case Review Groups.

13. During a similar timescale, a Rapid Review (RR) took place concerning another Shropshire family who shared similar experiences and issues faced by Family B. The Rapid Review determined that a Safeguarding Adult Review should take place for the mother of the family who had sadly died, as on the balance of probabilities she was likely to have experienced self-neglect due to her inability at times to self-care and the poor conditions of the house.
14. It was also agreed that a Local Child Safeguarding Practice Review should take place as the issues for the family were perennial and the mother's inability at times to provide sufficient care for one child, if not both, was of concern.
15. The decision was therefore taken to undertake a joint family review in respect of this family using the same overall approach and that any shared themes and learning should be highlighted and disseminated. This family, for the purposes of the review are known as Family A.

Practitioner Event

16. It was intended that a Practitioner Event for frontline practitioners involved in the family's life would be held. The full-day session would focus on Key Practice Episodes, which would have been used to illuminate some of the important learning.
17. Despite four attempts to engage practitioners there was not sufficient engagement to hold an event and an enquiry into the reasons for this lack of engagement has commenced.
18. The Lead Reviewer did meet with professionals from Harry's school and Children Social Care (CSC) to discuss the case and learning.

The Overview Report

19. This Overview Report of the Joint Review is set out in a way that:
    a. Provides a Summary of Key Events that enables the reader to understand what happened from the perspectives of Michelle, Emily, Harry and James.
    b. Focuses on Key Practice Episodes
    c. Considers system-wide learning.

The Review Panel

20. The Review Panel met on a number of occasions between October 2023 and December 2024
21. The overview report was ratified at the Adult and Children's Statutory Case Reviews Groups.
22. The Panel comprised of the following representatives:
    a. Independent Reviewers
    b. Shropshire & Telford & Wrekin Integrated Care Board
    c. Children's Social Care
    d. Adult Social Care
    e. West Mercia Police
    f. Domestic Abuse Strategic Lead, Shropshire Council
    g. Midlands Partnership Foundation Trust
    h. Named GP
    i. Education Access Service
    j. Housing Plus

Understanding the family's experiences

23. All of those taking part in this Joint Review have been keen to ensure that the voices of Michelle, Emily and Harry are at the heart of the reflection and learning that has taken place.

In order to achieve this several attempts were made to contact Emily to advise that a review was taking place and to invite her to contribute in a way that was comfortable and meaningful for them.

24. The Lead Reviewer met with James who contributed to the review and also provided information regarding Michelle, Harry and Emily.
25. Harry has limited communication and cognitive development, and it was felt that it was in his best interests that his experience should be captured through his father, school and CSC.
26. Unfortunately, Emily could not meet the Lead Reviewer at this time.

Agency Participation in the Joint Review

27. The following agencies participated in all aspects of this Joint Review:
    a. West Mercia Police
    b. West Midlands Ambulance Service
    c. Children's Social Care
    d. Adult Social Care
    e. Sixth Form College
    f. Early Help Services
    g. School
    h. GP Surgery
    i. Midlands Partnership Foundation Trust
    j. Shropshire Community NHS Health Trust
    k. Shrewsbury & Telford Hospitals Trust
    l. Shropshire Fire & Rescue Service
    m. Robert Jones & Agnes Hunt Orthopaedic Hospital
    n. Action for Children
28. This Joint Review would like to acknowledge the significant effort and commitment made by all agencies in providing their reports and chronologies; the resource implications of reviews can be significant and the hard work in providing a chronology or report is not under-estimated.
29. There have been significant delays in progressing this review due to the timeliness and quality of information provided by certain agencies. Additional information was requested from CSC but this was not provided within agreed timescales and was of a standard that limited analysis. This was escalated to a senior manager and further information was provided. The reviewers' analysis has been constrained by a lack of factual details, and for some instances, it has been necessary to hypothesise.

Terms of Reference for the Review

30. Terms of Reference were agreed by the Review Panel and can be found at Appendix A. These formed the framework for the submission of information and agency Information Management Review (IMR) and for the Review Panel discussions.
31. To simplify the reports the Terms of Reference have been consolidated.

1. <u>The lived experience of the family.</u>
    - Understand and explore the lived experience of Michelle, Harry and Emily including from a family perspective, how effectively did agencies engage with them and what, if any, were the barriers?
    - Did agencies recognise and respond to Emily as a carer of her brother and her mother?

- Did agencies recognise and respond to James's needs and role as a father and was he supported to care for the children?

2. <u>Assessment and consideration of Michelle's parenting capacity and the impact of health conditions.</u>
    - Was Michelle's parenting capacity considered or assessed effectively? In particular, did agencies consider historical information with regard to the cumulative impact of neglect and her mental and physical health?
    - Did Michelle's primary care, orthopaedic, cardiology services and other practitioners understand her illness and the mental and emotional impact of Michelle's weight on her accessing treatment and/or support and on her depression? How did Michelle's children and wider family understand her illnesses and weight issues? What support or information did they need?

3. <u>Single and multi-agency assessments and working</u>
    - Describe and analyse how effective agencies were in identifying, understanding and responding to vulnerability, safeguarding risks and concerns individually and as a family (including timeliness). Were practitioners reassured that Emily and Harry were safe and well and was professional curiosity exercised in identifying and exploring all risks and concerns?
    - Was hoarding and self-neglect considered an issue for Michelle?
    - Describe and analyse the way in which agencies, interacted and worked with Michelle, Harry and Emily and with each other. How well was information shared, understood and responded to between agencies? Is there evidence of collaborative working between agencies to identify and mitigate risks associated with Michelle, Harry and Emily?
    - Describe and analyse how each of the 5 child safeguarding referrals were responded to and how was risk to both children assessed? Specifically describe what risks were identified for Harry and for Emily? Were single and multi-agency assessments and interventions child focussed, accurate and acted upon? Detail each individual risk/ need that was identified and how each was assessed.

4. <u>Missed opportunities.</u>
    - Were there opportunities for agencies involved in the care, treatment and support of Michelle, Emily, and Harry to act sooner in respect of the risks to them? (To include key events that would have provided opportunities for preventative action outside the time frame)

5. <u>The impact of the Covid-19 pandemic.</u>
    - How did the COVID-19 pandemic impact upon Michelle, Harry and Emily and any support offered to them?

32. The period from January 2017 to 10th May 2023 will be the primary focus of the review. Any relevant background information prior to this time period to be included in the review as considered necessary.

Summary of Family history

33. What is known about the family history is detailed below.
34. Michelle was aged 52 years when she died, and the extent of her health conditions are explored in detail and are relevant to the review. Michelle's first daughter was born whilst she lived abroad, and this daughter went to live with Michelle's parents. Information indicates that there was brief contact between Michelle and this child.
35. Emily was born in 2004, and Harry was born in 2011. Both children had and continue to have regular contact with their father, James. James now cares for Harry.
36. Michelle gave up work following Harry's birth.

Overview of events and agency involvement

37. The period from January 2017 to 10th May 2023 will be the primary focus of the review.
38. Any relevant background information prior to this period is included in the review as it was considered relevant.
39. This section of the report does not chronicle every single agency contact with the family but describes key practice events and other information held by agencies.

Overview of Events and Agency Involvement

	Month	Events and Agency Involvement
		Pre 2017
	2014	Housing related matter, Michelle disclosed that she suffers verbal abuse from her ex-husband but no violence, the abuse had become worse since the birth of Harry. Information not shared with other agencies.
	May 2015	Michelle disclosed a significant traumatic event to GP and was exhibiting low mood. She declined counselling and started antidepressant medication.
	Sept 2015	Care needs assessment for Harry and a finalised Education Health and Care Plan (EHCP) issued.
	May 2016	GP changes the antidepressant medication as Michelle was experiencing volatile moods, poor sleep and Emily had identified concerns.
	Aug 2016	Michelle's antidepressant medication increased, reported that they were helping but still irritable.
	2016	Emily starts at secondary School
2017		
	January	Meeting in school with Michelle and Emily. Concerns regarding Emily not eating, lashing out at Michelle, worrying about everything and not wanting to come to school. Canteen menus to be shared with Emily, Michelle to provide a water bottle in school, and thoughts and feelings work with pastoral team. School nurse not informed.
	21/4/17	Michelle discloses to Shrewsbury and Telford Hospital (SATH) that she had struggled with her weight since her 20s, stating that she had experienced severe depression and used comfort eating as a mechanism to cope. Michelle was invited to attend a nurse led teaching session about surgical options.
	25/5/17	A non-related parent made a referral but no "referral" was recorded on CSC care systems. Information passed to the social worker conducting a full assessment who had visited the family at home. (1)
	May – July	School staff saw bruising on Harry's arms and leg on three occasions and that his boots were too small. Michelle provided an explanation to staff. Michelle was aware of CSC referral made by another parent. School did not share information with CSC.
	June	Social Work Assessment completed in respect of Harry's presenting needs (pattern of low-level concerns) plus concerns regarding the state of the family. Recommendation and agreements

		(with parents) for a Child in Need (CIN) Plan, Michelle declined referral to Adult Social Care (ASC).
	July	School - Thoughts and feelings work with Emily, who continues to be unhappy, worrying and not wanting to attend school, attendance being monitored. Information not shared with Michelle.
	August	Referral made to CSC (2) and Adult Social Care (ASC). Ambulance and Police attended at the home and were unable to move through due to rubbish, human and animal faeces and soiled baby nappies lying on the floor. Professionals did not feel it was fit for children to live in. Michelle was taken to hospital with Sepsis. Children collected by James. Police identified that Emily was a carer.
2018		
	January	Third appointment letter sent to Michelle for asthma review for Harry
	May	Michelle discharged from gastro weight clinic
	May	Community Paediatrics - Letter dictated to parents due to not booking clinic appointments after letters sent.
	June	Core Group meeting with Michelle, who had not obtained a pendant safety alarm for Harry. Michelle was supposed to be progressing this for almost a year ago, told it may escalate to Child Protection if she doesn't get it. Michelle said that she would order it that week.
	July	Police attend home, Harry had been found wandering with no shoes on in the street by a member of the public. Harry was described as appearing to have a dirty face with dried mucus around it, his room had no furniture, Michelle was decorating, and Harry was currently sleeping in her bedroom. On the landing was cat food and piles and clothes on the floor, and no carpet in the hallway or stairs. Referral made to CSC (3). Michelle subsequently declined referral to ASC
	August	Phone call from Michelle to Shropshire Community Health NHS Trust (SCHT) to book a doctor's appointment. She is struggling with Harry's behaviour. Email sent to the doctor to request a phone call to her.
	Oct	Letter sent by Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH) to Michelle requesting consent for Harry, two previous requests made. New footwear ready to be fitted since July but professionals are unable to progress without consent.
	November	School record that Emily is attending counselling.
2019		
	March	Advanced Nurse Practitioner at GP Medical Practice shared information with the School Nurse that Emily is a carer, and this is impacting her school attendance. The school nurse met with Emily, no record that this information was shared with the school.
	March	Letter to GP from Gastro weight clinic, Michelle has a weight increase, gastric sleeve planned, but cancelled 10/5/18 and Michelle is to have colonoscopy and iron treatment.
	May	Hearing test for Harry needs to be shouted to hear, and trial wearing a soft band, but he wouldn't tolerate headband.
	June	Community Paediatrics - Harry is seen in a routine Doctors clinic. Michelle is still concerned with Harry's behaviour awaiting Occupational Therapy for safety measures at home.
	June and July	Emily attends GP Practice on two occasions regarding physical health conditions. She reported stress at home with Harry and Michelle's health issues and feels unsupported at school. Michelle requested antidepressants, but the GP advised they could not prescribe these. Second visit - attends with Michelle and Harry. Emily was very tearful, had poor eye contact, and was frustrated that Michelle and another person were talking over her. Emily declined a referral to Bee U[1] but was offered a self-referral to Kooth[2].

[1] https://camhs.mpft.nhs.uk/beeu - emotional wellbeing and mental health services for children and young people

[2] https://www.kooth.com/ (Kooth is a free, safe, anonymous online emotional wellbeing community)

	July 2019	Police attend, report from neighbours who have seen Harry in the windows appearing to try to get out. They attempted contact with Michelle, who was present within the house but was unwell in bed, allowing Harry to roam the house unsupervised. Police Officers described the outside of the house as unkempt and uncared for, the inside as an unacceptable state for human habitation, with a smell of urine, dirty with a significant amount of rubbish, it was clear no cleaning had taken place for some time. Michelle had open wounds on her legs and did not appear to be concerned about the state of the house or the danger to her son. Harry was collected by his father. Referral made to CSC (4).
	July 2019	Following a 999 call, Michelle conveyed to SATH due to painful legs which were getting more painful, vomiting and redness to her legs was travelling.
	August	CSC chased up a toilet repair with Housing, unknown how long the toilet hasn't been able to flush.
	September	Harry gets onto the school bus in pyjamas, school provided uniform.
	October	Emily reported missing to Police but located at James's house, finalised as misunderstanding.
	November	Education Access Team (EAS) send 1st letter of concern to Michelle regarding attendance of Emily.
	November	GP Practice send fourth appointment letter to Michelle for warfarin management
	December	EAS send further letter to Michelle due to further absence. A telephone call between EAS and Michelle who described the family's situation and advice with signposting to support services.
	December	Michelle did not attend warfarin and gastro clinic appointments, discharged back to GP from the Bariatric Weight Clinic.
2020		
COVID 1st National Lockdown 23rd March to June		
	January	New bathroom required
	January	EAS close case as no further involvement required around school absence for Emily. School speaks to Michelle, as she is concerned about how Emily is coping in school. School refers to school counsellor for anxiety.
	February	GP makes a referral to BeeU for an urgent appointment for Emily as GP believes she is very high-risk patient. Concerns regarding low mood, anxiety, recent self-harm and suicidal thoughts, with over a year's history of low mood and anxiety, which has been worsening. Referral also highlights Michelle's and Harry's health conditions, and Emily had been taking on a caring role within the family. School attendance is 70% due to her mental health, and she is reportedly self-harming and having some suicidal thoughts. Emily reports she is reluctant to let her mother know about the feelings she is having. Attempts were made over 2 days (3rd and 4th) to contact Emily via phone, which were unsuccessful. A 14 day opt in letter was sent to the home address requesting contact if support still required.
	February	Michelle responds to letter (15th). Michelle discloses Emily's self-harm, suicidal thoughts and daily low mood for 5 years and also confirms carer role. Emily speaks to BeeU Staff. The outcome of the assessment is for Emily to self-refer to psychological well-being services, attend children's society drop-in sessions if she wishes and on-line resources given. Emily is to be closed to Bee U. No action taken regarding the carer role.
	April	Michelle advises Housing that she is self-isolating
	April	GP Practice - Michelle requested an earlier appointment due to Harry's challenging behaviour. Seen with school staff and a plan is in place to help support the challenges with his behaviour.
	May	Email welfare check on Emily by school, no response, no follow-up.
	May	Annual Gas service completed, check of smoke alarms in the hall, landing and kitchen. No information was recorded about conditions.
	June	Michelle contacts RJAH (orthotist), desperate for new boots for Harry. School nurse agreed to assist with measurements, and new boots posted.
	August	GP Practice –Letter and call to Michelle re non-compliance with the blood test team, (International normalised ratio INR Test), 3 calls re skin infection, Tinzaparin prescribed.

	October	Michelle reports family are self-isolating due to a friend contracting Covid.
COVID 2nd National Lockdown 5th November		
	November	Child in Need (CIN) visit CSC. Michelle acknowledged that the home conditions had "got on top" of her due to the demands associated with Harry being home full-time. The social worker noted that both the house and garden were in a bad state and needed some urgent attention and identified what needed to improve. Michelle was clear that she would be able to do this and, in the subsequent visits soon after, the social worker noted compliance and improvements.
	December	School records show that Michelle had recorded in Harry's book that morning that he had put his right hand on the radiator and that he is now complaining of hand, three blisters seen by school. School spoke to Michelle, who acknowledged the radiators are very hot, and encouraged to contact her Housing Officer. School nurse was asked to review Harry's injuries on the same day (plus a few days later to ensure there were no signs of infection). School reported the burn to CSC.
2021		
COVID 3rd National Lockdown January to March		
	February	GP sees Emily regarding knee pain and depressive disorder. GP was given a note from Michelle which summarised self-harm and suicidal thoughts. Emily seen with Michelle, declined to be seen alone. Encouraged to access BEAM[3].
	March	Referral from CSC to School Nurse, Shropshire Community Health Trust (SCHT). Phone call conversation with School Nurse to discuss referral for targeted behavioural support. Harry recently had an appointment with a Community Doctor, and it was agreed the CSC would refer him to Bee U. SCHT sent the referral back to the CSC as referral was sent to the incorrect team.
	March	CIN plan stepped up from short breaks to CIN.
Phased Exit from Lockdown March to July		
	March	CSC advised School that Harry has been upgraded from CIN (Short Breaks) to Child in Need. Short breaks review - Referral to short break service to look at help for Michelle at home
	March	CSC referral to Bee U Access Service (16th) for support in managing Harry's behaviours - aggression. Occupational Therapy assessment believes that the issues are "social" rather than the "built environment". Wheelchair used to manage his behaviours and safety, but Michelle has found the behaviours more difficult to manage and Harry has hit Michelle in the chest multiple times. Michelle has bruised Harry on his upper arms when getting him out of the bath. Michelle stated that she was unable to support Harry on her own without the use of the wheelchair. CSC assessment is underway, he is in school daily and is supported weekly with short breaks and behaviour plans. School Nurse provides advice on behaviour management and routines around toileting. Michelle's poor physical health is highlighted, and that Emily is often involved in his care. Harry sees his father regularly. Advice is requested on positive parenting strategies and techniques to support Harry as he matures and develops. Referral is not accepted, as it is identified as behavioural support. Signposting advice is given to Michelle.
	June	James was admitted to hospital.
	June	Emily leaves school
	July	School found that Harrys's pads and pants sent in from home were too small and digging into him. Michelle responded that she would purchase bigger pants the same day.
	July	Harry required a mastoid exploration[4] and myringoplasty[5] and required grommets fitting.
	August	Letter to GP Practice, Michelle was non-compliant with the blood test team and discharged from warfarin clinic.

[3] BEAM is an emotional wellbeing service for Children & Young People under 25 years old who are registered with a GP in Shropshire

[4] A cut is made behind the ear or above the ear opening, to get a good view of the middle ear. The surgeon may also explore the air spaces of the mastoid, behind the middle ear, and remove any infection.

[5] Also known as a Type 1 Tympanoplasty, is an operation to repair a large hole (perforation) in the eardrum that has not healed itself within a few weeks. The procedure is generally carried out to improve hearing, avoid recurring infections and to be able to get the ear wet.

	August and September	New shower but a fault in the toilet resulted in waste going straight into the garden and drains blocked (12-23rd). Excavation work meant the family had to use the outside toilet.
	September	Emily attends College. 15th - Spoke to tutor to drop a subject. Attendance 48%. Emily disclosed her role as a carer and information about her family's health. Also disclosed self-harm and had 8 attempts at suicide since March, suffers from PTSD & suspected BPD. Introduced to safeguarding mentor, 19th - Further meeting took place between Emily and SG mentor.
	October	Further meetings took place between Emily and SG mentor at college (1st and 13th). Risk Assessment completed, spoke to Michelle in the presence of Emily. No current intention to commit suicide. Risk assessment and referral shared with BeeU Access Team
	October	BeeU Access Team assess referral, outcome for Emily is that she can self-refer to the Adult Psychological Therapy Service (IAPT) and closed to Bee U. GP and College informed of outcome.
	November	College speaks to Michelle and Emily on phone to discuss concern over her attendance and poor input into her subjects. Emily disclosed she was up until 3am completing her work. There has been no self-harming or suicidal issues. 17th – Further discussion between College and Michelle regarding attendance and falling behind to the point of failing. Michelle highlighted mood swings but was unaware of any self-harming. Michelle had to get rid of the dog at the request of CSC and this has upset Emily. College suggested Beam and Kooth, but Michelle felt she would not open up to them or use them as she only trusts College.
	November	Michelle did not attend Mammograph appointment but had contacted GP that week with cellulitis and chest infection
	December	Emily leaves college and intends to re-apply the following year. College records closed.
	December	Special School Nursing - Harry had surgery on his left ear and stayed in hospital overnight. Michelle advised to book a follow-up appointment.
	December	Bee U received a referral from the GP for Emily – with concerns that she may have ADHD and has requested an assessment. Referral declined, a letter from her college that identifies difficulties that they have observed that may relate to ADHD is required. Emily was advised to speak with her college regarding her concerns in the first instance.
	December	Letter from paediatrician, improvement noted in Harry's behaviour and action plan agreed.
2022		
	April	Michelle calls MH Services as she was concerned regarding Harry's behaviours, that he would only "go with certain people" and if he didn't want to do anything he would drop to the floor. Michelle expresses that Harry had a reduced awareness of danger and he would walk straight out in front of a car. Michelle states that she is unsure whether this is Autism. Michelle reports he is difficult in school and getting to the stage where she needs extra support, and he won't visit his father without her. Michelle was advised that she needs to speak to either the school, social worker or the GP for a referral to Bee U Access. Michelle is asked if she has had early help services previously. Michelle agreed to speak to the school for a referral to Bee U and given the contact details for early help services.
	June	GP Practice, letter from cardiology re Michelle - heart murmur diagnosed
	June and July	Harry attends SATH for examination and treatment of ear under anaesthetic. Follow-up appointment a month later, ears much improved and clear, medication instilled in ear again. Harry had left his soft band hearing aid at school for the summer holidays, although his compliance with wearing it was intermittent.
	July	Out-of-hours call to Housing, front door will not open, only point of access for Harry in a wheelchair.
	September	(14th) Emily attends college, speaks to staff and outlines details of her family, her depression and stress. Disclosure of historical CSE, Emily was groomed at 14 years, with no police involvement. Agreed to meet weekly and discuss adult MH services or EHWB in college. College sends an email to CSC for further information.

	September	(21st) Further meeting between Emily and College staff who outlined how her caring impacts on college and advised to communicate this. Last self-harm was 2-3 months ago. College advised teaching team of caring responsibilities. Agreed to referral to IAPT but will do that next week, would like ADHD / ADD assessment - signposted to GP.
	September	Harry was not brought to an appointment at the SATH sensory clinic. The Consultant telephoned Michelle, who explained they had spent 45 minutes trying to find a parking space close to the hospital as they both have mobility issues but were unable to find one. The consultant suggested Harry's care be moved to Royal Shrewsbury Hospital with a plan to get his hearing tested and to check his left ear. GP
	October	Hearing Test - SATH. Current hearing support provision discussed and noted Harry's soft band was for use at school and not at home and his compliance was intermittent. Examination of his ears was satisfactory, but the hearing test showed little improvement compared to March. Teacher of the deaf at School to visit Harry and trial the Ponto sound processor on a hard band to see if usage is more consistent.
	October	College staff contact Emily, will be 18 next month. Michelle is very stressed, respite support for Harry has been cut. Explains that because of her caring she can be late for college, she has spoken to her teachers about this. Using I am Sober App - feeling suicidal but 6 months since the last suicide attempt. Signposted to Access, IAPT and MH services. Emotional health and wellbeing (EHWB) referral completed; Risk assessment recorded.
	October	Michelle attends GP Practice, referred to a food bank by care coordinator.
	November	College contact Adult MH services regarding a referral for Emily. Advised College to make the referral to BeeU and then they will refer to Bee U access. As a referral has already been made for EHWB at college, Emily decided to wait until she is 18 and then make a referral direct to Bee U access if EHWB is not yet in place or it is not suitable.
	November	(9th) Weekly meeting between College and Emily. Discloses that she is struggling to live with her disabled family, no longer wants to be a carer for Harry who is getting bigger and more difficult to support. CSC have provided carpets but not anything else. Mum's depression is getting worse. Discussed Young Adult Carers.
	December	Concern recorded by School. Harry was sore and discussed with Michelle, who requested help. She is really struggling with Harry at home, toileting, bathing, and getting him changed. Harry had turned off all the alarms and was late to school. Information shared with CSC.
	December	College changed RAG rating to Amber as Emily has missed the last couple of meetings, her attendance is good in college, and concerns are ongoing but monitored regularly.
	December	(3rd) Inpatient Admission at SATH for Michelle, Severe IDA (Iron Deficiency Anaemia). Staff checked with Michelle and Emily and James were looking after Harry. No indicators that necessitated a contact or referral into children's safeguarding and a screening tool identified no requirement for referral into ASC. Discharged home on 7th. Michelle had made school aware of the situation.
	December	(12th) CIN Review. CSC planned to visit and discuss the house conditions with Michelle. Michelle has been working with Social Worker (SW) to de-clutter the house and organise Harry's bedroom; funding has been secured for new flooring in his bedroom; the next action was for the sitting room to be de-cluttered from washing and rubbish. James had purchased a new bin in the sitting room and was asked to tidy up when he visited.
	December	(15th) Meeting between College and Emily. Disclosed that she was sexually harassed by a male member of staff on her work placement and made a personal statement. She was provided a number for Health Assured.
2023		
	January	Emily meets with college staff. Discusses conflict with another student, signposted to BEAT[6] due to concerns regarding eating habits. Emily was wanting ASD assessment.

[6] NHS Eating Disorder Service

	January	Michelle contacts SCHT - Community Paediatrics - to speak to a doctor about Harry, "his own way, his behaviour can become very bad, and he lashes out". Staff emailed Doctor.
	January	(11th) CIN visit. Michelle agreed referral to ASC – Occupational Therapy and Mental Health, CSC assisted Michelle with the referral. (12th) CIN Meeting. Harry has had extra stays at the short break provision because of Michelle's illness.
	February	(1st) Last recorded CSC visit to the house. No concerns in respect of the home environment or the care Harry was receiving, conditions in the front room had improved considerably, there was no rubbish or washing lying around and Michelle had created an area at the far end of the room for all of Harry's favourite toys, games and activities. Case Notes show that there were attempts to visit in March 2023 however these were not successful as Michelle had health appointments which clashed with the arranged dates.
	February	(4th) SATH, Inpatient admission for Michelle, by Ambulance from GP surgery - Community Acquired Pneumonia (left), Infected leg wounds, microcytic anaemia. Michelle reported that normally she was able to mobilise around her house with minimal outside mobility, but she stated she could walk around the supermarket comfortably. Now she said she was short of breath and only able to walk about 20 yards. Discharged home 10th. Emily advised that James moved in to look after Harry whilst Michelle was in the hospital.
	February	Referrals made for social prescribing and also to Sustain[7] by the ASC MH Team. ASC MH Team made contact with Michelle whilst she was in hospital to discuss requirements.
	February	(24th) Special Education Needs (SEN) - Letter sent in response to annual review. Intend to amend had been sent on 10/03/22 but this was not actioned. EHCP was considerably out of date and should have been amended.
	March	Emily went to see college staff. She had obtained a job and had recently self-harmed but had spoken to her GP about depression. Missed EHWB assessment, advised to re-refer herself, but Emily said she didn't want to go on the waiting list. Signposted to Silvercloud[8].
	March	(13th) CIN Review, Michelle and James did not attend. Action for Children raised concerns about the smell of cats in the house. CSC stated there had been no smell on the last visit, and the house had been de-cluttered.
	March	(16th) GP appointment Emily. Referral to IAPT, prescribed Sertraline, signposted to advice on the drug.
	March	(16th) Shropshire Access Team receives a referral from the GP for Emily, requesting a review. GP reports Emily has attended the surgery with notes of traits possibly linked to Bipolar disorder, Autism, ADHD, depression and anxiety. The GP reports Emily is "very keen for a diagnosis" and feels her mental health has worsened. Emily had reported suicidal thoughts that were almost constant, writing suicide letters and previously attempting to take her own life. Emily reports alcohol abuse, deliberate self-harm, excessive spending and "self-sabotage". GP reports that they have commenced medication and provided details for the crisis team. A handwritten note is shared with the referral form where Emily documents symptoms linked to conditions stated.
	March	(16th) Emily is contacted by the Shropshire Access Team and struggles to remember her childhood during consultation. Emily shares she attends college 3 days per week. She enjoys this but finds it stressful. Emily reports poor concentration and memory, stating she has completed NHS screening questionnaire for Autism Spectrum Disorder, ADHD, bipolar disorder and self-identifies with the conditions. Emily reports she feels conflicted by her parents and is unable to trust them, stating they are inconsistent and dismissive of her. When discussing risk, Emily identifies she can keep herself safe and can distract herself. Emily confirms she is seeking support from IAPT and is working

[7] http://search3.openobjects.com/kb5/shropshire/cd/view.page?record=FVkDcu9F2Bc. Sustain is a consortium of providers delivering consistent housing support services across Shropshire for vulnerable people of any age and including people with physical disabilities, young people's services including homelessness.

[8] SilverCloud - online therapy programme that allows people to access Cognitive Behavioural Therapy techniques

		to understand her behaviours. Emily was referred to IAPT for psychological therapy and referred to the Shropshire Autism Hub.
	April	(13th) Emily has an appointment with counsellor. (17th) Emily did not attend her planned telephone consultation with IAPT. (27th) Shropshire Access received email from IAPT stating that Emily has been discharged after non-engagement.
	April	(27th) CIN Review. Michelle was unable to attend due to an MRI appointment which came up last minute, James did not attend either.
	May	(5th) Housing attended at House. No answer, but the neighbour confirmed she was in. Harry shouted to staff that his mum was ill in bed. Michelle rang staff and apologised for missing the appointments but said they have all been ill with a 'bug'. She agreed to a further appointment on 9/5/23.
	May	CIN Meeting
	May	(9th) Michelle collected Harry from school due to him presenting as unwell.
	10th May	Police attend following a report of Harry in the street naked. Whilst talking to officers, Michelle had a medical episode and was pronounced deceased. Police officers recorded that the property was in an abysmal state, with a strong smell of urine and faeces within the address. A cat litter tray was seen to be full of cat faeces and had not been emptied for some time. Graffiti was evident on internal doors within the property. There was no carpet on the stairs/upstairs landing. Dirty plates and dishes were piled high in the kitchen, along with other forms of waste. Remnants of talcum powder were also evident in various places within the home. Referral made to CSC (5)

Analysis

40. The analysis is set out in response to the key lines of enquiry agreed by the Review Panel which formed the terms of reference for the review. The analysis is informed by:
    a. chronological information provided by agencies,
    b. Additional information provided by Children's Social Care in response to questions asked by the independent reviewer.
    c. Research
    d. Analysis of other serious case reviews

Term of Reference 1: The Family's lived experience:

Michelle.

41. Michelle was described as intelligent and was good at organising other people and events. Agencies reported that she was often positive about her children's achievements and would attend events.
42. Agencies records show that Michelle was living with multiple complex health conditions, including lymphedema bilaterally, depression, morbid obesity, infective endocarditis, and infected leg wounds producing excessive exudate. In 2015, she had infective endocarditis, which was followed by a replacement of her aortic valve. Also, in 2015, Michelle disclosed to her GP that she was suffering from low and volatile mood, poor sleep and irritability and shared details of a significant past traumatic event. From this date, the GP prescribed her antidepressant medication. Michelle also disclosed that she had to inject herself daily. This combination of physical and mental health conditions would have been challenging and would have significant physical, emotional, and social impacts. These health conditions did impact Michelle's ability to care for herself and her children.

43. Michelle's physical and respiratory limitations may have impacted her ability to breathe and engage in physical activities. Alterations were made to her home, and she was seen using a mobility scooter and walking stick and on one occasion it was noted she could only walk 20 yards, but the GP recorded that Michelle was generally NOT housebound. The assessment of her mobility is explored later.
44. Michelle has been known to the Police since 2014. She was the victim of four offences, theft, harassment and two incidents of receiving offensive communications. Between 2014 and 2019, there were five police child protection records relating to four of the referrals to CSC and the missing person matter with Emily) There was also an incident at a nearby property which led to the Fire Service visiting. The numbers and nature of these incidents may have left Michelle feeling anxious and potentially unsafe in her home and the community.
45. In 2015, Michelle disclosed details of her mental health to her GP but there is limited information in how the GP considered this in a wider context. There is also limited information recorded by other agencies about Michelle's mental health. In speaking to James and practitioners, it appears that Michelle suffered substantial trauma whilst living abroad several years ago. In addition to the birth and giving up, of a child, there were two other significant events (One being the same disclosed to the GP). At this time, her relationship with her parents broke down and this was a cause of concern for Michelle throughout her life. Practitioners were aware of partial details about these events and some of the complexities and challenges within the whole family, but there is no evidence that agencies fully explored the possibility of trauma when speaking to her. In 2019, Michelle mentioned her first child and family conflict to CSC, but this was not explored further. Agencies felt that she could be guarded about what she told agencies and in allowing access to her house. Records evidence that it was only whilst in A&E (December 2022) that Michelle talked about her mental health and made reference to trauma when she was younger and undiagnosed PTSD. In 2014, she disclosed domestic abuse that dated back to 2011. Emily did disclose concerns to several agencies about her mother's feelings and mental health.
46. There is a reference to a network of friends around Michelle and some social participation. It is believed that she went out most days after Harry was at school to a cafe. It is not clear if she met friends there or because of the regularity became friendly with other people frequenting the place. In discussions with professionals, there may have been an element of loneliness in Michelle's life.
47. Michelle had received various allowances and payments since 2012, including allowances on behalf of Harry. Whilst there were no rent arrears on the house, in October 2022, the Medical Practice referred Michelle to a local food bank that she contacted. In February 2023, a referral was made to the Sustain Consortium, which provides community support, as she was anxious about paying the rent. In the referral to ASC, Michelle did allude that she struggled with budgeting. James informed the lead reviewer that Michelle had amassed significant arrears on a utility bill which was only identified after her death and there were other indicators that Michelle was in debt. CSC did provide support for funding opportunities, but Michelle failed to progress these, and her motivation is considered more in the next section.
48. Michelle and her family lived in the same house from 2014 onwards. Whilst agencies made some adjustments to the family home to assist Michelle, there were difficult periods for all the family with the repairs and replacements, loss of electricity and drainage problems, and some repairs took time to complete. The living conditions within the house will be explored in detail and would have impacted on Michelle's and the children's quality of life.
49. Overall, several stressors were impacting upon Michelle.

Harry.

50. Harry lived with a number of complex health conditions, including Trisomy 21 (the most common cause of Down syndrome), asthma, obesity, sight and hearing deficiency, and he

needed orthotics. Although Harry is mainly none-speaking, he is not non-verbal, he can say some words and can make sounds/noises. His lived experience is influenced by a combination of physical, cognitive, and sensory factors. At an eye test in September 2018, Michelle and James also raised a diagnosis of ADHD and Autism, but it is not known if this has been formally diagnosed. Agencies recognised the close bond between Harry and his parents. Harry's health conditions will have impacted his daily lived experiences, and it may be that he was not always comfortable or fulfilled. By virtue of his disabilities, he is eligible for assessment as a child in need section 17 under the Children's Act 1989.

51. Having a hearing and sight impairment could have presented communication challenges, but he was good at signing. The management and treatment of Harrys's ears was a reoccurring issue. He required surgery and tried various hearing aids, but he struggled to tolerate these.
52. Mobility would have been impacted by obesity and his asthma the conditions of the home environment may have limited him. Michelle used the wheelchair to move and manage Harry due to her limited mobility and to keep him safe and manage his behaviour.
53. Harry's social interactions are influenced by his communication and sensory needs. He is described as at an early developmental stage (2–3-year-old) of social interaction; he doesn't like sharing and is not toilet trained. Harry has a lower cognitive level, which means he takes longer to process non-verbal communication. The school recognised his personality and that he always presents as happy, but he can be stubborn. He is engaged in the classroom, enjoying play-based or sensory learning, and leaving the classroom to go on adventures. The school also recognised that he likes to help adults and works hard to make friends.
54. The school has made adjustments to support Harry with relevant equipment. An inclusive educational setting that accommodates the child's unique needs and provides necessary support services is crucial. This may involve collaboration with special education professionals and the use of assistive technologies. The EHCP was considerably out of date, which resulted in a lack of progress and understanding of Harry's lived experience.
55. Throughout the review, there are incidents that are referred to as challenging behaviour and intentionally falling down. Given his limited communication skills, these non-verbal behaviours may have been a means of expressing a need, emotion, or discomfort. There is no evidence that agencies explored these as signs of unhappiness or anxiety. The impact of this behaviour resulted in bruising to Harry when his mother attempted to lift or stop him from falling. Michelle raised these concerns with professionals on many occasions. By March 2021 this had escalated with Harry hitting her, and she was using the wheelchair, and he would not visit his father without her. This was still a problem in 2023 when Michelle contacted Community Paediatrics and advised that he "lashes out".
56. Communication with Harry would have been more challenging, given that this required non-verbal communication. Whilst it is recorded that he was often happy, there is minimal information of his day-to-day feelings and voice other than observed behaviour. He may have been affected emotionally by witnessing Michelle's health struggles, hospitalisations, or fluctuations in mood. Through discussions with the school, the reviewer established that staff are practised in using methods of communication that enable Harry to communicate through the use of Augmentative and Alternative Communication[9] including Makaton[10]. Whilst there were challenges in understanding his lived experience daily and particularly at home, staff could ascertain his voice for specific matters. The school also used trained pastoral staff to undertake bereavement work with Harry, which is good practice. Staff at the school evidenced a good relationship and knowledge of Harry. Michelle did seek support from the school with Harry's communication and social interaction and she was given cards

[9] https://www.oxfordhealth.nhs.uk/cit/resources/aac/

[10] https://makaton.org/ - children and adults use Makaton symbols and signs, either as their main method of communication or as a way to support speech

to assist. CSC also used Makaton but mainly captured his lived experience through observations of him in his home environment (on a 6-monthly basis between 2017-21), and information provided from school and at short break provisions. There was also an acknowledgement by agencies that Michelle provided his voice and expressed his concerns, and she was able to communicate effectively with Harry. Overall, there is little evidence of Harry's voice. There is no record indicating that the parents were trained in Makaton, but they could communicate with Harry with informal signing and cues.

Emily.

57. The main sources of information about Emily's lived experience are from her school, college and GP. CSC only had limited conversations with her as part of Harry's assessment and subsequent CIN plan and there was an expectation that she would raise concerns rather than professionals adopting a proactive approach to understanding her lived experience. CSC alluded that Harry was often the centre of attention. Given this assumption, Emily's needs and well-being may have been overlooked or "hidden" amidst the family's broader health challenges. Emily did open up to other agencies at times and provided some insight into her life.
58. There are long periods of minimal agency involvement and during these times, a lack of exploration of her lived experience and emotional health. When Michelle did share concerns about Emily this was sometimes minimised or overshadowed by Michelle's health conditions. Whilst this was relevant to understand the context of Emily's lived experience, this may have minimised Emily's needs and wishes. Emily is described as intelligent and the staff at college established a good relationship with her and were able to provide support and gain some understanding of her lived experience.
59. Emily was affected by dysmenorrhoea, which led to stomach cramps and nausea, which then impacted on her attendance at school. There were also several entries regarding a knee problem but is unclear how this may have impacted upon her day-to-day life or carer activities.
60. The review explores Emily's two significant areas, mental health and her role as a carer. Her mental health appears to have been impacted by several factors, but her role as a carer was a significant contributing factor. In 2017, Michelle had shared concerns with the school about Emily's anxiety and unhappiness at school, which resulted in not wanting to attend and "worrying about everything". Michelle had also arranged for Emily to access a counselling service. CSC reported that this had a significant impact on her mental health. There was minimal support provided regarding a concern around eating and no record of any follow up and by January 2023 this was again a concern. The school did provide pastoral support later that year.
61. By 2020, Michelle stated Emily didn't go out much, and both parents recognised that she would sit in her room. CSC records show that when she reached 17/18 (2022) she was going out more.
62. Emily disclosed to the college study support teacher, that she did not have a close relationship with her mum or dad. In 2017, Michelle disclosed Emily lashing out at her. In 2021 she described her upbringing as "troubled" with domestic issues between parents and health issues. Emily expressed a feeling of not being supported, at school and by her parents. CSC did sense pressure on Emily around her education and that she was seeking approval from her parents. Emily didn't feel as if her Mum cared about her and her younger brother Harry (10 years old at the time), and this may have come from witnessing Michelle's health struggles, hospitalisations, and conditions within the house and particularly from the

responsibility of undertaking a carer role alongside these. Conflict between the caring role and the child's own needs can lead to feelings of guilt and resentment[11].

63. Harry's school recognised Emily's value in encouraging him from the car to school, but this was at the expense of her being late for school. Emily talked about Harry on a number of occasions, and she plays an important part in his life. It is clear that Harry feels a strong connection with her. She described Harry as having lots of complications, and he was always demanding and shouting. By November 2022, she told College staff that she no longer wanted to be a carer for him; he was getting bigger and more difficult to support.
64. There were incidents at school and college around bullying and sexual harassment that may have added to her trauma and impacted her mental health. In 2022 she made a disclosure to her college that she had been groomed online at the age of 14 which was not reported to the Police.
65. In January 2020, at a GP appointment, Emily first raised concerns about self-harm and having daily suicidal thoughts and low mood for over five years (2015). These concerns and vulnerabilities continued throughout the remainder of the review period, and she disclosed self-harming in many ways. The GP Practice, School and BeeU Access Team did undertake work with Emily at the start of 2020 and it appears that Michelle was the conduit for information sharing between her school and the GP. There was a significant gap until February 2021 when her GP discussed Emily's mental health, but only because she had attended with knee pain.
66. The next contact with professionals was when she started college in September 2021, her attendance was 48%. She approached her tutor and disclosed the challenges she faced with her family and wanted to drop a subject. She also disclosed that she had been one month 'clean' from self-harming & pill-taking, and had made eight suicide attempts since March, she self-diagnosed that she was suffering from PTSD & suspected borderline personality disorder (where she would hyper-fixate on someone). In particular, she was taking tablets and drinking and described relief from taking the paracetamol and then being sick. Emily did allude that she was up till 3am to finish studying, which is an indication of her opportunities to work, caring for others, and finding a quiet time in the house. This also shows a determination to complete work. Attendance was a concern to school and college, but understandable against her lived experience and caring for others. During this period, the College did engage, assess risk and provide support to Emily.
67. In December 2021, Emily dropped out of college, and it was not until September 2022, when she returned to college, that agencies again engaged with her and were able to assess her mental health. It is at this time that she raised the question of an ADHD/ADD assessment with the college. Soon after, she disclosed that she was still feeling suicidal, but it had been six months since the last suicide attempt. The college was supportive again and worked with Emily in managing her mental health. This involved signposting and referrals but resulted in minimal interventions by agencies.
68. It is unknown what Emily thought of the conditions of the family home and how this impacted her. The decision to get rid of the family dog for hygiene reasons caused upset to her and she referred to it as a therapy dog. This was at the request of CSC, but there is no evidence of exploration with her of the dog's function or alternatives. Emily had previously admitted to a social worker that she had graffitied inside the house (and this was still present in May 2023), but the reasons were not looked into, and if this was a method of expressing her feelings.

[11] Edwards and Smith 1997; Barnett and Parker 1998.

69. There is limited information about the lived experience of Emily. She was often invisible and given the complexity of Harrys and her mother's health conditions; she was rarely in the limelight. She was supportive of others at the expense of her mental health and had to regularly deal with self-harm and suicidal thoughts alone. Despite this, she showed determination to succeed in her education.

Did agencies recognise and respond to Emily as a carer of her brother and her mother?

70. Several agencies did recognise that Emily was a young carer for her mother and her brother, but crucially CSC, Early Help (EH) and her school did not formally identify her and respond accordingly. Police records state that Emily started caring for her mother at the age of 13 (2018) and she was able to look after herself by this age. CSC did recognise she was providing some care, and CIN plans in 2022 identified a need to support her "in her caring role". Certain agencies did provide support as a carer mainly through signposting, she completed a young carers course, was known as a carer with the Red Cross and was signposted to a Young Carers Youth Club. She was not assessed as a young carer in her own right but was mentioned as a carer for Harry in his CIN assessment, but this didn't trigger a S17 carer assessment.
71. The Police identified her as a carer in referrals made to CSC, and although the Medical Practice shared this information with the school nurse in 2019, it appears that her school did not record that Emily was a carer. There appears to have been a significant correlation between the increased demands of caring and the decline of her mental health, and she often talked about caring for her mother and brother and highlighted this link.
72. If Emily had been formally assessed and recognised as a young carer, she would have been entitled to a statutory Transition Assessment as a child likely to have care and support needs after she turned 18 years old[12]. Within Shropshire, a charity is commissioned through Early Help to support young carers[13]. Records do not show any referral made between 6th April 2019 and the end of the review period.
73. The Government's Carers' Strategy acknowledges the role of young carers and the difficulties they may have in identifying themselves 'because of family fears that they will be taken into care or because the young people themselves are concerned about the reaction of others and bullying by their peers' (HM Government 2010d, p.8, paragraph 103). Emily did at one point express a fear of her mother dying and disclosed to professionals that her mother struggled to cope.
74. Records provide some insight into Emily's experience as a carer for both Michelle and Harry. There are differences in caring for a parent compared to a sibling. In caring she cooked, cleaned, administered medication, provided personal care for Harry, and got him ready for school. Michelle described that she had "trained her to look after us".
75. Caring for Michelle may have involved a more significant role reversal, with Emily taking upon responsibilities typically associated with parenting, and this may have impacted on her relationship with her mother. Emily's role as carer did impact her emotional and psychological health and she did raise concerns to professionals and there has since been a

[12] Sections 58-66 Care Act 2014, Chapter 16 Care and Support Statutory Guidance, Children Act 1989, Carers (Recognition and Services) Act 1995 or under the Carers and Disabled Children Act 2000.

[13] https://www.shropshire.gov.uk/early-help/practitioners/the-early-help-offer-provision-of-early-help-services/young-carers/

recognition by the School Nursing Team that more could have been done to explore these issues. There were missed opportunities by agencies to collectively recognise and refer Emily as a carer despite the information available.

Did agencies recognise and respond to James's needs and role as a father and was he supported to care for the children?

76. Records indicate that James was affected by a medical condition with his back that impacted his mobility. Whilst CSC considered this, it was not a concern in his ability to care for the children. He also disclosed to the Reviewer that he suffered from White Material Disease[14].
77. CSC placed a significant responsibility on James to support the family and to undertake actions to improve the home conditions. Upon reflection, there is an acknowledgement that there was an overreliance on his ability to impact and deal with complex issues and home conditions, particularly against a decline in his health. He increased support to the family in response to requests from agencies under his own initiative. James was concerned about Michelle's health and raised concerns with her about her weight, diet and home conditions. He would clear up rubbish from the floor and furniture in the family home. James's was not assessed in his own right and despite the CIN plan recognising a decline in his health, there were no additional support measures put in place.
78. James attended numerous CIN meetings and a parenting course. He lived approximately 25 miles away and worked which did impact his ability to respond to requests. He was the only family member who could drive and would take Michelle (and the children) to appointments using a car financed through Disability payments. He would also undertake and deliver food shopping for Michelle.
79. Records show that, in November 2020 James was challenged by the social worker regarding his level of support, that this needed to increase from just the alternate weekends, which he took on board and subsequently offered more practical and emotional support. It is apparent that, overall, the CIN process helped James to take on a more involved role with his children.
80. James did not feel that he received sufficient support from agencies during the review period in that he was not listened to but does now feel that he has sufficient support.

How effectively did agencies engage with them and what, if any, were the barriers?

81. Overall, there was a significant level of involvement and contact with the family and the effectiveness of engagement by professionals varied between agencies. Michelle and Emily did communicate with practitioners regularly and were generally open with them and often attended at agency premises.
82. The term "non-engagement" was generally used in agency records yet there was no information to identify what the barriers to engagement might be or if the family were able to access services. Research has shown that agencies sometimes disengage on the basis of assumptions about a person's situation. This can be about a belief that a person is making a 'capacitated choice' and not considering the impact of mental health or trauma on how the person is living their life. On many occasions, agencies did not differentiate between

[14] White matter disease is an umbrella term for damage to your brain's white matter caused by reduced blood flow to the tissue. It can cause issues with memory, balance and mobility.

intentional non-engagement or that changes to their health or daily challenges may have prevented them from accessing services or attending appointments[15]. Professional curiosity protects practitioners from making assumptions about what is happening in a person's everyday life, how and why they make decisions, and what is important to them[16]. The use of terminology is important in reframing the responsibility around accessing services. Agencies should consider alternative wording such as "services were unable to engage with the individual" which would place an alternative emphasis. This emphasis is highlighted by the NSPCC "The responsibility for ensuring access and engagement with services should be with the agencies themselves, not the users[17]."

83. The review will explore in more detail the conditions and home visits by agencies. There is an acknowledgement that home visits could have been used more, not only as a way of assessing risk but also as a means of engaging with the family in a potentially more calming and accessible environment than agency buildings. Given Michelle's health conditions, limitations in mobility and caring for two children with their health conditions, it may have been easier for Michelle if home visits had been considered more. There are some examples of good practice in engagement, particularly by SATH, in recognising the challenges that Michelle faced.
84. The review has established that day-to-day living was extremely challenging for Michelle, Harry and Emily. At times, the conditions in the house may have been so poor that Michelle was reluctant to allow professionals into the house. Understandably, Michelle may have been reluctant to engage at times and at other times she may have been unable to access services. Records show that Michelle was often in but did not always respond to knocking or requests for access.
85. There is evidence that agencies, including ASC, did offer support to the family, which Michelle declined, giving various reasons. Some practitioners showed determination in attempting to speak to Michelle and Emily. Michelle disclosed to CSC and James that she was worried that Harry may be taken into care and the statutory nature and legal powers of certain agencies may have made Michelle extremely anxious about the potential consequences of disclosing that she was struggling to cope and possible shame. The use of warning notices may have increased this fear. Given the history of what happened to her first child, this fear could have been exacerbated.
86. Caring responsibilities would have been physically demanding for Michelle against her physical health limitations and the review has identified how this impacted her mental health. Agencies did enquire about her mental health, but this was superficial, and her refusal of support may have been perceived as non-engagement.
87. Similarly, Emily was attempting to maintain her education, a job and caring for her mother and brother and this would have undoubtedly impacted her ability to attend appointments and may have again been perceived as non-engagement. There was a lack of curiosity in exploring the reasons for "non-engagement" and in doing so responding appropriately.
88. The use of referrals and particularly signposting and the expectations of Michelle and Emily to self-refer are explored in more detail. Overall, these methods were unsuccessful in

[15] [15] Manthorpe, J; Harris, J; Burridge, S; Fuller, J; Martineau S; Ornelas, B; Tinelli, M and Cornes, M (July 2021) Social Work Practice with Adults under the Rising Second Wave of COVID-19 in England: Frontline Experiences and the use of Professional Judgement. BJSW Vol 51 no 5 pps 1879-1896.

[16] Thacker, H; Anka, A; Penhale, B (2019) Could curiosity save lives? An exploration into the value of employing professional curiosity and partnership work in safeguarding adults under the Care Act 2014 The Journal of Adult Protection Vol. 21 No. 5 2019, pp. 252-267

[17] https://learning.nspcc.org.uk/news/why-language-matters/not-hard-to-reach-reframing-responsibility-for-accessing-services

accessing services and resulted in no further contact and, more importantly, support for the individual. This review has identified examples that can be described as "windows of opportunity" for both Michelle and Emily where they had indicated they were seeking support from agencies, but this was not forthcoming. This was through a combination of the complexity of the system or Michelle's/Emily's understandable lack of motivation and/or confidence in agencies. Agencies should recognise and respond to these windows and share what works with each other. This will help to identify what type of engagement a person can tolerate, who may be able to help, and whether their current circumstances mean that they may be more open to support than in the past.

89. Learning from this and other reviews highlights the need for a creative approach to engagement. Agencies need to remain involved and determined to facilitate engagement. Methods and plans may require flexibility to help engage with the person, for example, visiting a person rather than sending letters or appointments, working outside of usual hours to secure engagement, and extending the expected time taken to work with a person. In Harry's case, this could be by creating an environment and methods to allow him to express his voice. These adaptations are consistent with a personalised 'making safeguarding personal' approach. Good practice requires positive engagement that demonstrates tenacity, consistent support, compassion, concern, and liaison between the professionals involved[18].

Term of Reference 2: Assessment of Michelle's Parenting Capacity and the impact of health conditions.

90. According to a survey of practitioners, a simple definition of the ability to parent in a 'good enough' manner long term requires four elements:
    - meeting children's health and developmental needs
    - putting children's needs first
    - providing routine and consistent care
    - acknowledging problems and engaging with support services[19].

    From the same survey, risky parenting was associated with:

    - neglecting basic needs; putting adults' needs first
    - chaos and lack of routine
    - and an unwillingness to engage with support services[20]

Physical and emotional impacts on Michelle

91. Michelle was central to this family, and there was an unreasonable expectation that she was able to care for her children given her health conditions, both physical and emotional, and she often failed to care for herself. When she was unable to do this, the responsibility often fell to Emily and James. Again, this was an unreasonable expectation given the level of care required for Michelle, Harry and Emily. In discussions between the reviewer and CSC, this hypothesis was accepted. Agencies should have recognised that this position was not satisfactory, and appropriate measures were needed to be put in place to provide support

[18] Preston-Shoot, 2019, Preston-Shoot, Michael (2019). Self-Neglect and Safeguarding Adult Reviews: Towards a Model of Understanding Facilitators and Barriers to Best Practice.)

[19] Conley, 2003, A review of parenting capacity assessment reports.

[20] (Kellett and Apps, 2009).

and where necessary increase support at times of heightened pressures such as school holidays.

92. The previous section outlines Michelle's significant physical and mental health issues and mobility and in analysing her parenting capacity it is essential to recognise these and the limiting implications upon Michelle. The importance and time required to manage her health, (and at times the neglect of her health) did impact on her capacity to parent. CSC recognised that her health conditions may have impacted her ability to keep the home clean. Records show that at one point Michelle was 172 kilograms (27 stone) with a Body Mass Index of 67, which would have made simple activities difficult, walking over a distance and a risk of falls and balance. In 2017 she did tell CSC of her intention of having a gastric sleeve to lose weight, which may have increased mobility and her ability to physically manage Harry. Whilst she didn't highlight this point, it may indicate that her health impacted her parenting. She was motivated to undertake this and met other people who had gone through the process. Appropriate management of her health was vital so that she could appropriately care for her children and maintain the house.
93. Michelle was seen in the Bariatric Weight Clinic and met with a dietician and psychologist before surgery. Following the decision, by health professionals, not to proceed with sleeve gastronomy she failed to attend further follow-up appointments and was discharged back to her GP's care due to "non-engagement". Michelle disclosed to SATH that she had struggled with her weight since her 20's and used comfort eating as a mechanism to cope with her depression. James also provided some details of her eating habits. There is limited information about Michelle's eating patterns. At times she did evidence positive weight loss, but this is balanced against weight increase and not attending at the weight management clinic. Poverty may have been a factor in limiting a nutritional diet, but this was not explored. This case exhibited many factors in Shropshire's Healthier Weight Strategy[21].
94. James witnessed Michelle, Harry and Emily following a poor diet. The whole family would mostly eat takeaway food and she and Harry were constantly eating snacks such as crisps. The school advised that he was not an overeater and was willing to follow a balanced diet at school. James challenged Michelle about her and Harry's increase in weight and the lack of nutritional food and indicated that Michelle would simply throw food wrappers and food containers on the floor. Concerns were raised with Michelle at a CIN meeting in January 2023 about Harry's diet which led to some positive change.
95. The referral to ASC in 2023 does provide some insight into her low self-esteem and motivation which might have been at the core of why she found it hard to keep the house clean and prioritise her own health needs. ASC felt that support needed to come from Mental Health Services as Michelle had disclosed that her depression prevented her from managing daily tasks. Taken together, there were interlinked factors impacting each other; her mental health, her weight and her ability to parent. This potential link could have been explored much earlier by agencies. The referral resulted in a subsequent referral to social prescribing to help improve health and well-being [22] but there were no home visits to assess and an emphasis on Michelle taking the initiative rather than agencies supporting her directly. There was no indication if this referral considered any symptoms of depression, anxiety, or low self-esteem related to body image or societal attitudes toward obesity were

[21] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://shropshire.gov.uk/committee-services/documents/s36062/November%202023%20HWBB%20Healthier%20Weight%20Strategy%20-%20Appendix%20A%20Report.pdf

[22] https://www.england.nhs.uk/personalisedcare/social-prescribing/#:~:text=Social%20prescribing%20is%20an%20all,needs%20which%20affect%20their%20wellbeing

discussed with Michelle. Sustain subsequently graded the referral as medium and no support was actioned before Michelle's death.

96. Given that Michelle did disclose the impact of her mental health on her parenting following the referral to ASC in 2023, the link between her mental health and the emotional impact of her weight may have been a continuing factor. The gastric sleeve may have resolved some of her self-esteem issues and improved her physical ability to care for herself, the children and the house. The review has found no evidence that agencies considered the impact of Michelle's weight on her mental and emotional health or on her ability to parent and there are no records that this was assessed. Findings from previous SCRs highlight the importance of considering the impact of the stresses of parenting on the parent's mental health and the impact of the parent's mental ill health on the safety and well-being of the child.
97. Although Michelle was known to visit a café regularly, the extent and availability of regular communication through a support network, including healthcare professionals, family, and friends would have been beneficial. Michelle would regularly go out after Harry had left the house, without dealing with the matters of concern and being reminded by CSC and James. She would return home and was then tired. This behaviour displayed a lack of motivation to resolve the house conditions, which may have been driven by her mental health. Agencies did utilise respite services and James also cared for the children at times. Whilst the physical limitations may have been easier to observe, the mental health of Michelle was less so, and this may have been a significant factor in her motivation to change.
98. Emily talked to professionals (College and BeeU Access) about her mother's challenges in caring for and maintaining a clean house. Emily also recognised the impact that these challenges had on Michelle's mental health and Michelle referred to this in 2016 at the GP surgery. Whilst Emily seemed to understand the impact of Michelle's health conditions, there was no specific mention of Michelle's weight issues and how this affected her. There was no reference or exploration of this when Emily did open up to professionals.
99. Michelle's mental health, self-diagnosed PTSD and trauma may have had a significant impact on her ability to parent. Agencies did not identify or explore the historical trauma that Michelle had endured. Historical trauma often leads to chronic stress, which can result in anxiety, depression, PTSD, and other mental health issues. Michelle did allude that she was suffering from symptoms of PTSD in December 2022 to CSC and ASC, but this was not sufficiently explored to understand its impact on Michelle's physical and mental health and upon her parenting. There are known links between trauma and the development of chronic diseases such as cardiovascular disease, diabetes, hypertension, poor nutrition, and lack of physical activity. Trauma can also result in mistrust of agencies and Michelle was concerned about the involvement and consequences of statutory agencies. Parents affected by historical trauma may struggle with being emotionally available and responsive to their children's needs due to their unresolved trauma. Trauma can also disrupt the parent-child attachment process, leading to insecure attachment patterns that can affect the child's emotional and social development and influence parenting practices, sometimes resulting in overprotective parenting styles, or in some cases, neglect or abuse[23].

[23] (Smith C, Freyd J. 2013, Dangerous Safe Haven: Institutional betrayal exacerbates sexual trauma. Van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., & Sagi-Schwartz, A. (2006). "Attachment across diverse sociocultural contexts: The limits of universality." In K. H. Rubin & O. B. Chung (Eds.), *Parenting beliefs, behaviors, and parent-child relations: A cross-cultural perspective*.).

100. There were several periods when the health of Michelle declined, and she spent periods in bed and there were several medical emergencies, leading to hospitalisation. These would have been particularly challenging given the caring demands and ensuring that Harry and Emily were safe and that suitable care arrangements were in place. Again, this may have caused anxiety. Michelle was known to be organised in certain aspects and hospitals did check about the welfare and care of Harry and no concerns were raised. James was also able to take care of the children when required.

101. The demands of treatment, monitoring and testing for Michelle were significant and whilst records indicate that she did complete a significant amount of INR testing, it was necessary for the GP Practice to raise concerns about non-testing. It is not clear if the impact of non-compliance and potential risks were shared or considered between agencies. There was a similar picture around how Michelle managed her leg wounds, with numerous visits to the Medical Practice and hospitalisation. Michelle's respiratory conditions may have led to tiredness or exhaustion, and whilst the extent is unknown, she was known to be too tired to clean the house.

How Michelle's physical and emotional health impacted upon Harry and Emily

102. Terms of Reference 3 (page 29) summarises a number of vulnerabilities, risks and concerns. These were individual incidents or continuing or repeated concerns over a period of time that had a cumulative impact on both Harry and Emily. These are relevant in assessing Michelle's capacity to parent.

103. Emily's school did not investigate the reasons for her non-attendance which may have included Michelle's parenting and following a warning letter, matters were closed.

104. In considering the issues of self-harm to Emily, Michelle may have been unaware of the details as Emily reached adulthood, as she was able to make informed decisions and become more independent. At this point, she would not have needed permission or Michelle to accompany her to appointments and Michelle may have been less informed about the extent of Emily's mental health. Emily's relationship with her parents was fragile at times and she may not have wanted to share details of what was happening. Given the dynamics within the family, with Michelle managing her own health and caring for Harry, Emily may have received only limited attention from her mother.

105. The bruising to Harry was explained in that she struggled to lift and move Harry, who was also prone to falling to the floor and in the process, sustaining bruising. Whilst these fall within the definition of harm this may have been difficult to prevent, but the school failed to share details of the bruising with CSC, which may have initiated enquiries and action. With Harry's increase in size as he got older, physically managing him became harder. Even more so against Michelle's own poor mobility and physical health. It is reported that on one occasion she fell whilst helping Harry out of the car which led to a review by the Occupational Therapy teams in December 2022.

106. Michelle regularly used a wheelchair for Harry to move and keep him safe, as he could run away, and she was unable to prevent this. In April 2022 she raised concerns with SATH that he had a reduced awareness of danger, and he would walk straight out in front of a car. There does not appear to be a medical necessity for its use, but it helps transition Harry from home to vehicles. Added to this were the occasions when Harry would lash out at her. This view is supported by the assessment of the Occupational Therapist, who believed that the issues were "social" rather than the "built environment" It appears that she was reliant on this method, which is acknowledged by CSC. In April 2021, she told CSC that she was unable to support Harry on her own without using the wheelchair. CSC recorded Harry

sitting in his wheelchair on a number of home visits. There are physical health implications for the prolonged use of a wheelchair, and, from a mental health perspective, it can lead to a loss of independence. On the occasions, when Harry 'escaped' from the house and was found wandering on the street Michelle could not meet his needs and keep him safe, but these occasions did not lead to a family-focused discussion or assessment about how Harry, Emily and Michelle's needs could be met and how to keep Harry safe in the home environment.

107. Harry went to the GP's clinic, but it is unclear if the agencies discussed, monitored, or escalated diet, nutrition, and sleeping arrangements. CSC discussed food plans with Michelle, which were satisfactory but could not confirm if they were implemented. At the CIN meeting in January 2023, James raised concerns about Harry's weight. The meeting recorded concerns about Michelle and Harry's weight, as well as concerns about Emily's eating. This was detailed as neglect and self-neglect from a diet and nutritional perspective.

108. Throughout the review period, the house required repairs and maintenance, including problems with electrics, drainage, doors and bathrooms. Some of these took considerable time to be dealt with. These would have added to the challenges of maintaining the inside of the home with adequate furnishing and carpets. Whilst progressing, certain repairs and improvements, Michelle depended upon other agencies, but there were other matters that Michelle had control of and did not progress in a timely manner. The CIN meetings did not challenge the lack of progress and there was only one escalation to Housing services around the delays in repairs.

109. The garden was neglected and not able to be used for exercise or play. CSC suggested that there were cyclical improvements, but this is at odds with James's view, who felt that it was unsafe for the review period. The reliance on the wheelchair limited Harry's opportunities to exercise, and a garden would have been beneficial.

110. The referral in 2018 (3) Identified that Harry was sleeping with Michelle, in her bed, as there was no furniture in his. In discussions with James and CSC, it has emerged that this situation continued throughout the remainder of the review period, which was a physical and emotional risk. Michelle had excessive exudate which could have caused infection to Harry and given that Harry was not toilet trained, the spread of urine may have been a risk to Michelle. Given Michelle's weight, there was also a risk of suffocation, rolling into Harry or being able to move quickly if there was a problem. From a psychological perspective, Harry may have developed an insecure attachment style. (James reports that he wants to sleep in his father's bed). Both Michelle and Harry may have developed separation anxiety. Michelle showed some reluctance for Harry to attend short breaks and Harry also displayed anxiety at leaving Michelle at certain times. By April 2022, she stated that Harry would only "go with certain people". Co-sleeping can disrupt the mother's sleep, contributing to poorer mental health and increased stress levels. Over five years, there was no suitable provision of a bedroom for Harry, which meant that he had to sleep with Michelle in her bed. Whilst this is not unusual for children in some circumstances, there were risks to both Michelle and Harry, not only physically but psychologically. CSC were aware of the situation but did not progress this through CIN meetings or visits despite it being a documented need in the CIN plan. Establishing healthy boundaries and transitioning to separate sleeping arrangements was crucial for Harry's independence and Michelle's emotional health.

111. In bringing together the reliance on a wheelchair, no garden facilities and poor diet, the result was that Harry gained weight. This may have been compounded by additional factors, such as fitness and muscle maintenance, and linked emotional factors of the inadequate bedroom and sleeping arrangements. It is unknown if Michelle understood the impact of sleep, diet and mobility and choices that she made for her children. Taken

together, this indicates that Harry's needs were not being met and Michelle's physical and mental health restricted her ability to parent. James provided an update in that Harry's weight has decreased, and he is more physically active, playing in the garden and outdoor clubs. Whilst this loss in weight may be because of growth and maturity, the previous arrangements may have a causation factor in weight gain. His school has also identified an increase in mobility.

112. Examples of deficits in parenting capacity compounding issues for Harry include that he made little progress year on year, because of his learning needs or the family not using visual cues with him at home. Records did not demonstrate any encouragement to sign at home. There is no record that Michelle was teaching adaptive skills for daily living, including self-care tasks, mobility, and communication, which are important for fostering independence. The CIN plan and meetings do not evidence meaningful progress. Again, Michelle's health and lack of mobility may have been a factor. Failing to maintain a timely EHCP was also a missed opportunity for agencies to work together and consider Harry's development.

Assessment of parenting capacity

113. The Police and Ambulance Service and a non-related parent identified concerns and made referrals to CSC relevant to Michelle's parenting capacity. CSC did not consider that the conditions or incidents evidenced a cumulative decline which would impact on any assessment of Michelle's parenting capacity and could be managed under a continuation of the CIN plan.

114. James did regularly clean-up and was aware that Michelle would pay Emily and her friend to clean up before planned CSC visits. Concerns were identified when other agencies visited unannounced, indicating that Michelle could not maintain the house to an adequate standard. Agencies were aware that gaps in her capacity were mostly being met by Emily and, to a lesser extent, James. On one visit, the Police indicated that cleaning had not taken place for some time and raised concerns about faeces and smells caused by pets. There were variations in the views of agencies, whether the conditions were adequate or inadequate, which indicated a fluctuation in her parenting capacity.

115. In contrast, School staff reported regular communication with Michelle, and she asked for support for Harry around toileting and getting on the school bus. The school highlighted that Harry was generally well presented, and Michelle would often ring and enquire about Harry's welfare at school and on short breaks, but this may have been linked to attachment issues. During a specific piece of pupil voice work on transition (home to bus), Harry's anxiety attachment for Michelle was recognised. The school recorded concerns in 2017 for Harry and, whilst they discussed these with Michelle; it does not appear that they were raised at CIN meetings, which may have triggered an assessment of parenting capacity. Of relevance were the three occasions of bruising over a short period.

116. An essential part of the assessment process is evaluating parents'/carers' ability and motivation to change. This is characterised by parents accepting responsibility for their own actions; sustaining changes over time; and taking up offers of support and resources from services. Practitioners should note evidence of changes and improvements made because of previous interventions. They should also assess a parent's ability to translate information into action (Department for Education, 2010b). There was some inconsistency in Michelle's motivation to change. In certain aspects of Harry's care, she was organised and proactive yet in other aspects she struggled to progress matters and was known to procrastinate and

found it hard to maintain acceptable home conditions. CSC acknowledged a presumption that Michelle would undertake necessary actions, but there was insufficient professional challenge to her when matters were not progressing. The review has established that Michelle struggled to deal with household matters and maintain improvements. As outlined, Michelle would go out on most school days even though the house required work, which may have been an indicator of how she felt, but not explored. It is unknown if the conditions in the house and the arranging of repairs, new carpets and other items were because of financial challenges, mobility, health conditions (physical and mental) or a lack of motivation. Understanding the reason may have informed care and support planning or escalation.

117. Many of the caring responsibilities for Harry centred around physical support, whilst there were significant psychological factors for Emily. In both cases, it was necessary to transport and attend appointments, administer medication and work with professionals in implementing care and support. Overall, Michelle managed this well.

118. The finding in this case echoes the findings of analysis cases by the Child Safeguarding Review Panel[24]. Michelle attended many of the CIN meetings and communicated with professionals but there were no sustained improvements or changes in how she cared for her children. The review has not established if there was a genuine motivation to change by Michelle, or if she could undertake the necessary improvements. Both parents attended the Understanding your Child with SEND course in 2022. There was not enough information gathered to say how well they engaged in the course, although they attended the minimum 80% sessions. There was a lack of professional curiosity by professionals in assessing Michelle's capacity to parent.

119. Because there was no parenting assessment, agencies did not individually or collectively fully understand the extent and complexity of the challenges that impacted this.

120. In summary, Michelle was known to have overlapping vulnerabilities which impacted her parenting capacity, and agencies could have taken all factors into account and undertaken a parenting assessment. There is no evidence that Michelle's physical health, mobility, weight, previous trauma and her mental health formed part of any whole family assessments. CSC have since recognised assessments should have considered the whole family, including James.

Term of Reference 3: Single and multi-agency assessments and working

Michelle

121. The Rapid Review concluded that Michelle did not meet the Social Care Institute for Excellence or National Institute for Health and Care Excellence definition of self-neglect in its entirety as she engaged well with health services, but she was likely to have experienced self-neglect because of her inability at times to self-care and the poor conditions of the house. This criterion led to the decision to commission a Safeguarding Adult Review.

122. In considering the wider review period, then a similar picture of regular and, at times, cyclical self-neglect is seen. This is primarily based on analysing the potential for self-neglect from the conditions of the house, poor diet, infection and compliance with medical

[24] https://www.communitycare.co.uk/2024/01/30/leaders-must-foster-professional-curiosity-and-challenge-to-improve-child-protection-finds-review/

advice and treatment as key indicators[25]. Some other aspects of her self-care did not identify concerns and professionals highlighted a good standard of personal hygiene. There is insufficient understanding of why this inconsistency occurred. Key factors of how services engaged with her, her weight, and how this linked to mobility and her mental health were not explored collectively and there were several indicators of unmet needs.

123. There is no information that Michelle lacked mental capacity, she communicated effectively with professionals, and often accessed advice and guidance, particularly out of hours. There is no evidence that she disagreed or refused treatment and was able to make decisions about her health.

124. Although Michelle was prescribed medication for her depression, there were no supportive interventions until 2023. Numerous indicators could have alerted agencies to consider the impact of her mental health and the lack of disclosure by Michelle should have prompted increased professional curiosity. Michelle was careful in disclosures about her mental health and coping, and she may have been reluctant to disclose the extent due to her anxiety about the children being taken into care. The review has considered how mental health may have impacted how Michelle engaged with services, her parental capacity, and self-neglect. Agencies did not assess these factors together and, although a referral process began in January 2023 with ASC, the subsequent support was minimal.

125. Whilst mobility may fluctuate, there are variances in agencies' assessments of her mobility. Records indicate that assessments were based on the agency's individual knowledge and not on a collective formal assessment. Between 2015-2016, Michelle was open to the occupational therapy team, to enable alterations at her home for bath and shower adaptation. Professionals described her as having limited mobility and she presented as being unfit. She did use a mobility scooter to attend hospital appointments, and the GP described her as a wheelchair user. In December 2022, Michelle was reviewed at the Shropshire Orthopaedic Outreach Service as she had fallen whilst helping Harry out of the car. This considered wastage and sensory disturbance and led to an urgent referral for nerve conduction studies. She had been able to mobilise around her house with minimal outside mobility and walk around the supermarket comfortably, but this had declined, and she was short of breath and only able to walk about 20 yards. In February 2023, SCHT recorded Michelle as being independently self-caring and mobile with a walking stick. GP records do not evidence home visits over several years and recorded that Michelle was generally NOT housebound. Overall, Michelle's limited mobility was an important factor in the care of her children and the home and a collaborative assessment of this would have helped to identify the unmet needs and risks for Michelle and the children.

126. The review has established that Michelle was managing both personal physical and mental health challenges. Multiple stressors impacted these, including mobility, finance, diet, appropriate sleeping arrangements, conditions of the house, and concerns for the children against their health conditions. There was no overall assessment of these and how they impacted Michelle's ability to care for herself and her children.

Neglect

127. There were a number of incidents and trends that raised concerns and highlight vulnerabilities, some would fall within the neglect criteria.

[25] https://www.scie.org.uk/self-neglect/at-a-glance/#:~:text=Self%2Dneglect%20is%20an%20extreme,who%20self%2Dneglect%20extremely%20challenging.

a) Decision to initiate a CIN plan. Harry was on a Child in Need Plan since 2017 because of his presenting needs and concerns regarding the state of the family home, in addition to the criteria of a disabled child.
b) Conditions of the home and garden over the review period.
c) Bruising seen on Harry on separate occasions.
d) Referral made by non-related parent around concerns in how Michelle cared for Harry.
e) Harry's presentation at school – a concern with Michelle over his fingernails, described as very very long and very dirty. Michelle disclosed struggling to cut them.
f) Harry's safety in the home and incidents where he managed to leave the house unaccompanied.
g) Pendant Safety Alarm. This had not progressed for over a year and Michelle had to be reminded to deal with it.
h) School records show that Harry was wearing shoes that were too small.
i) Harry was found to have blisters on his hand, it transpired that he had touched a radiator at home.
j) Harry and Emily were not brought to appointments.
k) Inadequate bedroom facilities and sleeping arrangements.
l) The lack of nutrition and detrimental food choices for Harry and Emily.
m) Limited opportunities for Harry to be mobile, an over-reliance on a wheelchair and a lack of physical activity.
n) Periods of poor attendance at school by Emily[26].
o) Emily (Aged 13 in 2017) caring for Harry and Michelle with such complex health conditions, placing an inappropriate burden on Emily and compromising her well-being and the associated risks to Harry.
p) Emily's continuing self-harm.

128. These incidents were identified through referrals, observations and disclosures made by Michelle, Emily and James. Whilst agencies did consider and assess specific incidents and show understanding and exploration of some of these challenges, there was no whole family assessment of all indications of possible neglect. CSC acknowledged a wider assessment would have been beneficial. Records indicate that whilst agencies knew and recorded particular concerns, crucially, some were not shared between agencies to enable this complete picture to be fully understood. A crucial factor remains a failure to recognise and respond to Emily's needs as a carer and her vulnerabilities. These concerns do fall within the definition of neglect, but whilst the individual examples may not fall within the criteria of serious impairment of a child's health or development, the cumulative impact was more significant[27].

129. The family home was part of the Housing Plus Group and Community Care and Support services are provided through Care Plus. Care Plus is the lead agency for the Sustain Consortium that provides community support within Shropshire.

130. The conditions of the house remained a concern throughout the period of the review and In May 2023, the Police reviewed the footage captured from the home and assessed that the house was indicative of someone who has a hoarding disorder. The Rapid Review considered if hoarding was a risk factor but assessed that the house was cluttered and unclean.

[26] Persistent failure to send children to school is a clear sign of neglect. DofE

[27] The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. (Gov.uk)

CSC observed occasions where clothes and bin bags of "stuff" but no unsanitary or unsafe conditions and no reference to hoarding behaviours. In considering the information contained within the records, there does not appear to be evidence of hoarding but one of squalor[28].

131. Even if the house did not reach a clutter scale rating scale[29] to fall within the more serious hoarding criteria, the conditions were of such concern as to describe the house as potentially this. A number of agencies visited the home over the review period and were aware of the poor conditions, and other agencies were also aware. Records show that James raised concerns. In 2019, the Police assessment of the house was "unacceptable state for human inhabitation" and in 2023 "she (Michelle) appears to have been unable to manage the home or look after her son to a sufficient appropriate level."

132. As outlined, the family had an Alsatian dog until November 2021. The dog lived inside the house, mostly in the kitchen, but was known to be upstairs as well, and its presence prevented CSC from looking around the house, as professionals were anxious about it. Whilst the decision to rehouse the dog to another family was initiated by CSC, this was after four years of the CIN being in place. CSC did record concerns that the dog may be damaging the house, and that the family struggled to control it. Given the size of the dog and the amount of cleaning required and the risk of unhygienic conditions within a kitchen, this could have been dealt with earlier. There were also a number of cats in the house and reference to two sets of kittens and concerns about the smell, which again was an infection risk. Whilst professionals raised concerns about pets, there was no agency support in managing and maintaining them.

133. There was also a significant risk to Michelle from Bilateral lymphedema, which can lead to chronic swelling, discomfort, and an increased risk of infections and dealing with infected leg wounds producing excessive exudate requires meticulous wound care. This could pose a risk to both Michelle and her children. These wounds had to be dressed regularly and at times she didn't attend appointments for this and the conditions within the home may have increased infection risks. Her leg wounds led to hospitalisation because of infection and given the lack of hygiene within the house over a protracted period, this could have been a causation factor. There was an obvious concern that the children were at risk of neglect due to Michelle's inability to maintain a clean and safe environment, and she was vulnerable to self-neglect through infection.

134. The conditions within the home were a factor in leading to the CIN Plan in 2017. The review has established that there was a variance in what was deemed acceptable standards between agencies. Both the Police and Ambulance services escalated concerns to CSC, but a GP failed to follow up on concerns following a visit. On repeated occasions, assessments between CSC and other agencies did not match. There was some disagreement between agencies at a CIN meeting, with CSC claiming conditions were not as bad as other agencies thought and an acceptance by agencies of CSC's position of the home conditions, without challenge.

135. CSC visited the home with the social worker recording that the conditions were acceptable (and not worsening). This is contrary to the Police's view in July 2019 indicating that there had been no cleaning for some time. CIN meetings took place between February and May 2023, but the last home visit was in February 2023. CSC noted there were significant improvements in the home conditions but accepted that by the 10th May 2023, the conditions had deteriorated.

136. Michelle declined numerous home visits from agencies and there were missed opportunities in initiating these and utilising other agencies and sharing information to enable conditions to be observed. Housing had limited contact with Michelle, and gas safety checks needed to be escalated when staff could not access the property. Of note, there is no

[28] https://hoarding.iocdf.org/about-hoarding/is-it-hoarding-clutter-collecting-or-squalor/

[29] https://www.shropshiresafeguardingcommunitypartnership.co.uk/partnership-priority-areas/adult-safeguarding-and-protection-practice/self-neglect/hoarding/

information from this agency to describe the conditions within the home. CSC also evidenced declined home visits. ASC recognised that there was a focus on signposting rather than assessing the home and that Michelle may have underplayed the level of difficulties which prevented a home visit or full Care Act assessment. GP records do not evidence home visits, which again was an opportunity to assess living conditions and to potentially speak to all family members. There were also opportunities through referrals and the use of other agencies to access the house which were not maximised. Agencies did not evidence or recognise the reasons for declined visits nor utilise other agencies to act as eyes and ears, which could have provided a more informed understanding of risk and need.

137. Michelle was unable to maintain the house to an adequate standard or sustain long-term improvements by herself. Despite this, CSC continued with the CIN plan and collectively there was an insufficient response in preventing this reoccurring pattern of decline.

Medical appointments and treatment.

138. Michelle did experience challenges in accessing and managing her health conditions and particular adherence to testing. There are risks of not undergoing the international normalised ratio (INR) blood test and monitoring. This advises the time it takes for blood to clot. The lack of monitoring effects the ability to manage potential blood clots and bleeding risks. Given Michelle's responsibility to care for her children alone, this could have been a concern. It is not evident that this risk was shared with or considered by CSC.

139. There are also entries highlighting that Michelle failed to attend medical appointments. Besides the warfarin (INR), this includes a mammograph, leg-ulcer dressing and Bariatric Weight Clinic appointments.

140. There were significant demands for the family in maintaining health appointments, tests and communications. Analysis of records around compliance with medical tests (INR) and attendance at appointments for Michelle, Harry and Emily has been conducted between 2017 and 2023. Taken together, there was a 70% compliance in 2017 and 2018, rising to 80% in 2019. The lowest figure of 65% is in 2020, but then this rises to 94% in 2021 and 78% in 2022 and 2023[30]. There were significant challenges against the numbers involved and both Michelle's and Harry's mobility. Records also reveal a number of calls to ShropDoc (out of hours medical service) for both Michelle and Harry. CSC noted that Michelle had a strong bond with Harry and school/medical appointments were good. SCHT also noted that Harry had been taken to his appointments by both parents and there was no clinical reason for a home visit to be done. Whilst Michelle had difficulties that impacted upon appointments, she made a significant effort in attending these.

141. School records recognise Michelle and Jamess' attendance at CIN meetings as reasonably good but highlight that some CIN meetings were organised at late notice resulting in their non-attendance. Given the health conditions of both parents and potential mobility challenges, this is understandable. Both parents shared details of their health regularly at the meetings.

142. There is also a recognition by certain agencies that there was a failure to apply professional curiosity to assess if there was an intentional decision or what factors prevented attendance at agency meetings and appointments. In applying this level of scrutiny, agencies should have considered what action, escalation or increased support was necessary. The most notable positive example is the transfer of care by the hospital.

Emily's emotional health

143. Emily's mental health was a significant factor throughout the review period and there were long periods when agencies did not interact or communicate with her.

144. Emily disclosed her mental health concerns and linked self-harming to educational and health agencies. Whilst some conversations took place with Emily alone, others were in the presence of family members, and for some, records did not specify which. As outlined later in this section, there were a significant number of referrals and signposting made to other agencies, and often there was an expectation that Emily should progress or access support herself.

145. Michelle first shared concerns about Emily's mental health with her school in 2017, but between 2017 and 2020 there was limited contact or communication by agencies with Emily, to ensure she was safe and to understand her lived experience. Her drop in school attendance in late 2019 was potentially an indicator of concern and a method of expressing her voice but not shared with CSC, who assessed that she was presenting well and was happy at home. In contrast, the GP practice assessed her as very high risk in January 2020.

146. The first agency record of self-harm was to her GP in 2020, but it transpired she had been self-harming and having suicidal thoughts since 2015, which was the time she first started caring for Michelle and Harry.

147. When Michelle disclosed that Emily had self-harmed by cutting, Emily denied this to professionals. It is not known if this conversation was a three-way conversation or undertaken separately and which account was the most accurate or explored further.

148. Following a GP appointment in February 2020, Emily was advised to self-refer to support services. In May 2020, when the school emailed her, she did not respond, but there was no follow-up. It was in February 2021, when seeing her GP for a knee problem, that her mental health was next considered. She was again encouraged to self-refer to BEAM with a review in two weeks, but there are no records indicating that this took place. The next time agencies considered her mental health was in September by the College. There is no evidence showing that agencies were attempting to maintain contact, provide additional support or monitor her safety in this period. It appears that referrals were again used despite little or no success.

149. The GP practice assessment between 2020 and in the early part of 2023 suggests Emily "had not indicated that she remained distressed" when other agencies recorded that in early 2023, she was still self-harming, had been sexually harassed (Late 2022), almost constant suicidal thoughts, writing suicide letters, excessive spending and "self-sabotage". She was also keen to identify if she had Bipolar disorder, Autism or ADHD and reported that her relationship with her parents was conflicted.

150. The College developed a positive relationship with Emily, and she disclosed and discussed her feelings and concerns, including specific details of her mental health and self-harm. The college met with her on several occasions and developed safety plans. The college shared information with other agencies but did not make a referral to CSC, although they did later make a referral to ASC MH services.

151. In March 2023, Emily (aged 18) was prescribed medication for her anxiety but had reported self-harming when she felt her parents were inconsistent and dismissive of her. She failed to attend an appointment at her GP, which was not chased up, IAPT closed services due to "non-engagement" and her college attendance reduced and there was no contact from her or Michelle. In essence there was again no obvious monitoring or communication by agencies to assess if she was safe and an expectation that she would self-refer to agencies as an adult.

152. The level of response was not proportionate to the risk and often focussed on presenting issues rather than a holistic view. There was a superficial response to eating concerns and the Education Access Service (EAS) issued a warning notice for non-attendance. In contributing towards the review, the Education Access Service has acknowledged a lack of professional curiosity and an absence of other agency involvement. Despite Michelle and Emily disclosing details of Emily's vulnerabilities, there was no evidence of critical thinking, professional curiosity or a multi-agency response at crucial times.

Care and Support Planning

153. Harry had been on a CIN Plan since June 2017, and this continued over the period of the review. Between 2017 and 2021, the CIN plan was around the provision of short breaks reviews with visits on a six-monthly basis. The plan was stepped up in March 2021 but remained a CIN status. Between 2017 and 2023, the focus of social work practice was one of support and not safeguarding. Short breaks included short periods away from parents, community outreach and then weekend stays at short break service provision. CSC felt it was the appropriate focus as they were undertaking relationship-based practice and had a duty to support the family long-term due to Harry's disability. The plan was agreed to by Harry's parents.

154. Respite care arrangements were in place to allow Michelle to have a break from caring for Harry but also so that she and Emily could spend quality time together. Michelle and Emily advised the social workers that this worked well.

155. A trainee social worker worked with the family and the Team Manager had previously been the social worker for the family. Whilst this offers some continuity in cases, it raises the question if the social worker who previously held the case should then go on to supervise the case when dealing with complex long-term cases such as this.

156. Between 2017 and 2023, there were five referrals made to CSC. In 2017, the referral by a parent was not recorded as a referral and the information formed part of an ongoing assessment, but there was no additional action taken. Had CSC liaised with the school, the bruising incidents may have come to light which may have impacted decision making.

157. The Police and WMAS referral in August 2017 raised concerns about the state of the house and James also raised his concerns. Again, there was no additional action taken and whilst records show that conditions had improved within a week, it is not clear to what level and given that visits were pre-planned on a six-monthly basis, there was insufficient monitoring to evidence long-term improvements. Whilst records indicate that Emily was referred to Young Carers, there was no recognition of her status under the Children's Act.

158. The referral in July 2018 again resulted in no additional action and was treated as an isolated incident. CSC records focus on the safety of Harry, but there is no information that agencies recognised the decline in conditions and took any necessary action. Whilst Michelle's health was noted, there was no assessment of her ability to supervise Harry. Of note, Harry was sleeping in Michelle's bed, as his bedroom was unfurnished.

159. The referral in July 2019 was again by the Police who described the house as uninhabitable against CSC assessment that it was untidy. On this occasion, Michelle had disclosed that she was bedridden which again raised a question as to her ability to supervise Harry. Whilst CSC continued to work on the conditions, there was no additional action taken.

160. Despite the concerns raised, CSC next visited Michelle at home in October and described the house as "tidyish", not cluttered with no unpleasant smells but many cats. CSC again discussed purchasing a new stair carpet, and this had been "discussed on many occasions previously".

161. The last referral relates to the day when Michelle passed away. The Police evidenced significant concerns about the conditions in the house and Michelle's ability to care for herself and the children.

162. On this day, Emily called school as she couldn't get hold of Michelle. The school did not provide information as she was not named as a contact for Harry. This call was not reported to the safeguarding lead until the following day. The circumstances on the day of Michelle's death when Emily called the school to seek information about her mum have led to an internal review by the school. Had the safeguarding lead been notified of the call, this may have prompted a home visit or contact to be made with the social worker. Given Emily's mental health fragility, this may have caused additional trauma.

163. Three referrals took place around the long summer break from school. This was a potential pattern, and Michelle may well have struggled to cope when both children had been in the house for protracted periods. The social worker noticed these patterns and assessed this was due to there being less structure. The six-monthly period between pre-arranged visits limited opportunities to regularly monitor progress and respond to a decline in conditions or if Michelle could not cope. There were no referrals in the period 2019-23, but given the impact of Covid, there were fewer opportunities to visit Michelle and observe conditions. Despite the concerns raised by other agencies, there was no additional action or escalation. Harry's school was unaware of the deterioration of the condition within the house.

164. The three referrals provided an opportunity to review the effectiveness of the existing plan and step up the level of interventions and monitoring. Support plans could have focused on areas such as extended respite, home help, and practical input before the schools broke up.

165. Michelle's complex health conditions evidence that she was, at times, bedridden but the extent is unknown. It is not known to what extent she was able to look after herself including toileting and personal hygiene. On those occasions, it is unclear what arrangements were in place for caring for Harry when Emily was not at home (e.g. at work or college). The CIN plan did not identify James as a carer for Michelle but did recognise his support to her in caring for the children. As outlined, there was no additional support for the family when his health declined. The CIN meetings did discuss contingency planning but there was no follow-up or plan put in place. There were two occasions when Harry managed to get out of the house. To prevent this, the house keys were hidden from him, which was a risk. Overall, there were numerous incidents which raised concerns around the safety of Harry, but CSC decided that no further action was required over and above that of the work being undertaken under the auspices of the CIN Plan.

166. In assessing the CIN Plan for Harry, CSC did not consider that there were factors for Emily that fell within the criteria for a CIN Plan[31] and she was struggling to develop as per the CIN criteria. Emily was considered in the Child in Need plan for Harry but only as to the impact upon her from Harry. There was no specific assessment of her or as her mental health deteriorated there was no further consideration that she would have benefited from a CIN plan. This is despite CSC being aware that Emily was struggling with her mental health.

167. In considering the criteria, there are three key areas in which Emily may have benefited from this:

- they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority;
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority;
- young carers

[31] Section 17 of the Childrens Act 1989 places a general duty on all local authorities to 'safeguard and promote the welfare of children within their area who are in need.' Basically, a 'child in need' is a child who needs additional support from the local authority to meet their potential.

168. Critically neither CSC nor EH identified, assessed and responded to Emily as a young carer, and that she was providing ongoing, physical care of her mother and brother, and had been since 2015. This is despite the Police making a referral in 2017, which included this point. Furthermore, GP, School, College and the School nurse also identified this role. There is no record to indicate any challenge to CSC by Michelle or other agencies or liaison between agencies to clarify this important point. Even more so was that she was a carer for two people.

169. Given that Michelle was managing her complex health conditions, with times of hospitalisation, sometimes bedridden and caring for Harry, it is likely that there would have been limited time for Emily. This would have become even more difficult from October 2022 when respite support was cut. It is unlikely that Michelle would have been able to protect and supervise Emily and ensure she had access to appropriate mental health support. Emily disclosed she was reluctant to let her mother know about her feelings, which may have made monitoring her even more difficult. From the perspective of a CIN Plan, Emily fell within all three categories. Emily was left to pursue her own care and support by the use of self-referrals and signposting. There are links between the reliance on Emily to undertake carer roles for Michelle and Harry and the deterioration in her mental health and subsequent self-harming. Emily disclosed the stress and demands that this role brought, and, by September 2022, this became even more difficult. Michelle's health meant that Emily had to pick up more responsibilities and she felt she was struggling to live with her family. This role impacted on her college work and on her emotional health. Emily was included in the CIN plan and although updates were provided at CIN meetings, there was no progress in providing support to her despite recognising Michelle's hospitalisation and James's illness and inability to provide the same levels of support.

170. Targeted Early Help applies to "those children identified as requiring targeted support and who meet at least 2 of the 6 Strengthening Families criteria in the Whole Family Assessment. It is likely that for these children, their needs and care are compromised. These children will be those who are vulnerable to harm or experiencing adversity. In addition to the Whole Family Assessment, specific local tools and pathways should be used where there are concerns about possible harm to the child. These children are potentially at risk of developing acute/ complex needs if they do not receive targeted early help"[32].

171. There were opportunities where Targeted Early Help[33] could have worked alongside the Disabled Children's Team in providing timely support. Identifying and addressing a child or family's needs early on can increase protective factors that positively influence a child's well-being and decrease risk factors that may impact a child's life negatively. Retrospectively, CSC felt that the family should have been in receipt of Targeted Early Help but there was a presumption given Michelle's reluctance to referrals to ASC, CSC felt she may not have consented as this service is also consent driven. Whilst agencies considered Early Help, there was no referral. The involvement of this service would have given a basis for sharing information about Emily.

172. Research[34],[35]suggests that early help and intervention can:

[32] https://www.shropshiresafeguardingcommunitypartnership.co.uk/procedures/threshold-documents/

[33] https://next.shropshire.gov.uk/the-send-local-offer/local-area-send-inspection/#:~:text=Ofsted%20and%20the%20CQC%20revisited,the%20six%20areas%20under%20review.https://www.shropshire.gov.uk/early-help/practitioners/the-early-help-offer-provision-of-early-help-services/targeted-early-help-family-practitioner/

[34] Haynes, A. et al (2015) Thriving communities: a framework for preventing and intervening early in child neglect.

[35] Early Intervention Foundation (EIF) (2021) About early intervention: why it matters.

- protect children from harm.
- reduce the need for a referral to child protection services.
- improve children's long-term outcomes.
- improve children's home and family life.
- support children to develop strengths and skills to prepare them for adult life.

173. Certain agencies were unaware of the existence of the CIN plan and given the involvement of CSC with the family, their role was pivotal in working with other agencies. The tension between support and safeguarding can sometimes create challenges in terms of information sharing. While the CIN plan does have responsibilities for information sharing, there was no indication of a consensual discussion with Michelle to maximise information sharing between agencies. Given that she was communicating openly with several agencies, a lot of information was already known, and so the existence of the plan may have been a simple addition. The importance of knowing the existence of a CIN plan could have impacted decision-making and escalation by other agencies, particularly around missed appointments or the identification of concerns. Understanding the bigger picture is crucial in assessing risk and harm from a more informed perspective.

174. Whilst the emphasis on support encourages building strong relationships with parents and maintaining confidentiality, safeguarding requires the sharing of information when there is a risk of harm to individuals, especially vulnerable ones, such as children or adults at risk. Striking the right balance between these two aspects is crucial. Harry's School had to complete their own separate minutes from the CIN meeting because CSC did not share minutes, which was additional and unnecessary work. Since the review period, CSC now share minutes.

175. CSC recognised protective factors regarding Michelle and Harry's communication and relationship. Records also show Emily's support despite not being formally identified as a young carer. CSC recognised that the family was "increasingly well supported" by James but has since acknowledged an over-reliance on him. CSC records also show friends and contacts supported Michelle within the local community.

176. Analysis of six CIN plans and meeting minutes between June 2022 and May 2023 and case notes between March 2019 and March 2023 has been undertaken. There are minimal changes to the CIN plans despite concerns being raised at meetings which could have been added to the plans and allowed a structured process and monitoring. The CIN meeting records primarily contain updates from agencies and parents, with minimal focus on achieving the objectives of the CIN plan or dealing with emerging issues. Harry's school also provided a similar analysis of the CIN process. Discussions took place around contingency planning when Michelle was ill, James being unable to provide support and Harry's weight and diet, but these did not materialise into action. There is minimal progress in improving key areas such as adequate bedroom facilities, decluttering the house and the out-of-date EHCP. The levels of discussions, assessment and monitoring were not balanced against the need to improve and maintain a suitable environment. Overall, the care and planning process did not evolve or respond to emerging issues within this period, and more significantly, since the CIN process started in 2017. There were ineffective links between the CIN plan, CIN meetings to manage the progress of actions and visits to encourage Michelle to make and maintain changes and monitor the home and Harry's development.

177. For four years of the plan, visits were mostly prearranged, and Michelle would undertake remedial action and use other people so that the house appeared satisfactory. Up to 2021, the visits were scheduled at six monthly intervals. Analysis shows that between 2019 and 2021, the time between visits was between three weeks and seven months. When the plan was stepped up, visits should have been scheduled on a six-weekly basis, but records show that some took place on this basis, but there were periods of four and six months between others. There were three visits in a month to support Harry getting on the bus, which was positive practice, but this fell within a period of 11 months when the house conditions

were not seen, partly because the visits were focused on supporting Harry onto the bus. Case records do not detail the conditions within the house on many visits. In discussions, CSC acknowledged that there was insufficient oversight over a period of time.

178. The CIN plan continued over a six-year period without any sustained improvement to the conditions within the house or in improving Harry's health and development. It appears that the positive protective factors of Michelle's relationship with Harry outweighed the analysis of Michelle's parenting capacity and motivation. Whilst there were small areas of improvement, there was an over-optimism that the plan was effective and in Michelle's ability to deal with the necessary areas of concern and that James could fill the gaps in support.

179. Harry has a lifelong health condition and will always require care and support at some level. There was no evidence that Michelle's health and mobility were improving and given her diet, this would have further declined. There would have always been a point when additional measures were necessary and could have been implemented earlier.

180. In considering the Rapid Review, CSC did not consider that the children had suffered serious harm or that risks were present but acknowledged that there may have been a different assessment and decision if the relevant information about Emily's college attendance, trauma and grooming or Harry's bruising had been shared. This review has established a similar opinion from CSC in that there were no safeguarding concerns or risks to Harry that required the plan to be stepped up and there would have been no improvement in Harry's quality of life if the case had moved to a child protection process. CSC suggest that no concerns were raised which would have necessitated an unannounced or urgent home visit (one was attempted), but this position has changed following discussions with the reviewer.

181. Overall, given the concerns raised in the period 2017 and 2019, there was evidence which questioned the effectiveness of current arrangements and should have prompted an escalation in safeguarding procedures. Increased agency support rather than a reliance on James, with regular monitoring of conditions and an assessment for Emily, were obvious areas. Despite these concerns, the plan remained unchanged until 2021. There was a lack of rigour and over-optimism by CSC that the plan was working and a lack of challenge by the agencies involved.

182. Although the EHCP process was not maintained effectively, some agencies contributed to both plans. The EHCP was mentioned within the CIN plans, but there was no recognition or action taken to address the failures in the EHCP plan. There were similar objectives in both plans around developing Harry's independence, but there was no evidence of consolidating the two processes which may have added value or at least prompted challenge between the effectiveness of both plans. The Special Educational Needs and Disability Team were not aware of the home conditions which may have again impacted decision making and planning.

183. The EHCP had not been amended since it was first issued in 2015. There was no phased transfer as Harry was in an all through school and was not changing settings, but there should have been amendments to outcome stages even if the outcome did not change. The school refused a request for an amendment in 2020, when the plan was significantly out of date. A review was closed as incomplete in December 2021, an intend to amend was issued in March 2022 but was never followed up and a maintain was issued in January 2023. Despite the SEN team and School holding a biweekly meeting along with a representative from early help and health, this case was not discussed. SEN Team records indicate that services did not raise Harry or any family member as a cause for concern, yet there was information, including within the school that identified concerns. Records show that Michelle attended the annual reviews but that no social worker was in attendance or report received. SEND have acknowledged that amendment and quality assurance and review should have taken place and there was no escalation or challenge by either the school or SEND team. SEND cited pressures on capacity and cases at the time. The Ofsted inspection also found similar concerns in the quality of SEN work.

"https://next.shropshire.gov.uk/the-send-local-offer/local-area-send-inspection/inconsistency-in-quality-of-input-from-education-health-and-care-into-ehc-assessment-and-planning/Inconsistency in the quality of input from education, health and care into EHC assessment and planning[36]"

184. Following a separate review, there have been significant changes and improvements around safeguarding systems, including IT systems and procedures at the school. This also includes improvements to the EHCP process. The school acknowledged that procedures were not of an acceptable standing during the period of this review. Health agencies have also made internal changes that enable additional information to be shared, attendance at meetings and oversight of cases.

185. Harry's unique needs and strengths should be central to developing a care plan and the EHCP. Tailoring interventions to address his specific challenges and abilities, while fostering a supportive and inclusive environment, can contribute to a positive lived experience despite the complexities of multiple health conditions. Appropriate oversight internally and where necessary externally should ensure that this critical planning process is conducted, and in a timely manner.

Multi-agency working

186. There were a significant number of impacting factors for Michelle, Emily and Harry, and the interdependencies between these created additional complications. Understanding this bigger picture was critical. Michelle did share information with various agencies about her health and needs and whilst some aspects of these conversations may have differed due to the specialist nature of the service and treatment on offer, much was similar across all professionals. This was a similar pattern for Harry. Emily's perspective was slightly different in that she was often the provider of information. There was vital information known by health and educational agencies regarding Emily's mental health, self-harm, Post Traumatic Stress Disorder, online grooming and role as a carer that would have informed decision-making and identified that Emily was vulnerable and at risk of harm from herself and others. This meant that Michelle and Emily had to often repeat potentially distressing details on multiple occasions. This often led to delays in accessing support and, on many occasions no support.

187. A holistic assessment involving all agencies could have enabled coordination and more effective multi-agency working. Identifying unmet needs requires a comprehensive assessment that considers the physical, mental, and social aspects of an individual's well-being. Collaborative efforts involving healthcare professionals, social workers, community organisations, and support networks can help address these indicators and improve the overall response to individuals and families with complex needs. Evidence suggests that joint approaches may uncover unmet needs, which can result in increased support in the short term[37].

188. Robust multi-agency chronologies would have assisted practitioners in recognising patterns in behaviours, including declining home conditions and critical periods when stress may increase. This would have been particularly helpful in understanding the potential of linked impacts between family members. Agencies must be able to monitor progress and maintain accurate records and where applicable include contributions and views of other agencies.

189. There was no wider assessment of needs as a family and, whilst this may have been a complex assessment, it was essential to inform care and support planning. ineffective information sharing impacted upon assessments which were often undertaken by individual agencies considering individual issues.

[36] Inconsistency in the quality of input from education, health and care into EHC assessment and planning

[37] https://www.scie.org.uk/integrated-care/research-practice/activities/joint-needs-assessment-care-planning/

190. Whilst there were CIN and EHCP plans for Harry, there was no integrated care and support plan for Michelle or Emily or for the family. This was an opportunity to bring together the care aspects under health partners with the support aspects from other agencies. There were missed opportunities in utilising existing multi-agency approaches in Shropshire through the Earl Help pathway[38].

191. A Think Family approach recognises the context, challenges, views of the family and areas to enable a high-quality service[39]. Shropshire has a continuum of need and think family approach. There is no evidence of either process being used in this case. Findings from other Serious Case Reviews highlighted the importance that sufficient emphasis on the need to consider previous and historical concerns that might reoccur in the life of a child, such as the re-emergence of a serious parental mental illness is referenced in these tools[40].

192. The EHCP was an opportunity to consider Harry's physical health, cognitive development, sensory needs, and emotional well-being and would have allowed agencies to coordinate activity through a recognised process, but the ineffective management did not enable this.

193. There was an accepted position that CSC was the lead agency for Harry through the CIN process but there was no wider coordination of care and support planning for the family. The GP practice did discuss the family at monthly clinical meetings but only kept the case under review as other agencies were involved. The GP practice has reflected that they didn't appreciate the totality of the challenges faced by the family. The GP practice and SATH held significant information that could have impacted assessments and may have initiated discussions with Michelle by other agencies.

194. Emily was at times hidden and for long periods had no contact with agencies. The GP practice did see her and was the one agency that had the most information to coordinate her care needs and referrals to mental health services. In reviewing a sample of CIN meeting minutes and plans, there is no evidence that Emily's mental health was discussed, or information shared with her GP.

195. Better coordination of support and/or care plans can facilitate efficiencies by reducing duplication and more effective service delivery. There were windows of opportunities to engage with Michelle and her family, or potentially access the house and assess and observe conditions and her parenting capacity. These opportunities were available to many agencies and if information sharing had been more effective and coordinated, this could have involved other agencies. This was particularly evident in the use of referrals which may have enabled home visits for assessments. Housing highlighted a lack of involvement in multi-agency working and given their role and responsibility, this was a missed opportunity. Housing Plus highlighted that they are often overlooked in such circumstances. This is a recurring theme in other national reviews.

196. Given the complexities with this family, there was a need for an effective multi-agency response, to develop an integrated care and support plan for the family. This would enable the key components of effective information sharing and joint assessment to inform planning and appropriate oversight in the delivery of agreed objectives.

Referrals and signposting.

197. Throughout the review, there are numerous references to the use of referrals and signposting to promote personalised care and support planning so that Michelle and her

[38] As part of One Shropshire, the use of multi-disciplinary integrated practitioner teams and community and family hubs, developing in local communities. The teams provide an efficient means of considering and exploring how best to identify and meet the needs of families, children and young people, where their current situation is negatively impacting on them

[39] https://www.scie.org.uk/publications/ataglance/ataglance09.asp

[40] https://www.hundredfamilies.org/wp/wp-content/uploads/2019/12/EMMA-JACKSON-Mar-17-SCR-Exec-Summ.pdf

children were supported. This should be a process of sharing information, identifying medical and non-medical support needs, discussing options, contingency planning, setting goals, documenting the discussion (often in the form of a care plan) and monitoring progress through regular review.

198. When SATH assessed Michelle in December 2022, there were no indicators that necessitated a contact or referral into CSC and additionally, a screening tool for Adult Social Worker referral was completed with no requirement for referral into ASC, but it is unknown a discussion took place to consider a consensual referral.

199. CSC reported that their preference would have been for Michelle to agree to a referral to ASC, and this took until January 2023. In previous attempts Michelle declined the offer of a referral, stating that she "didn't want to be a burden", with appropriate support from Action for Children, James, family and friends. James also recognised that she was reluctant to ask for help. Agencies did not fully explore this reluctance to accept support, and there may have been a fear of negative consequences or repercussions, particularly a perception that she could not cope. CSC were not aware they could have referred her through the adult safeguarding pathway had they identified the risks justified overriding her consent. This demonstrated the lack of a Think Family approach.

200. Even at the point of the referral to ASC, there was insufficient information to make a judgment under the Care Act, no reference to the home circumstances and was no reference to Michelle's bariatric needs, any child safeguarding concerns and no reference to Emily's needs. The referral was made by telephone and not backed up in writing.

201. At the same time a referral was made for Michelle to the Sustain Consortium, which provides community support, as she was anxious about paying the rent. This referral lacked vital information about Michelle's situation and vulnerabilities which resulted in a medium grading and delays in responding. There was no feedback to CSC from ASC. The referral was placed on a waiting list and was not actioned before Michelle's death.

202. SATH recorded that Michelle was independently self-caring and mobile with no requirements for packages of care and neither was a referral required for support required on her discharge from hospital in either 2022 or 2023 following admissions for anaemia and sepsis. The issue of mobility and home environment has been explored and there was information within the system that Michelle would have benefited from care and or support.

203. There were five referrals made to BeeU Access (MFPT) for Harry and Emily, and none led to either child accessing support. On three occasions, Emily was signposted to IAPT and for Harry, Michelle was told that statutory agencies should make the referral. On one occasion CSC made a referral in March 2021 to Bee U Access Service. This was triaged incorrectly by the Access Team and Harry was incorrectly signposted. The referral should have gone straight to the Bee U Learning Disability Team. The referral was classed as 'no mental health need', so Michelle was signposted to Early Help.

204. By April 2022, matters remained difficult for Michelle when she was worried about Harry and raised concerns to Shropshire MH Services. She was told a professional would need to make the referral and that she should contact the social worker, GP or school to make a professional referral on her behalf. There was no further contact with the service, which may have been because of these complexities. ASC have since recognised that they focussed too much on signposting and identified they should have explored more with Michelle and CSC.

205. Throughout the review period, there were many referrals and signposting involving Emily. She attended appointments with professionals and disclosed significant mental health and self-harm concerns. She was initially advised to self-refer Beam and Kooth. She did decline Child and Adolescent Mental Health Services CAMHS (Bee U) in 2019 but was referred in 2020 when her GP described her as very high risk. She was subsequently told to self-refer IAPT and advised the same nearly 18 months later following a subsequent College referral.

206. In December 2021 Emily raised concerns with her GP about ADHD but a subsequent referral was declined, and she was advised to liaise with the college to progress this. When the college met with Emily in September 2022, she agreed to self-refer to IAPT. The college contacted Access MH services and made a EHWB referral and were advised to again make a referral to BeeU. Emily decided to wait until she was 18 and could then make a referral directly to access if EHWB was not yet in place or it was not suitable. She subsequently missed the EHWB assessment and was advised to re-refer.

207. When in 2023, she disclosed being sexually harassed and was signposted to Health Assurance and when she raised concerns about her eating habits she was signposted to Beats.

208. Following concern raised to her GP in March 2023 a further referral was made to Shropshire Access Team. Emily was referred to IAPT for psychological therapy and referred to the Shropshire Autism Hub. Emily did not attend a planned telephone appointment and due to "lack of engagement" with the service, she was closed. Emily was prescribed medication for her anxiety but in the same month was closed to IAPT as she had not engaged.

209. The GP, hospital and Police all reported that they had not received/do not receive feedback from Social Care on referrals that they have made. ASC reported not being aware of the referrals for Michelle to Sustain and social prescribing were received and actioned. The two-way expectation regarding requesting and receiving feedback from referrals would encourage oversight and where necessary, professional challenge.

210. There was an expectation that Michelle and Emily should have progressed their own referrals and signposting, even though there were factors that may have led to reluctance or lack of motivation to do so. Records show that Emily was required to refer herself on eight occasions and there are no records that indicate any treatment or care and support planning resulted. Throughout this period, she was self-harming regularly, living with low mood and anxiety and caring for her mother and brother in an environment that was described as not fit to live in. It is not surprising that she did not progress these referrals or attend the one appointment that was offered against these challenges. The GP Practice acknowledged a lack of knowledge of the pathway for young people with anxiety.

211. Similarly, the review has explored Michelle's mental health and her motivation to make positive changes and deal with matters. It appears that she often struggled to progress matters and the challenges and complexity in undertaking self-referral processes or suggested signposting may have been unmanageable given her poor emotional state.

212. The majority of occasions when signposting was suggested did not lead to support which raises the question if the use of signposting was appropriate at that point. There is an acknowledgement that the use signposting by professionals is a recognised method of enabling people to seek further help and advice, and there is a limitation in the level of scrutiny and follow up that can be achieved against increasing demands of signposting.

213. In this case, the complexity of parts of the care and support system, including eligibility criteria, administration, and bureaucratic processes, may have acted act as a barrier for Michelle and Emily to navigate the system independently and confidently. In analysing the collective use of referrals and signposting, there was insufficient support and encouragement from agencies and a lack of scrutiny in checking if Michelle or Emily had progressed matters that could have been an indicator to escalate matters.

Professional Challenge and Escalation

214. The Child Safeguarding Practice Review Panel highlighted the importance of "safe professional challenge" within and between agencies and there has been a lack of challenge found in many cases[41].

[41] https://www.communitycare.co.uk/2024/01/30/leaders-must-foster-professional-curiosity-and-challenge-to-improve-child-protection-finds-review/

215. There were a number of opportunities when the views of agencies differed, but there was a lack of challenge between agencies.

216. There is no evidence that agencies challenged the effectiveness of the CIN plan. One professional highlighted that the CIN meeting enabled agencies to update rather than ensure oversight and management. On occasions, CSC appeared to provide explanations and minimise the conditions and incidents and agencies appeared to accept this position. Whilst there were disagreements raised around the housing conditions, there was no formal challenge made that questioned the continuance of the CIN plan and methods adopted.

217. The GP, Harry's School or CSC did not challenge the incorrect referral outcome for Harry from the referral to the BU Access Team or that the CIN plan didn't identify CAMHS Learning Disability Teams as a possible source of support.

218. The effectiveness and timeliness of the EHCP process and the contribution and involvement of agencies were not challenged or escalated.

219. There was a failure to recognise, assess and collectively support Emily as a young carer that was not escalated or challenged between agencies.

220. Bray et al (2017)[42] highlights that practitioners who work with people who self-neglect may struggle to manage the tensions between respect for autonomy, self-determination, and the legal duties to safeguard and protect, which can then result in practitioners failing to employ respectful challenge and concerned curiosity. There was insufficient challenge by agencies to Michelle to resolve matters, outstanding actions and tasks.

Term of Reference 4: The impact of the COVID-19 pandemic.

221. The COVID-19 pandemic exacerbated existing vulnerabilities, contributed to uncertainty and financial instability for many, and triggered pervasive parental stress, anxiety, and depression for some parents. Many parents were required to juggle employment, childcare, homeschooling, and housework with no advance notice and without the regular support of teachers, school programming, mental health professionals, medical providers, friends, family, and colleagues, further increasing the burden on parents. The lockdown affected families differently based on their resources and circumstances prior to and during the pandemic, but the consensus is clear—parents were stressed[43].

222. Overall, there was less contact with Michelle, Harry and Emily over the lockdown period, which would have limited opportunities to engage, assess and monitor their welfare and the conditions within the home. There was no evidence that Michelle was shielding, but both Michelle and Harry were vulnerable because of their health conditions and Michelle was concerned about Harry catching the virus. Given what was known about the impact of summer holidays and Michelle's ability to cope the fact that the children were at home full time for long periods meant that the amount of cleaning and maintenance would have increased, and conditions may have again declined. This assumption is supported by the visit in November 2020 which identified a decline in the house and garden conditions and that Michelle was struggling. Agencies should have been more vigilant about this potential risk and applied additional support and scrutiny.

223. There was no COVID RAG rating for Emily and Harry had a Green RAG rating as he was seen to be completing online learning, but this should have been red.

224. Harry's School highlighted that children with learning disabilities do find the use of online teaching, with video calls a challenge cognitively. Given the use of these techniques

[42] Braye, S., Orr, D. and Preston-Shoot, M. (2017), "Autonomy and protection in self-neglect work: the ethical complexity of decision-making", Ethics and Social Welfare, Vol. 11 No. 4, pp. 320-35

43 Parental Challenges During the COVID-19 Pandemic: Psychological Outcomes and Risk and Protective Factors. Whaley, G and Pfefferbaum, B. 2023

during the lockdown period, the success of this type of technology is not known but this may have limited Harry's development.

225. The EAS were unaware of Michelle's health needs or the extent of the poor home conditions and the expectation that the children should have been in school during lockdown. Emily's school did not record conversations with the Education Welfare Officer which was said to be unusual.

226. Emily was not open to the EAS but should have been during COVID-19. At that time, she had fallen into the category of severe absence at 50%. Following the deterioration in attendance in 2019, there was no evidence of follow-up by the EAS and the case was closed during the COVID lockdown period. This is despite Michelle informing the EAS that Emily was a carer, and she was having counselling. Given the demands of caring for Michelle and Harry, it is understandable that her attendance would have been affected, particularly with the reduction of support from other agencies. There were attempts to make contact with Emily, but when no response was received, there was no follow up. There is no evidence that agencies were in contact with Emily and ensuring she was safe and well. CSC did recognise that the Covid-19 pandemic had an overall detrimental effect on Emily's mental health and a cancelled school trip that led to particular disappointment.

227. There were restricted opportunities for the community and overnight short breaks may have affected the psychological benefits and opportunities for dedicated time between Michelle and Emily. This would have affected this supportive facility, and Michelle reported that there were no breaks in their 'bubble' as the children's father also caught the virus. There may have been an increased pressure on the family.

228. Although the respite may have been advantageous, records indicate that Michelle wanted the children at home. Whilst this may have reduced the risk of infection, it also limited agency contact, particularly the children. In doing so, there would be less opportunity to observe them and the inside of the home, at a time of increased vulnerability.

Term of Reference 5: Missed opportunities.

229. The previous sections have identified missed opportunities within the period of the review which are now brought together.

230. The identification of Emily as a carer varied between agencies. CSC failed to formally recognise and assess this despite the Police identifying this in a referral in 2017 and GP, School, College and School nurse also identified this role. There was no challenge to CSC by Michelle or other agencies or liaison between agencies to clarify this important point. In doing so, there was a missed opportunity to consider her under the Children's Act, which may have enabled increased support at an earlier stage and may have led to preventive opportunities. Emily undertook this role for a long period and was even willing to attend a parenting course which shows her intention to support her mother and brother.

231. Emily did provide professionals some insight of her lived experience at home, but often at times of crisis, and there were long periods when this was unknown and not explored. Of note, the limited information between 2017 and 2020 which may have been an indicator of her challenges. Her drop in attendance in late 2019 was also potentially an indicator of concern and a method of expressing her voice. The indicators of lashing out at Michelle, eating concerns, graffiti and behaviour in school could have prompted professional curiosity and an increased level of exploration, assessment and support.

232. Previous sections explore the use and outcomes of signposting and referrals for the family. The family contacted agencies seeking support, indicating a willingness to engage and disclose information. The agencies' expectation, in accordance with agreed protocols, was

for Michelle and Emily to take responsibility and self-refer. On other occasions, they did self-refer they were told that referrals must go via professionals. On most occasions, this process was unsuccessful and led to minimal support for the family. Given the demands, complexities, and possible lethargy, this was to be expected and maybe too difficult for her. There is no evidence to demonstrate that agencies recognised this potential process failure and provided scrutiny and support. This was at a time when the family showed a willingness to engage.

233. There were occasions when agencies could have made referrals but didn't, particularly to ASC and CSC/Targeted Early help. Whilst consent is beneficial, more could have been done to enable more effective information sharing and opportunities to escalate concerns. There were also occasions when agencies either triaged referrals incorrectly or did not include sufficient information, resulting in a failure to provide vital support. Agencies did not feedback the outcome of a referral which could have enabled challenge or escalation if the originating agency were not satisfied.

234. Agencies visited the home and there was a range of responses around the conditions from no concerns noted, to messy through to potential hoarding. Throughout the review period, agencies regularly raised concerns about the conditions in the house and also about Harry's safety in the home environment. There was no common assessment or agreed standard of conditions shared between agencies to benchmark this. Urgent repairs and gas safety checks were opportunities to access the house. CIN visits were not undertaken from February 2023, which may also have enabled an assessment. Visiting the house and observing the living conditions was an opportunity to identify concerns or progress. Utilising other agencies, particularly when visits were declined, was an opportunity to work together and share information. Agencies did not consider declined home visits or increased calls about home conditions collectively, which may have informed risk assessments and escalated action.

235. The decision to follow a support route in a CIN plan rather than safeguarding may have been proportionate initially, but there was no long-term improvement which questions the effectiveness of the plan. Several incidents raised concerns about the health and well-being of Harry and Emily. Agencies missed opportunities in not sharing vital information about Michelle, Harry and Emily which may have led to alternative decision making and escalation. Changes to care and support plans and Increased support may have been beneficial in preventing risks from escalating.

236. Given the interdependencies between family members, single incidents, and long-term concerns, a Think family approach could have enabled a more holistic and coordinated assessment and care planning. Given the complexities, multi-agency chronologies would have enabled a more informed view of the family and an opportunity to identify patterns. Agencies recognised this would have given a basis for sharing information about Emily. There were opportunities where Targeted Early Help could have worked alongside CSC.

237. There was also information that was not shared by agencies which was relevant in assessing the parental capability of Michelle and opportunities to explore her past.

238. Not all agencies were aware that Harry was subject to a CIN plan and this was a missed opportunity to share information and contribute to assessments and decision-making.

239. The EHCP was an opportunity to assess Harry's needs through a multi-agency approach and involving parents. Failing to maintain this within timescales a d without necessary information and the active involvement of all agencies may have detrimentally affected Harry's development.

240. There were a number of periods, school holidays and during the COVID-19 pandemic when Michelle, Harry and Emily were in the house for long periods. This created increased challenges for Michelle to maintain the house and emotional challenges for the family. CSC had recognised patterns when Michelle struggled and increased support would have been advantageous.

241. During the Covid-19 pandemic, there were missed opportunities to check on Emily's welfare, at a time when she had disclosed significant self-harm concerns. There was no evidence that Michelle was shielding, and professionals should have viewed this as a potential barrier to the families' engagement during this time. EAS could have explored the impact of COVID-19 more with the family against Emily's attendance at school and worked with other agencies to provide support.

242. Whilst agencies considered Michelle's mobility individually, there was no overall assessment between agencies in understanding her limitations. In developing a shared understanding, agencies may have been able to explore engagement and nonattendance/compliance with medical matters.

243. On the day of Michelle's death, there was a missed opportunity once Emily had raised concerns with the school about Michelle's welfare. If matters had been escalated, this may have prompted a welfare check at an earlier stage.

Linked Key Learning and Recommendations- Family A and Family B

Think Family Approach

244. There were numerous agencies involved with the families however there was no co-ordinated whole family approach in either case. A Think Family Approach would have enabled agencies to formulate a coordinated plan that addressed the known and unknown needs of the family and to identify and manage risks. The use of a multi-disciplinary team approach and where appropriate, multiagency chronologies would have assisted agencies in understanding the family dynamics and any relevant information, for example parental trauma and health diagnosis, which could have informed plans and decision making.

245. A whole family approach to need and risk would have addressed many of the following learning themes in these two cases.

246. Agencies should promote the use of Think Family Approaches and ensure that practitioners are supported through supervision and training to do so.

The Children's Lived Experiences

247. The daily lived experience of the children in both families was not understood or explored by professionals. They were living in homes which were, at times, unsafe, unhygienic and inappropriate. Their daily needs were not always met by their mothers, and, in the case of Harry, he was not always kept physically safe.

248. For the girls in both families, caring for severely ill and morbidly obese mothers (and in Family A for a younger sibling with significant needs) meant that their daily lives were difficult, and their mental and physical health and their education were adversely impacted.

249. The voice of non-verbal children, as in family A, is a recurring learning point highlighted within Shropshire reviews. The child's extreme vulnerability meant it was vital that his daily lived experience within his home was thoroughly explored.

250. Agencies must establish the daily lived experiences of all children within families with complex child/ adult needs particularly when children have caring roles. Recommendation.

The Mothers Lived Experiences

251. Agencies did not explore any historical trauma that the mothers had experienced. In each case these experiences will have had a significant impact upon their mental health and wellbeing. There were missed opportunities to explore these, particularly in Michelle's case, therefore there was no understanding of how they affected her parenting and how she engaged with services, given that she was in fear that authorities may have taken her children into care.
252. Daily life for both women was extremely difficult and their serious health conditions and significant weight meant that they could not fully look after their children or manage their home environments.
253. The unhygienic conditions in both homes would have caused them distress and embarrassment so much so that they prevented professionals from visiting. Self-neglect was an issue for both women, and this would have added to their complex feelings about asking for and accepting help.
254. Agencies must take into account the daily lived experiences of parents who have multiple needs and the impact that this has on their parenting.

Engagement

255. There was an inconsistent approach by agencies in engaging and communicating with the families. Agencies did not explore why the families did not respond to communications and the term "non-engagement" was the generally used. Agencies did not differentiate between intentional non-engagement or consider that changes in physical or mental health, daily challenges or anxiety of agency involvement may have prevented them accessing services or attending at appointments. There was an emphasis that this position was due to the family rather than the accessibility of services. There was at times a need for a more creative, determined and proactive approach to engagement.
256. Professionals should work together to maintain engagement particularly at times of increased risk and vulnerability. There should be a recognition between an intentional decision not to engage with services and where services are unable to engage with an individual.
257. There were occasions when the families were signposted or referred to supporting agencies with an expectation that the family, including the children, should take personal responsibility and a presumption that the family had progressed the referral. Most referrals and signposting resulted in minimal support to the families. Agencies should be alert to circumstances where there is a potential that individuals are unable to progress self-referrals and provide the necessary scrutiny and support. A lack of interagency communication around feedback and progression of referrals was also a factor resulting in minimal or no support.
258. Because there was little or no understanding of the reality of life for the children and their mothers the expectation that they would have the capacity and energy to follow through a self-referral was overly optimistic.
259. There should be appropriate feedback and monitoring of referrals by individuals and between agencies to ensure that they are triaged appropriately and acted upon, and where

necessary escalate action to ensure appropriate support. Agency use of self-referrals for children should be particularly closely monitored and reviewed.

Visibility.

260. There were numerous occasions and time periods when the families became invisible to agencies. This included declined home visits, failure to respond to communications and non-attendance at appointments. Agencies did not show sufficient determination, curiosity or creativity in establishing contact which would enable an assessment of the family and home conditions.

261. Agencies should consider what arrangements may need to be put in place when there is a reluctance or where services are unable to engage and that this may be an indication that a child's needs are not being met or that risk is increasing. Agencies should be professionally curious when there is a lack of information and communication and offers of support are declined where necessary share this information and escalate concerns.

Young carers.

262. There was information across the system that evidenced that the three girls from both families were carers, but the identification and recognition of this role varied between agencies. There was a failure to respond to their needs as carers and particularly how this impacted upon their mental health and education. There was lack of professional curiosity by some agencies in exploring what their caring responsibilities meant daily and in Emily's case a lack of challenge between agencies in responding to her as a carer.

Neglect

Parental Assessments.

263. There is no evidence that a single agency or collectively, agencies fully understood Michelle and Samantha's capacity to parent and the extent and complexity of challenges that impacted upon this. There was insufficient assessment pre-existing and ongoing trauma, vulnerabilities and other psychological impacts which affected how each woman was able to care for herself and her two children, each of whom had their own specific needs.

264. In each case the mothers' health conditions and weight impacted upon their ability to adequately care for their children and this should have prompted consideration of a parental assessment leading to identify support needs and risks.

265. The impact of their serious health conditions and self-neglect meant that the parenting of both mothers was compromised, and the home conditions of both families were of concern. The links between self-neglect and neglect of children is well established and was not assessed or explored in either case.

266. Parenting assessments should have considered the whole family, including the fathers where they were involved.

Information sharing.

267. Agencies identified or were alerted to concerns in respect of both families yet there was a lack of recognition that this information should be shared. Sharing information could have prevented ongoing harm.

268. Sharing the learning from these cases will remind practitioners that sharing (or seeking) information is a vital part of their roles.

Additional learning from this review.

Care and Support planning.

269. Michelle was central to this family, and there was an unreasonable expectation placed upon her to adequately care for her children through the CIN process. Agencies should have recognised that this position was not adequate and that appropriate measures were in place to provide support and increase support.

270. A CIN plan continued over six years without sustained improvements to the conditions within the house or in Harry's health and development. Whilst there were small areas of improvement there was an over-optimism that the plan was effective.

271. Whilst the decision to pursue a support rather than a safeguarding approach for Harry may have been proportionate at the start of the review period, there were a number of further concerns that should have resulted in an escalation of safeguarding procedures.

272. The EHCP process during the review period was ineffective and lacked rigour. Agencies involved in EHCP should work together to contribute effectively and manage this process. The EHCP was an opportunity to regularly assess Harry's needs through a multi-agency approach and involving parents. There was no read-across into the CIN planning process despite agencies being involved in both.

273. There should be a thread running through planning, meetings and visits to ensure that objectives are progressed and monitored.

Assessments.

274. The conditions within the home were a significant factor throughout the review. There was a variance by agencies in what was an acceptable standard. CSC had an overly optimistic belief that improvements had been made and other agencies accepted this assessment. There was information which indicated that the conditions were at least difficult and at other times unsuitable for occupation. This was even more critical against the complex health conditions of all the family and the potential for harm from infection or other hazards. Agencies should use agreed common thresholds as identified in the continuum of need framework.

Challenge and escalation.

275. There were occasions when agencies appeared to disagree with the decisions and assessment of other agencies, but there was no formal escalation or challenge. There was a lack of challenge from agencies to CSC over the effectiveness of the CIN plan. Michelle did fail to comply in a timely manner with certain actions from CIN meetings or agency requests and there was an acceptance of her intentions without questioning or scrutiny. Agencies should be professionally curious and were necessary challenge routinely and consider escalation processes.

Good Practice

276. The reviewer visited Harry's school as part of the process and met with staff. This provided an opportunity to discuss how staff communicate and understand the lived experience of non-verbal children through the use of Makaton. Staff also provided details of pastoral work with children and highlighted the work with Harry around bereavement. Staff at the school evidenced a good relationship and knowledge of Harry.

277. SATH supported Michelle in moving treatment for Harry to another hospital following a missed appointment when the family were unable to find a car parking space close enough

to the hospital given their mobility needs. This change in Harry's care allowed easier access for the family. SATH showed consideration and support for Michelle when Harry had left his sound processor at school and contacted a department to arrange an appointment.

278. The GP put a safety plan in place following the disclosure of self-harm by Emily.

279. Emily's college developed an effective relationship with her in facilitating conversations around her vulnerabilities and subsequently developing safety plans and maintaining regular communication.

280. CSC did provide support to Michelle during a period when Harry was struggling with transitioning from home to school transport.

Recommendations

281. The section acknowledges the recommendations from the Rapid Review process and seeks to expand upon them towards system wide learning.

1. Agencies should adopt a consistent, proactive, and creative approach to engagement, understanding the reasons behind non-engagement and addressing barriers to accessing services.
2. Agencies should improve methods and understanding to actively engage with and understand the lived experiences of all family members, including non-verbal children. This must include the lived experience and voice of the child within the home environment and consider the impact of trauma on all family members.
3. The SSCP may wish to develop awareness, understanding and methods when services are unable to engage with an individual.
    a. This should include a reframing of terminology and system wide change in responsibility and ownership of agencies.
    b. Agencies should also be professional curious where communication and contact with vulnerable people is declined or not responded to and work together to use innovative methods to enable engagement.
4. Agencies should ensure that family assessments are comprehensive and consider individual and collective risks and needs, and the abilities of parents to care for children. Assessments should adopt a multi-agency approach and where necessary, multi-agency chronologies to address the needs of all the family and provide a holistic understanding of a family's situation over time.
5. The SSCP should seek assurance that agencies are effectively:
    a. identifying cumulative trends and significant concerns across multiple incidents rather than isolated events
    b. incorporating standardised levels of thresholds of risk.
6. Agencies should promote interagency awareness and responsiveness to the presence and needs of young carers to ensure that they are identified, assessed and supported.
7. The SSCP should seek assurance that agencies work together to:
    a. effectively share information to identify risk and facilitate informed decision-making.
    b. maximise opportunities to engage with and monitor vulnerable people who have become hidden.
8. Based upon the use of signposting and referrals in this case, the SSCP should review referral processes to ensure they are user-friendly, more accessible and less bureaucratic for vulnerable people. Referral processes should include timely feedback and monitoring between agencies. Agencies should be alert to appropriateness of signposting and where necessary, provide support and scrutiny for signposting and self- referrals.

9. The SSCP should seek assurance that care and support planning:
    a. monitor the progress of families and are effective in achieving outcomes.
    b. are timely, dynamic and deal with any escalation in risk.
    c. are effectively communicated with and involve all agencies who are working with families.
    d. promote the use of professional challenge and escalation between agencies and where necessary with parents.

Conclusion

282. This Review has been conducted with the Independent Reviewer's acknowledgement that supporting families in circumstances such as those experienced by Michelle and her children is challenging. Whilst comments are made about practice and approaches, the Review is focused on a reflective practice approach and recognises the benefit of hindsight. The intention is to support agencies in Shropshire to develop and improve how they work to minimise risk and harm when working with families who share similar challenges.
283. The Review has considered the individual aspects of each family member as well the linked impact between family members in order to understand the broader perspective as a family. For each family member, this included either physical or emotional health and often both. Complex health needs are demanding and require additional medical, psychological and social support. Parents and professionals face a unique set of challenges and needs, especially in families where the child has a lifelong condition, and the review acknowledges the improvements in Harry's physical health.
284. For this review and Review A, the impact of serious health conditions, morbid obesity, immobility and self-neglect meant that the parenting of both mothers was compromised, and the home conditions of both families were of concern. The links between self-neglect and neglect of children are well established and were not considered or explored in either case.
285. Learning from this review reflects learning in the analysis of other safeguarding reviews and findings from independent inspections undertaken in Shropshire.

Rapid Review Learning and Changes to Organisational Practice

286. This section will recognise changes made by agencies since the decision to undertake a review and also changes made against immediate learning from the Raid Review.
287. Harry's school have undertaken improvement work around safeguarding processes to include professional curiosity, record keeping and information sharing.
288. Housing Plus has changed the recording of safeguarding incidents to include matters of concern that fall below the safeguarding threshold, particularly where a person has mental capacity.
289. MFPT have made changes to the triage system for referrals which would prevent a recurrence of the incorrect outcome for Harry's referral.
290. <u>Raising awareness of Young Carers.</u>
291. Midlands Partnership Foundation Trust are developing a learning briefing on Young Carers support, to include what is meant by the term young carers, what support is available

to them and how to access it. The role of young carers will also feature in their safeguarding week. The learning briefing will be shared across the Partnership.

292. Emotional impact on children.

293. The Children's Safeguarding and Protection Practice Oversight Group to consider the emotional impact on children who have parents and/or siblings with long-term health conditions for whom they may have to provide care for, and what support is available to them.

294. Working with families of disabled children.

295. The Children's Safeguarding and Protection Practice Oversight Group to consider the different approach that is taken to working with children with disabilities and their families (support rather than safeguarding) as opposed to other families to determine if these are appropriate responses to families with complex needs. They will need to consider the following question, Had Harry not been a disabled child, would he have been considered as needing to be on a Child Protection Plan?

296. The Special Educational Needs and Disability Team to ensure that the review process for Education, Health and Care Plans is overhauled to ensure that timely reviews take place for children. Reports from agencies as part of this process should be quality assured and appropriate challenge made to schools, health agencies and Children's Social Care.

297. Following a separate review, there have been significant changes and improvements around safeguarding systems, including IT systems and procedures at Harrys's school. This also includes improvements to the EHCP process. The school acknowledged that procedures were not of an acceptable standing during the period of this review.

298. Considering the needs of obese patients.

299. All agencies to consider the wider needs of obese patients/service users. This should include the psychological affects, practical needs and implications on functioning as well as the impact on any caring roles they have for children or adults with additional support needs.

300. Primary Care practitioners should ask obese patients about their psychological needs and eating behaviour patterns associated with their obesity, in order to understand the reasons behind it including giving consideration to whether person has an eating disorder to be able offer treatment for the condition effectively and provide the appropriate support.

301. Assessing home conditions.

302. When practitioners identify concerns about the state of a home, they should seek permission to take photographs, or provide detailed objective descriptions on a room-by-room basis.

303. Practitioners should be using the Clutter Image Rating Scale when assessing home conditions.

304. When there are concerns about whether a home is habitable, there should be consideration of a Fire Safety Check referral being made to the Shropshire Fire and Rescue Service.

305. Where home visits are declined this should be a red flag and practitioners should be professionally curious as to why the visit has been declined and should persist with attempts to carry out a home visit.

306. Safeguarding referrals.

307. West Mercia Police to ensure that the recording of safeguarding referrals details which member of the family referrals are being made for, and to which agency the referral has been sent.

308. Children's Social Care and Adult Social Care to ensure feedback is given to referrers. Adult Social Care are planning to undertake an audit on cases with regards to whether or not feedback was given to referrers.

309. Agencies who have not received feedback on referrals should request the required feedback and escalate any issues using the Shropshire Safeguarding Community Partnership Escalation Policy.

310. School attendance.

311. Education Access Service to raise awareness amongst education professionals about what is deemed an acceptable attendance rate and when the Education Access Service should be involved.

312. Education Access Service to improve record keeping with respect to attendance issues, any action taken by the service and the rationale for a decision to close a child.

313. Voice of the non-verbal child.

314. All agencies to ensure that practitioners are aware of how to hear the voice of the non-verbal child, including documenting observations of the child's behaviour, presentation, home conditions, lived experience and attachment to their parents and siblings.

315. Proactive referrals versus signposting.

316. All agencies to be proactive in making referrals to the appropriate service for a child and family members to ensure that services are accessed, as opposed to just signposting a family to a service where they are then expected to self-refer, as this may not be followed-up.

317. Assessment of risk.

318. All agencies to give consideration to children and families with complex needs and what additional support they may require during school holidays or when there is a change in their routine. They should consider if the changes reduce or increase the level of risk, to whom and what should be done about it if needed).

319. Robust multi-agency chronologies should be used to aid practitioners in recognising patterns in behaviours, periods of stress for a family and declining home conditions.

320. Information sharing.

321. Shrewsbury College to share information with Children's Social Care when historical safeguarding disclosures are made and to share any on-going mental health concerns where it is known that the student has caring responsibilities for family members and further support may be required.

322. Education, Health and Care Plans.

323. The Special Educational Needs and Disability Team has an annual review recovery plan underway, with a focus on all Education, Health and Care Plans being of a high quality and current. The case officers have and are attending Independent Provider of Special Education Advice training, which covers statutory duties and the writing of quality plans.

324. ICB have made changes to the EHCP process to include that Social and Medical Questionnaires are submitted as part of the Annual Review or reassessment process. Health have agreed to attend review meetings in person, but if this is not possible, they should share their most recent report and ICB weekly panel meetings to consider amendments to EHCP's and quality assure a sample of new and amended EHCP's. Evidencing impact of parenting courses.

325. Parenting courses which are goal based should have the goals revisited with parents at the end of the course. The achievement, or otherwise, of these goals should be documented in service records. Consideration to be given to feedback also being gathered

from the children of the parents attending to evidence changes made by parents and the impact of their learning.

326. Think Family.

327. All agencies should Think Family when working with adults and/or children with complex needs. Practitioners should be professionally curious and work together to support such families and employ a Think Family approach to ensure the right support is in place.

Glossary

ASC	Adult social Care
Bee U	Bee U (Emotional health and wellbeing service, previously CAHMS)
CSC	Children Social Care
CIN	Child in Need
EAS	Education Access Service
EH	Early Help
EHCP	Educational Health and Care Plan
GP	General Practitioner
IMR	Information Management Report
MCA	Mental Capacity Act
MHA	Metal Heath Act
MH services	NHS Trust - Mental Health Services
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
SAR	Safeguarding Adult Review
SCHT	Shropshire Community Heath Trust
SSCP	Shropshire Safeguarding Community Partnership