A Local Child Safeguarding Practise Review

Child T - Overview Report

Independent Reviewer – Dr Jeremy Pearson

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Hartlepool & Stockton-on-Tees
SAFEGUARDING
CHILDREN
PARTNERSHIP

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Chapter 1 - Executive Summary

1. Introduction

1.1 This review examined the response of agencies over a four-year period in their attempts to safeguard Child T. The review was commissioned by the Hartlepool and Stockton-on-Tees Safeguarding Children Partnership (HSSCP) following an incident in June 2020 when Child T's mother (referred to as Mother) attempted to murder him by strangulation. Child T survived the incident and is now in foster care with his older sibling while Mother serves a term of imprisonment following conviction.

1.2 Case Summary

1.2.1 Child T first came to the attention of safeguarding agencies as a four-week-old baby in February 2016, when Mother attended a local hospital stating that her baby wasn't moving his leg properly. Medical investigations quickly determined that Child T had a broken femur and that the injury appeared non-accidental. Mother admitted that she had sole care of the child since his birth but denied causing the injury. Social Care and the police responded quickly, and an immediate Strategy Meeting was held with both agencies agreeing to conduct a joint investigation. At this time, it was understood that Mother had a criminal record, had served a previous term of imprisonment and most significantly, had previously been diagnosed with a personality disorder while detained for a number of years under a Hospital Order. The police subsequently failed to conduct any recognisable form of investigation and Social Care made the decision that following medical treatment, Child T would return to the family home with Mother. These facts amount to serious failings on the part of both agencies and are discussed in greater detail within this report.

1.2.2 Over the following weeks various supervision arrangements, including placing the family in a residential facility, were put in place to monitor Mother's interaction with Child T and his older sibling. A consistent feature of this period was Mothers failure to comply with supervision arrangements and her hostility towards staff tasked with the supervision role. The local authority began to form the view that given the circumstances, it would be in the best interests of Child T and sibling to be taken into local authority care. The Family Court proved resistant to this plan and ordered continued assessment within a residential unit.

1.2.3 A medical report was later received that confirmed that Child T's broken femur was a spiral fracture that had likely been caused by the application force in a deliberate twisting motion. In April 2016, the Family Court held a Finding of Fact Hearing and found that Mother had been responsible for breaking Child T's femur. The result of this hearing was never communicated to the police who remained unaware of the judgement. The local authority eventually applied to the court with an application that the children should be adopted. After signalling reluctance to agree to this plan, the court ordered that reports from the Childrens' Guardian and the Independent Review Officer (IRO) should be prepared, giving a view on the plan to adopt. These reports together with mental health assessments of Mother, all indicated that Mother was fit to continue living with her children. Faced with these facts, the local authority altered their plan of adoption to one of shared parental authority between Mother and themselves. A care order to that effect was subsequently made by the court. The Local Authority had correctly, if somewhat belatedly, attempted through the court process to safeguard

the children by removing them from Mother. However, these attempts were to prove unsuccessful, which in turn resulted in a failure to adequately safeguard the children.

1.2.4 Following the award of joint-parental responsibility by the court to allow the return of Mother and the children to the family home, some frontline practitioners harboured doubts about the court's decision. However, some staff were unaware of any mechanism to challenge the court's decision or to escalate their concerns despite existing procedure and guidance being available to practitioners.

1.2.5 During the course of 2018, a number of concerns began to emerge around behaviours being displayed by Mother. Concerns centred on numerous claims by Mother that Child T was suffering from various medical complaints, none of which could be substantiated by doctors. It was thought that these behaviours could potentially amount to a case of Fabricated or Induced Illness (FII) and multi-agency case conferences were convened to examine the facts. Ultimately, medical opinion was that the circumstances did not amount to a case of true FII and professionals were additionally reassured by Mother who provided explanations for her behaviour. The willingness of professionals to accept these explanations suggests a lack of professional curiosity and fails to take cognisance of the fact that the behaviours exhibited by Mother (whether FII or not), still potentially amounted to emotional abuse of Child T. There is no evidence that these behaviours were considered alongside all other previous case history as part of a wider assessment of the facts.

1.2.6 In December 2019, the Care Order granting joint-parental responsibility for the children was discharged and the court returned sole parental responsibility for Child T and sibling to Mother. At the time that this decision was taken, Mother's mental health was beginning to deteriorate, as evidenced by some episodes of self-harm. Information was not properly exchanged between agencies resulting in Social Care not being fully sighted on potential changes to Mother's mental health.

1.2.7 In April 2020, Social Care made the unilateral decision to step-down the case and refer the family to Early Help. This decision was made without the benefit of information held by other agencies regarding further indicators of Mother's poor mental health. No risk assessment was conducted prior to step-down and the decision was not communicated to partner agencies.

1.2.8 During Spring 2020, amidst the lockdown imposed by the government in response to the Covid-19 pandemic, Mother isolated herself and the children within the family home. Mother maintained regular contact with various agencies, though mostly in the form of telephone calls. It cannot be discounted that the withdrawal of face to face interaction by agencies together with the effects of social isolation, caused Mother's mental health to deteriorate further in the weeks leading up to her attempted murder of Child T.

1.2.9 Child T was a vulnerable four-week-old baby who had sustained an extremely serious non-accidental injury when he first came to the attention of agencies. Over the following four years, Child T was exposed to further risk of harm by the inadequate response of those agencies charged with safeguarding vulnerable children. Given the extensive history associated with the case and the overriding imperative to protect Child T, safeguarding agencies should have retained a determined focus on ensuring that Mother did not pose a current or future risk to either child. This failed to happen, and the recommendations contained within this report are intended to address these failings and to minimise the risk of recurrence.

1.3 Statutory Guidance

1.3.1 The Government provides statutory guidance[1] on the conduct of Local Child Safeguarding Practise Reviews, which states that:

- The methodology should provide a way of looking at and analysing frontline practice as well as organisational structures and learning.
- The methodology should be able to reach recommendations that will improve outcomes for children.
- All reviews should reflect the child's perspective and the family context.
- The review should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain the reasons why the events occurred as they did.
- The child is at the centre of the process.

1.4 Purpose of the review

1.4.1 The purpose of this review is to: -

- Establish whether there are lessons to be learned from the case about the way in which professionals and organisations work together to safeguard and promote the welfare of children and young people.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and,
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children and young people.

1.5 Periods of concern and key areas of consideration

1.5.1 Five significant events were identified during the review and all were examined in detail and analysis applied to the various actions of agencies. Examination of these events allowed the review to address those questions posed within the Terms of Reference while considering other areas of potential learning that lay beyond those questions. These key events are detailed within Chapters 4-8 of this report and specifically describe the following events:

- The response to the initial report of Child T having sustained a broken femur in February 2016 and the period immediately thereafter.
- The actions of the court leading to the decision to award joint-parental responsibility of Child T and sibling to Mother and the Local Authority in August 2016.
- The response to suspicions that Mother was displaying traits towards Child T that potentially amounted to Fabricated or Induced Illness during late 2017 to mid-2018.
- The decision of the Local Authority in late 2019, to apply for a revocation of the Care Order that had previously awarded joint-parental responsibility of Child T and sibling to Mother and the Local Authority
- The decision of the Local Authority in April 2020 to step-down Social Care services and to close the case.

[1] Working Together to Safeguard Children (2018)

Chapter 2 – Initiation of the Review

2.1 Terms of Reference (summarised)

2.1.1 The full version of the Terms of Reference is available from the Hartlepool and Stockton-on-Tees Safeguarding Children Partnership (HSSCP). The focus of this review is to examine the response of agencies to a number of significant events that occurred in the life of Child T.

2.2 Scoping period

2.2.1 The timeframe for the review is the period from February 2016 until June 2020.

2.3 General Terms of Reference for Review

2.3.1 The HSSCP Rapid Review meeting held in June 2020 identified that given the circumstances of the case, a Local Child Safeguarding Practise Review was required, and that the review should consider the following key questions:

I. **Whether the injury to Child T femur in 2016 was a precursor to the attempted murder of Child T in 2020**

- How did information around parental mental health, Mother's historical information (LAC child), parental behaviours and support networks inform decision-making in relation to the non-accidental injury in 2016?
- How did information-sharing between Social Care (finding of fact) and Police inform decision-making?

II. **Was decision-making appropriate in relation to the Courts decision to grant joint parental responsibility to the LA and Mother, versus the Local Authority plan for adoption in 2016?**

- What information went to court to inform court decision-making?
- What was the multi-agency view of the court's decision and how was this challenged?
- Was the outcome of the decision shared with the multi-agency partnership? If so, what was the response of the multi-agency partners

III. **Was decision-making around FII appropriate?**

- What information was shared from all agencies? How was this understood?
- What was the multi-agency response to FII at that time?

IV. **Was there a deterioration in Mother's mental health leading up to the incident and, if so, was this risk-assessed in terms of impact upon the children and appropriately communicated with professionals working with the family?**

- What did the decision-making look like in relation to the step-down and were all relevant agencies involved / informed?
- What information had been taken into account when the decision to step down was made?
- Did this include relevant information from all services, particularly MH services?

- What risk-assessment was undertaken at that time and were all historical factors taken into account alongside current circumstances?
- Did workload pressures impact upon decision-making?
- What difference would any added information have made to the decision and potential challenge around this?

2.4 Family composition

2.4.1 A full genogram showing Child T's extended family was obtained during the course of the review, however the significant parties to this case are detailed in the table below (*Table 1*).

Family member	**Pseudonym (if used)**
Child T	Child T
Sibling (half-sibling of Child T)	Sibling
Mother of Child T and Sibling	Mother
Biological father of Child T (sperm doner)	Father

2.5 Methodology

2.5.1 During the course of the review, the following activities were undertaken:

- A large amount of available and relevant documents were reviewed.
- Several multi-agency workshop style learning events were held with practitioners, managers and strategic leads.
- Updates were provided to agency executives and to Engine Room meetings.

Information gathered during these activities contributed towards the compilation of this report.

2.6 Independent Reviewer and Overview Report author

2.6.1 Dr Jeremy Pearson performed the role of Independent Reviewer and author of the Overview Report, having been appointed to carry out the Local Child Safeguarding Practise Review in September 2020.

2.7 Family Involvement

2.7.1 Sibling and Child T did not participate in the review due to their age and some speech development issues associated with Child T. Mother was not initially approached (as would be normal) due to the live criminal investigation that was ongoing at the time. This decision was made after advice was sought from the Crown Prosecution Service (CPS) regarding the propriety of speaking with Mother about the circumstances of the case, whilst awaiting trial. However, following conviction, the views of Mother were sought and are reflected within the review.

Chapter 3 – Analysis of key events

3.1 The key events of this case have been established with the input from the agencies and practitioners participating in this review. They have been anonymised and summarised to detail the established facts during the 2016-2020 time period, together with the professional action taken.

3.2 Background information

3.2.1 Mother had a troubled upbringing and was well known to statutory agencies during her teenage years. As a child. she suffered sexual abuse at the hands of her own mother's partner and sadly, this abuse may well have contributed towards a later deterioration in her mental health. During this period, Mother was arrested for criminality a number of times by the police which resulted in subsequent convictions. Mother's pattern of offending culminated in an episode in 2006, when she set fire to the family home. This incident resulted in a conviction in 2007 for Arson (being Reckless as to Whether Life was Endangered) and detention in a mental health facility under a Hospital Order until 2010. During Mother's extended stay in hospital, it was determined that she was suffering from a personality disorder and this was later formally diagnosed as Emotionally Unstable Personality Disorder.

3.2.3 In 2014, Mother gave birth to sibing and raised the child as a single parent without paternal involvement. In 2016, Mother gave birth to Child T having conceived the child using sperm donated by Father. Father had no involvement with the family whatsoever during the period examined in the course of this review and nor had he any involvement in the conception of sibling.

3.2.4 Child T was born in January 2016 and following birth, was brought from hospital to the family home which was also occupied by Mother and Child T's sibling. Initial contact was made with Mother by Footsteps, part of the Local Authority Childrens' Services to offer the support that is routinely offered to mothers with new babies. Notes of meetings attended by Footsteps staff indicate no causes for concern with the circumstances of the family, and the focus of the contact seems to have been completion of a nursery application for sibling. Details of the home conditions in which the children were living, were not recorded in notes by Footsteps staff.

Chapter 4 – Broken femur

4.1 Discovery of broken femur

4.1.1 On the 6 February 2016, Mother contacted NHS 111 and sought medical advice for an unexplained injury to Child T's leg. Mother stated that Child T was not moving his leg and was advised to attend North Ormesby out of hours GP service with the child. Following assessment, the duty doctor immediately transported mother and child to the James Cook University Hospital Accident and Emergency Department. Subsequent medical investigations quickly established that Child T had in fact, sustained a broken femur. At that time, Child T was 4 weeks old.

4.1.2 An x-ray confirmed that the injury had in all likelihood, occurred within the previous 10 days due to the lack of calcification being noted around the site of the broken femur. Mother reported that no-one else had cared for Child T during the previous 10 days and that no visitors to her home had been left unsupervised with the baby.

4.1.3 Later that evening, the James Cook University Hospital Accident and Emergency Department contacted the Stockton-on-Tees Social Care Emergency Duty Team (EDT) to communicate their concerns regarding the unexplained and serious nature of the injury sustained by Child T. Following receipt of this referral, the EDT instigated a number of actions and created a Service User Referral Record which acted as a record of activity. This document shows that a number of database checks were conducted into Mother's background by both social services and the police during that initial phase of activity and these included details of Mother's previous convictions and mental health history.

4.1.4 During the course of these early inter-agency enquiries, Mother denied deliberately causing the injury and offered a potential explanation for the injury to Child T. Mother suggested that the injury may have been caused whilst she was breast-feeding sibling as she held Child T. This suggestion was quickly discounted by one of the hospital doctors who stated that the injury sustained by Child T was not consistent with this explanation and that in their opinion, it was a non-accidental injury. The doctor's view that the injury was non-accidental was noted on the Service User Referral Record and appears to have been clearly understood by professionals at that time.

4.1.5 At 10.45pm that evening, a Strategy Meeting was held between social care and police professionals which resulted in a number of agreed actions:

- Child T would be admitted to hospital with a full skeletal survey to be arranged as soon as possible.
- Mother would be allowed to stay on the hospital ward with Child T but any contact with Child T must be supervised by a professional person (rather than family or friends).
- That sibling would be looked after by some of Mother's neighbours.
- Mother was not to have unsupervised contact with sibling.

At the conclusion of the Strategy Meeting, a decision was taken that a joint Section 47 (Childrens Act 1989) investigation[2] into the circumstances of the case would be undertaken, and this decision was recorded on the Service User Referral Record document.

[2] Section 47 Children Act 1989

4.1.6 On the 11 February 2016, a reconvened Strategy Meeting was held, and records show that number of positives were identified during the course of the meeting. These largely centred around the positive presentation of Mother to agencies in the days following initial attendance at hospital on 6 February 2016. At this time, Mother indicated that she would be willing to engage with the local authority and due to uncertainty around the exact cause of Child T's injury, a decision was made that Mother could return to her home address with both of her children as long as 24-hour supervision was put in place. The arrangements that were agreed involved the use of Mother's friends and neighbours to provide supervision of her within the home address. At this time, Child T was categorised as a Child in Need and a decision was made by Social Care to seek legal advice.

4.1.7 A Legal Meeting was held on the 15 February 2016 and during this meeting, the local authority were advised to seek further medical opinion regarding the cause of the injury to Child T and Mother's existing supervision arrangements were ratified. Over subsequent days, Social Care visits to Mother's home address found her to be unsupervised with both Child T and sibling, in direct breach of the supervision arrangements, on five separate occasions. Social workers noted at this time that Mother seemed unable to recognise the implications of her actions around non-compliance with required supervision. In light of those repeated episodes of non-compliance, on 24 February 2016, the local authority made an emergency court application that resulted in an Interim Care Order being granted. The order directed Mother and both children to reside at St James House, a facility that would be able to better manage the requirement for 24-hour supervision of Mother. At that time, a Children and Family Court Advisory and Support Service (CAFCASS) Childrens Guardian was appointed by the court and an Independent Review Officer (IRO) was appointed at the beginning of March 2016.

4.1.8 On the 18 March 2016, Mother reported that Child T was not moving his arm properly and had staff at St James House contacted the Ambulance Service. Child T was taken to North Tees Hospital and a full examination of the child disclosed that there was no evidence of injury. Mother and Child T both returned to St James House following attendance at the hospital.

4.1.9 During the period of the family's supervised stay within St James House, Mother proved to be uncooperative and was persistently challenging towards staff. Contact notes from this period show that Mother was found to have been co-sleeping with the children on four occasions, Child T's cot was often moved from the view of supervisors and baby monitors were disabled. Concerns were additionally raised by staff at St James House that day-time recordings of Mother with her children were not representative of the true situation. The relationship between staff at St James House and Mother began to rapidly deteriorate and ultimately became so toxic that a number of staff began cancelling shifts due to her challenging behaviour. Some staff refused to supervise Mother as they claimed that her behaviour towards them was causing them to feel vulnerable. During this period, the local authority also received a large number of EDT referrals from Mother, complaining about the conduct of supervising staff.

4.1.10 On the 15 April 2016, a medical report was received containing further detail on the nature of the fracture to Child T's femur. The doctor producing the report indicated a clear opinion that the nature of the injury was an undisplaced spiral fracture of the femur. This type of injury is known among child protection professionals as a twist injury and is recognised as being almost impossible to be caused accidentally.

4.2 Analysis of events related to Child T's broken femur

4.2.1 A number of the initial actions undertaken by social workers and the police on the 6 February 2016, such as checking databases and exchanging information appear to have been properly conducted in an expeditious manner. However, subsequent management of the case is characterised by a lack of focus and rigour. The joint investigation into the circumstances of the case that was agreed that evening, appears not to have happened to any great extent, if at all.

4.2.2 Following the initial report of the broken femur, officers from Cleveland Police recorded the incident as a crime and categorised it as an offence amounting to an assault under Section 18 of the Offences Against the Persons Act 1861. This offence is otherwise known as Grievous Bodily Harm (or Wounding) with Intent and in the hierarchy of assault offences, sits immediately below Murder and Attempted Murder. Given the gravity of the offence and the vulnerability of the victim, a comprehensive investigation of the circumstances of the case would be the usual response of any police force presented with similar facts. This would almost certainly involve the interview under caution of any suspected offenders and would frequently also involve their arrest. If named offenders are suspected, and following a thorough investigative process, the available evidence would be usually be forwarded to the Crown Prosecution Offence for an opinion as to whether the threshold had been crossed to justify a charge against those suspected offenders.

4.2.3 Authorised Professional Practice (APP) is national guidance to police officers that is published by the College of Policing. APP recommends that officers develop an investigative strategy when formulating their approach to a recorded crime. The purpose of an investigative strategy is to:

- identify the most appropriate line(s) of enquiry to pursue
- determine the objective of pursuing particular lines of enquiry
- identify the investigative action(s) necessary to efficiently achieve the objectives, taking into account resources, priorities, necessity, and proportionality
- direct and conduct investigative actions to gather the maximum amount of material which may generate further lines of enquiry
- understand and manage community impact.[3]

4.2.4 In this case, there is no evidence to suggest that officers from Cleveland Police formulated an investigative strategy, nor conducted any recognisable form of investigation. Mother was never interviewed by the police despite her initial voluntary disclosure to medical staff that she was the sole carer of Child T in the ten-day period prior to the 6 February 2016. This fact, accompanied by the opinion of hospital medical staff that the injury to Child T was non-accidental and that Mother's explanation was not feasible, should have caused the police to immediately categorise Mother as a suspected offender. Cleveland Police additionally failed to provide any file of evidence to the CPS and given the available medical evidence and the relatively uncomplicated nature of the enquiry, these investigative failures represent fundamental errors on the part of the force.

4.2.5 When serious offences are being investigated by officers, it is important that the conduct of those investigations is intrusively monitored by police managers.

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[3] College of Policing Investigation APP

In this case, the officers allocated responsibility for investigation of the case were not supervised or monitored correctly and this amounts to evidence of systemic failure within Cleveland Police.

4.2.6 While acknowledging that the action taken by the police fell far short of that required in this case, there is no evidence of any element of professional challenge towards the police from any other agency. Together with the judiciary and the medical profession, the police are often viewed by fellow professionals as an agency that should not be challenged and asked to account for their actions. This is unhealthy and professional curiosity and challenge among inter-agency professionals should be encouraged to provide enhanced scrutiny of the actions of all agencies. This concept is already described within existing guidance for practitioners[4], yet it did not occur in this case. A mechanism that allows and encourages the opportunity for professional challenge should be adopted by agencies.

Recommendation
In the spirit of true partnership working to protect children, agencies should feel empowered and be encouraged to provide professional challenge to one another regarding actions taken and rationale for decisions made. To facilitate this process, a structure to provide challenge opportunities should be incorporated into multi-agency child protection meetings.

4.2.7 When assessing the actions of Social Care staff following discovery of the injury to Child T's leg on 6 February 2016, consideration of the legal requirements incumbent upon the local authority adds valuable context. Section 47 of the Children Act 1989 states that should a local authority:

"*have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare."*

Therefore, given that the local authority's legal duty is to primarily focus upon actions to safeguard children in need of protection, the decision to immediately return Child T following his discharge from hospital in February 2016 to the family home, is questionable. The known facts at this stage of the case were that Child T had sustained a broken femur and despite being the sole carer for the child, Mother denied causing the injury and available medical opinion suggested that her only explanation was not plausible. It was also known the Mother suffered from a personality disorder and had the clear potential to commit acts likely to endanger others as evidenced by her previous convictions including Arson (being reckless as to whether life was endangered). Despite this, Mother was allowed to return home with Child T and sibling, only days after the injury to Child T was first disclosed. The supervision arrangements that were put in place at that time to ensure that Mother was not left alone with the children were extremely lax given the severity of the injury sustained by Child T and the known facts. Those arrangements consisted of 24-hour supervision of Mother by friends and neighbours, and social workers were unusually optimistic in their assessment of the potential effectiveness of these measures.

[4] Tees Safeguarding Children Partnerships Procedure Professional Challenge and Resolution of Professional Disagreement

The arrangements were subsequently described by practitioners and managers during learning events held as part of this review as "very loose" and "unusual". The safeguarding procedures[5] governing the Local Authority's own response to child protection states that*; "the safety of children is paramount in all decisions relating to their welfare. Any action taken by a professional should ensure that no child is left in immediate danger*". The same procedures further state that; *"where abuse is alleged, suspected or confirmed in children admitted to hospital, they must not be discharged until a referral has been made to the relevant Children's Social Care in accordance with this procedure and a decision made as to the need for immediate protective action"*. The arrangements implemented in this case were inadequate and did not provide immediate protective action. The local authority should have taken a more robust stance towards safeguarding Child T in those critical early days by separating him from Mother.

4.2.8 The presentation of Child T at hospital on 6 February 2016 marked the first opportunity for agencies to have instigated proceedings to remove Child T from Mother and to place the child into local authority care. This opportunity was not taken and during subsequent months, further opportunities to decisively intervene were also missed. Within days of Child T's return to the family home, it was found that Mother was repeatedly failing to comply with the supervision arrangements that were intended to safeguard Child T. This prompted the local authority to apply to court for an Emergency Care Order, however on 24 February 2016, the court ordered the local authority to identify supervision alternatives to the children being placed in foster care. On 25 February 2016, court granted an Interim Care Order that directed that Mother, sibling and Child T reside at St James House and that 24-hour supervision of Mother should be in place. While acknowledging that the local authority was directed by the court to implement these arrangements, they still represent a further opportunity missed to decisively safeguard Child T.

4.2.8 While the unfounded claims of Mother that Child T had injured his arm in March 2016 are unremarkable if taken in isolation, they are the first example of a pattern of behaviour that would escalate over time and is discussed in greater detail within Chapter 6 of this review.

4.2.9 The time spent by the family within St James House represents an extraordinary period of non-compliance by Mother towards the supervision arrangements ordered by the court. Throughout late February to April 2016, Mother exhibited confrontational and challenging behaviours towards staff and repeatedly indulged in non-complaint behaviour regarding supervision of herself and her children. These behaviours, taken together with earlier episodes of non-compliance within the home environment and the other known facts of the case should have acted as a red flag to agencies that Mother's continued supervision of sibling and Child T represented a risk to both children. Receipt of the medical report on 15 April 2016, confirming that Child T's broken femur was a spiral fracture, corroborates this view and if any doubts were still held, should have acted as the final tipping point for agencies in their understanding of the risk represented by Mother towards sibling and Child T.

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[5] Tees Safeguarding Children Partnerships' Procedure

Chapter 5 - The Family Court

5.1 The Family Court and (February – August 2016)

5.1.1 A court appointed Children's Guardian began involvement in the case following an initial hearing on 24 February 2016. At that time, the court ordered the local authority to identify supervision alternatives to the children being placed in foster care. Following a Case Management Meeting held on 25 February 2016, the plan to place Mother and her children in fully supervised accommodation was developed. An Interim Care Order directing that Mother, sibling and Child T reside at St James House and that 24-hour supervision of Mother should be in place was also granted on this date.

5.1.2 Concerns about the challenging behaviour of Mother within St James House and examples of her non-compliance with the supervision aspects of the court order, were articulated at a Directions Hearing on 14 April 2016. Despite these facts, and the desire of the local authority to place sibling and Child T foster care, on 19 April 2016, the court indicated that it would not sanction the removal of the children from their mother at this stage. The Court Order that was issued at this time stated that "the most appropriate placement for mother and children at this stage is in the Mother and Baby Unit". The order was made for a twelve-week period from the 22 April 2016, to allow an assessment to be made of Mother's parenting capability. At the point that this order was made, the court were fully sighted on the recently received medical report describing the spiral fracture to Child T's leg.

5.1.3 On the 24 May 2016, a two-day Finding of Fact Hearing was held to consider all available evidence and to determine, on the balance of probabilities, how the injury to Child T was caused in February 2016. During this hearing, medical opinion was heard that the injury was caused with the application of force in a twisting motion. Throughout the hearing, Mother continued to deny responsibility for causing the injury to Child T. At the conclusion of the hearing, a judgement was made that Mother was responsible for causing the injury to Child T and that in the opinion of the court, this represented "a much-regretted loss of self-control". The judge also indicated that psychological assessment of Mother should be considered during the ongoing assessment.

5.1.4 Assessment of Mother took place within a Residential Family Assessment Unit located in Bridlington and known as Chrysalis. During these visits, Mother appears to have presented very well to the Childrens' Guardian and to the Independent Review Officer (IRO) who both conducted a number of visits. However, there is evidence that Mother exhibited some of the previous behaviours that had proved challenging to staff at St James House and on 18 May 2016, she was issued with a verbal warning in connection with her interactions with staff. In the following weeks, initial staff concerns regarding Mother seemed to recede and doctors noted that she appeared to be *"functioning well enough on a day-to-day basis and that there were no clearly identified targets for psychological treatment"*.

5.1.5 On the 4 July 2016, a medical report was received by the court from a doctor within the Chrysalis Unit who wrote that they did not find evidence of current mental illness health, or reasons why mother could not work with professionals. The reporting doctor also stated that Mother was managing her borderline personality disorder but also reminded the court that a degree of future caution and vigilance would be required. The report also noted that Mother was capable of working with professionals in a constructive and positive manner.

The final Chrysalis Assessment Report, also received around this time, stated that Child T and sibling received “good enough” parenting from Mother but also noted that her ability to work with professionals remained a challenge. The report concluded by recommending that both children return home in the care of Mother.

5.1.6 Following the Finding of Fact hearing and judgement, the local authority formed the view that the children should be adopted and that leaving them in Mother’s care represented too great a risk. On the 19 July 2016 at a Directions Hearing, the local authority outlined their proposals which were opposed by the Childrens’ Guardian. The judge stated that the court would think long and hard before approving any adoption plan and went on to emphasis the many positives around Mother’s care of her children. Reports were requested from both the Childrens’ Guardian and the Independent Review Officer (IRO) before any decision would be made by the court. It is clear that both the Childrens’ Guardian and the IRO spent time with the family prior to compiling their reports and there seems to be consensus that Mother presented extremely well during this period. Examination of contact reports suggests that Mother exhibited positive and warm interactions with the children. Ultimately, this led to both the Childrens’ Guardian and the IRO recommending that the children should remain with Mother, with care orders in place.

5.1.7 Faced with opposition to their plan for adoption, the local authority altered their position and in August 2016, agreed to share joint parental authority for the children with Mother and accepted that the family should return home. This arrangement was ratified by the court on 19 August 2016 at a Final Hearing, and Care Orders were made by the court in respect of Child T and sibling that joint parental authority for the children should be shared between the local authority and Mother. The court ordered that the children should reside at the family’s home address with Mother.

5.2 Analysis of the Family Court and CAFCASS (February – August 2016)

5.2.1 The court first became involved in the case on 24 February 2016, and at that time held a view that Mother should not be separated from her children. This stance was adhered to in subsequent proceedings and would come to characterise the court’s position over the following months and years.

5.2.2 Given the facts of the case, the initial direction of the court to the local authority on 24 February 2020 that it explore alternatives to foster care, appears unusual. At this point in the case, the court was presented with circumstances that amounted to an extremely vulnerable child having sustained a serious injury that was believed to have been non-accidental. The only adult with opportunity to cause that injury appeared to have been Mother and she denied responsibility. Mother had a history of criminal offending and mental ill-health including a diagnosed personality disorder. Mother had been initially allowed home with Child T and sibling under supervision conditions and had persistently breached those conditions. At that point in the case, the local authority application to place the children in foster care was entirely appropriate and the court’s direction to explore alternative arrangements was questionable. This point in the case marked the second missed opportunity for an agency to decisively intervene and safeguard the children by removing them from Mother.

5.2.3 While subsequently undergoing 24-hour supervision at St James House, Mother exhibited numerous challenging behaviours including non-compliance with supervision conditions and confrontational behaviour towards staff. During this period, the medical report confirming that the previous injury to Child T was a spiral fracture, likely caused by twisting, was received.

In response to these circumstances, the local authority once again recommended placing the children into foster care. However, on 19 April 2016 at a Directions Hearing, the court directed that it *"would not sanction the removal of the children from their mother at this stage"* and that the family should be placed in a supervised Mother and Baby Unit. This provides a further example of the court's view that Mother and children should not be separated despite compelling reasons for that separation. This represents the third missed opportunity to have decisively intervened to safeguard the children by placing them in foster care.

5.2.4 On the 25 May 2016 following a two-day Finding of Fact hearing at court, it was found that on the balance of probabilities, Mother had caused the fracture to Child T's leg in February 2016. The judgement in the case concluded that the injury was an *"inflicted injury"* with the most likely cause that *"Mother has grabbed the leg in a much-regretted loss of self-control"*. While acknowledging that a court's role is to retrospectively determine how events occurred in any case, the language used in this statement appears indicative of a stance taken by the court towards Mother, that could be best described as sympathetic. This view is further corroborated by the fact that following the court's own judgement that Mother was responsible for causing the injury, she was allowed to continue residing with her children, within the Chrysalis Unit. This marks the fourth missed opportunity to have protected the children by removing them from Mother.

5.2.5 Despite the Finding of Fact against Mother by the court, this important fact was never communicated to Cleveland Police. If informed of this fact, the police may well have been prompted to finally begin to properly investigate the crime committed against Child T and it would almost certainly have been viewed as relevant by the CPS had a file of evidence ever been submitted. During learning events held as part of this review, it became apparent that some frontline practitioners believed that if they had informed the police of the Family Court Finding of Fact, that his may have resulted in them being in contempt of court. Upon further exploration, it was found that no process exists to routinely inform the police of court judgements in Finding of Fact hearings. This is an issue that could, and should, be quickly resolved with the implementation of a mechanism that updates the police when judgements of this nature are made by Family Courts.

Recommendation
Social Care and the court should develop a mechanism that provides updates to the police when Finding of Fact judgments are made by Family Courts in child protection cases.

5.2.6 The decision of the court in August 2016 to order that joint parental authority for the children was shared between Mother and the Local Authority, was made following receipt of reports from the IRO and Childrens' Guardian opposing the initial Local Authority plan of adoption. The court was also able to consider a mental health assessment of Mother that suggested that her personality disorder was under control and she was able to provide *"good enough parenting"*. It seems that the court was influenced by the opinion contained within those reports and accepted that the family should return home. This arrangement was ratified by the court on 19 August 2016 and care orders made to that effect. This represented the fifth missed opportunity during the case to have robustly safeguarded the children by removing their Mother.

5.2.7 During the learning events held as part of this review, it became clear that some practitioners were uncomfortable with the decisions of the court and the direction of the case. These feelings centred around a view that Mother could be a manipulative individual and that the court was not doing enough to robustly safeguard the children. However, some professionals exhibited a complete lack of understanding around any mechanism to register their dissatisfaction with decisions made by the court or how they might provide challenge, if in their professional opinion, challenge were required. In reality, a mechanism to challenge professional decisions already existed and is described within the Tees Safeguarding Children Partnerships' Procedures webpage[6]. Even without knowledge of these procedures, perhaps the simplest mechanism to express any concerns would have been for practitioners to hold a professional discussion with their managers, which is encouraged within the procedure. There is no evidence that any such discussions occurred in this case. To address this issue in the future, agencies should ensure that training is provided to staff to make them aware of the existing professional challenge mechanism.

Recommendation

Agencies should develop Continuous Professional Development (CPD) training for their staff that informs them of the mechanism to register their objection to court decisions and encourages them to do so, if in their professional opinion, the court's decision is wrong and fails to sufficiently protect children.

5.2.8 During the review process, a comment made several times by a frontline practitioner particularly resonated with the Independent Reviewer. The comment in question was that in the practitioner's view, "*focus was lost on the injury"* (to Child T). This simple comment strikes to the heart of the issue by highlighting that agencies' primary responsibility during these months should have been to safeguard Child T and sibling. No matter what the maternal rights of Mother, the general desirability of keeping families together, or how well Mother presented to some professionals, the primary focus of agencies should have been to protect Child T and sibling. Those agencies took an overly optimistic view of Mother's parenting ability and in turn, under-estimated her capacity to cause harm to her children given the simple facts available to them. This represents a serious failing, and some professionals appear to have exhibited a lack of objectivity in their decision making. The completion of formal risk assessments that additionally record the rationale behind any decisions made would assist in preventing future decisions being made that do not prioritise the safeguarding of children.

Recommendation

Agencies should ensure that risk assessments are conducted before making critical care decisions that may result in children being returned to home environments that have previously represented (or might yet represent) a risk to their physical or mental health. This process should include a record of the rationale behind any decisions that are made.

[6] https://www.teescpp.org.uk/safeguarding-procedures/17-professional-challenge-and-resolution-of-professional-disagreement/

Chapter 6 – Fabricated or Induced Illness (FII)

6.1 Fabricated or Induced Illness (FII) suspicions

6.1.1 From late 2017 to mid-2018, a number of professionals began to raise concerns regarding the behaviour of Mother. These concerns were characterised by Mother's persistent claims that Child T was failing to properly develop or was suffering from various illnesses. All of these claims were subsequently refuted by health professionals and led to formation of the belief that Mother's behaviours may have been indicative of a case of Fabricated or Induced Illness (FII).

6.1.2 The main episodes of concern over this period of time, are summarised in the following section:

- Numerous reports from Mother to health professionals that Child T was failing to feed properly and that the child was failing to develop physically at an appropriate rate.
- Reports that Child T gags upon feeding yet was seen to be eating crisps without issue.
- Attendance at hospital claiming that Child T was suffering from hip-pain. Examination of Child T by hospital staff showed no evidence of any irregularities.
- Mother starting a Facebook page to raise funds to allow Child T to attend a private paediatric consultation in an attempt to identify previously undiagnosed autism.
- Mother using a pushchair to bring Child T to nursery and claiming to staff that Child T was not properly mobile. This claim was contradicted by the observations of nursery staff who noted that Child T had no mobility problems within nursery.
- Child T being brought to nursery wearing ear defenders and Mother claiming that this was due to Child T being sensitive to noise (which as is sometimes characteristic of children diagnosed with autism). Nursery staff noted that Child T displayed no sensitivity to noise within the nursery environment.
- Claims that Child T was unable to climb and properly move, that were contradicted by Health Visitors who observed Child T perform normal movement function within the home environment.
- Untrue reports to Health Visitors that doctors had decided that Child T would be having a Nasal-Gastric Tube fitted to assist with feeding.
- A report that Child T was suffering from a viral rash that proved to be untrue.
- Mother's refusal to allow some investigatory medical examinations of Child T in response to those health concerns she had raised herself.
- Mother requesting a change of Health Visitor as she claimed the original Health Visitor was unsupportive.
- Mother appearing anxious to obtain a diagnosis of autism for Child T.
- Claims that Child T was rushed to hospital by ambulance in an unconscious state due to dehydration, that appear untrue.
- Untrue claims made on Facebook that six paramedics were needed to revive an unconscious Child T.
- Complaints made against a dietician and who failed to agree with Mother's assessment of Child T's needs.
- Claims to Health Visitors that Child T was easily tired and lethargic that were contradicted by Child T's lively and adventurous behaviour.
- Unfounded claims that Child T ran with an abnormal gait due to hip pain and that painkillers were required to allow Child T to walk.
- Claims that Child T suffered from hip pain six out of seven days that were medically unfounded.
- Claims that Child T suffered from a skin condition to his feet that could not be medically corroborated.

6.1.3 On 16 July 2018, a Health Visitor expressed concerns that if Child T were ever removed from mother's care, there would be a risk to herself as Mother was aware of her vehicle and her place of work. Records state that there was no direct threat made against the Health Visitor and that Mother's grievance related to a complaint against a Health Visitor. The Health Visitor was advised to complete a risk assessment if concerned for her safety.

6.1.4 As a result of these reports, a Single Social Work Assessment was held on 20 August 2018 to discuss the case and specifically address the concerns of professionals around FII. During the course of the multi-disciplinary meeting, professionals raised significant concerns around the possibility of FII and a comprehensive risk assessment was conducted. Some of the comments noted by professionals within the document used to record the risk assessment are replicated below:

- *"She is showing the classic behaviours of FII. She is doctor shopping and showing intimidating behaviour towards professionals".*
- *"Typical behaviour of FII".*
- *"Very concerned that mum`s behaviours may escalate when she realises why we are concerned. Worried about the long-term emotional impact on Child T".*
- *"We are at a level that is nearing significant harm, and we worry that this will escalate to the next level".*
- *"There has been a lot of evidence shared today that mum is fabricating some kind of illness, despite numerous assurances, especially from dietician. Mum continues to push for a feeding tube to be inserted (percutaneous endoscopic gastrostomy (PEG)".*

6.1.5 Due to these concerns, it was decided to hold an Initial Child Protection Conference that took place on 5 October 2018. The conference was chaired by the IRO, who had been involved throughout the duration of the case, up to that point. Mother was invited to attend and participate in the conference discussions and provided explanations for the suspected FII concerns detailed by professionals. It was established during the conference that a Health Visitor had incorrectly plotted Child T's growth data on a centile chart used to measure the physical development of children. Acceptance of this fact by professionals, appeared to allay some of the concerns exhibited by Mother regarding Child T's development.

6.1.6 The view of the lead medical professional present at the conference was that Mother tended to exaggerate Child T's symptoms, misreports the outcome of consultations and sought changes in professionals who did not agree with her views. The doctor concluded that *"this is not a case of true FII but has elements of the carer`s behaviour which, if allowed to continue unchallenged, has potential for physical and emotional harm to the child, with this being in keeping with example 2 in the spectrum of cases where FII concern may arise"*. At the conclusion of the conference, a further risk assessment was conducted, and it was the collective view of the professionals present, that the element of risk represented by the suspicion of FII, had lessened significantly.

6.2 Analysis of Fabricated or Induced Illness (FII) suspicions

6.2.1 The long list of behaviours exhibited by Mother that led to suspicions of FII are extremely troubling. Professionals rightly identified the possibility that they were dealing with a case of FII and responded appropriately with multi-agency discussions to consider the available information. Analysis of the two risk assessments compiled in July and October discloses a significant de-escalation of FII concerns between the

former and the latter. When the significant change of stance was examined as part of this review, it was suggested that the explanations provided by Mother when confronted with evidence of her behaviours, reassured professionals. It is striking that such a sea change in attitudes occurred on the basis of verbal explanations provided by Mother and begs the question of whether sufficient levels of professional curiosity were exhibited at this time. Professional curiosity could be characterised as a robust examination of available evidence, reflecting upon information received and refusing to accept a single source of information at face value. That said, it is worthy of note that following the October 2018 conference when Mother was fully appraised of professional concerns over her behaviour, those specific FII related behaviours that concerned professionals, appeared to settle.

6.2.2 During the October 2018 conference, medical opinion was offered that placed Mother at the level of Example 2 within the accepted FII matrix of behaviours[7] (*Child's symptoms are misperceived, perpetuated or reinforced by the carer's behaviour; carer may genuinely believe the child is ill or may have fixed beliefs about illness*). Examination of the matrix document during the review disclosed that Mother actually appeared to exhibit many of the characteristics of Example 3 within the FII matrix of examples (*carer actively promotes sick role by exaggeration, nontreatment of real problems, fabrication (lying) or falsification of signs, and/or induction of illness - sometimes referred to as 'true' FII*). Underlying factors within Example 3 include *"a history of frequent use of, or dependence on, health services; carer may have personality disorder or the child's 'illness' may be serving a purpose for the carer".* During this review, the doctor who advised the October conference was invited to provide clarity around this apparent discrepancy. The doctor agreed that many of the characteristics of an Example 3 case were present, which made this a borderline case that lay between Example 2 and Example 3. Further helpful clarity was provided by the doctor who explained that a case of true FII would involve a carer proactively seeking to induce illness in a child, which was not a feature of this case.

6.2.3 The conduct of Mother during the months leading to October 2018 conference, should have led to the suspicion that Mother's mental health was beginning to deteriorate. Whatever the motives behind Mother's behaviour during this period, it seems to have been indicative of a deterioration in Mother's ability to rationally assess Child T's health needs. This behaviour should have acted as a red flag to the local authority who at that time still retained joint-parental responsibility for Child T and sibling. Given that Mother was known to have been previously diagnosed with personality disorder, a mental health assessment should have been commissioned at this point, however no such assessment was ever conducted.

6.2.4 During the two meetings held to discuss FII concerns in July and later in October 2018, not all agencies were fully sighted on Mother's mental health history. For example, the Consultant Paediatrician who provided expert guidance on the likelihood of this case amounting to FII was not aware of Mother's full mental health history. Though this did not materially change the doctor's assessment of circumstances in the case, it does provide an example of inadequate information sharing of relevant material between agencies. During this review, some evidence of a reluctance to share adult mental health records among partner agencies for reasons of patient confidentiality was noted. It is clear that Mother was often anxious that her mental health history was not shared and on occasion, directly challenged health professionals on this issue. Moving forward, agencies should ensure that safeguarding children takes precedence over patient confidentiality when deciding whether to share relevant material such as adult mental health history.

[7] Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians

6.2.5 While the behaviours exhibited by Mother during this period may not have amounted to a true case of FII, they still represented evidence of conduct that might well have amounted to emotional abuse of Child T over an extended period of time. It is worthy of note that as far back as March 2016, Mother was seeking medical advice for medical conditions suffered by Child T, that could not be substantiated. Once again, the cumulative effect of all the known factors in the case, together with the information gathered into the suspected case of FII, could, and should have caused the local authority to return to court with an application to remove one or both of the children from the family home and place them into care. This opportunity was not taken and represents the sixth occasion when a decisive safeguarding intervention could have been made but was not.

Recommendation
Agencies should take a risk-based approach to safeguarding and consider the cumulative effect of known factors in a case rather than treating separate episodes of concern as individual matters, managed in isolation.

Chapter 7 - Discharge of Care Order

7.1 Discharge of Care Order (December 2019)

7.1.1 During the latter part of 2018 and throughout 2019, the assessment of the local authority was that Mother's behaviour had stabilised and that any concerns over the welfare of Child T and sibling were fast receding. Child in Our Care assessments and review meetings held during this period report that both children were doing well, and that Mother enjoyed a good relationship with them.

7.1.2 On 18 June 2019, a local authority Legal Meeting was held when it was decided that there was no longer any justification for continued shared parental responsibility between Mother and the Local Authority. The meeting recommended that an application should be made to the court with a plan to revoke the existing care order. On the 15 July 2019, this decision was ratified by a Social Care Scrutiny Panel with a recommendation that further checks on Mother's mental health condition should also be undertaken. On 21 August 2019, the Community Mental Health Team were contacted, and a Community Psychiatric Nurse confirmed that there were no concerns regarding Mother's mental health at that time. The Community Mental Health Team stated that they would work with Mother to complete an initial assessment and could provide support to Mother should her mental health begin to deteriorate. It was noted at this time that Mother refused permission for her health information to be shared among agencies.

7.1.3 From January 2019 onwards, Health Visitors recorded that Mother began to state her belief that Child T was displaying autism traits and requested that an autism diagnosis was pursued. On 24 January 2019, initial assessment of the case found that Child T did not meet the criteria for onward referral to autism services. Mother was advised that the Early Help outreach team and nursery could provide additional support if required. The next day, Mother made a series of phone calls to health services insisting that Child T was displaying classic signs of autism. Mother was informed that a further examination of the facts would occur, and a referral made if required. On 7 February 2019, a multi-disciplinary meeting was held to discuss Mother's concerns and to assess Child T's progress. It was noted at this time that Child T had delayed speech and language skills and limited engagement with observers. Mother relayed concerns around the level of care provided and staff ratio allocated to Child T by the current nursery school. It was also noted that a previous nursery had offered a higher level of support, but following a dispute with staff, Mother chose to move Child T to the current nursery.

7.1.4 Examination of records shows that during 2019, Tees, Esk and Wear Valley Foundation Trust (TEWVFT) made a referral in relation to mothers self-reported Obsessive-Compulsive Disorder (OCD) symptoms. These symptoms took the form of obsessive cleaning and anxiety that her children would become ill or that harm would come to them if she did not clean. Mother also disclosed that she was restricting her own food intake, cutting herself as a coping strategy and that she had a long history of this type of behaviour. This resulted in ongoing support from the Stockton Affective Team being provided and medication was prescribed. As a result of these disclosures, the potential impact of mothers mental health on the children was discussed with Children Social Care on several occasions.

7.1.5 During 2019, the North East Ambulance Service received two telephone calls from Mother via the 111 service. Both of these calls related to Mother self-harming.

On 4 December 2019, the Head Teacher of the Primary School provided feedback in response to a request from the Childrens' Guardian. The school reported that Mother's anxiety and OCD could impact upon the children (Child T and sibling). The head teacher went on to state that Mother worked well with the school and that there were no safeguarding concerns.

7.1.6 The local authority's application to discharge the 2016 care order was finally submitted in December 2019 with the support of the Childrens' Guardian and the IRO. On 19 December 2019, the same judge who had made the care order in 2016, discharged the order and returned sole parental responsibility for Child T and sibling to Mother.

7.2 Analysis of decision to discharge Care Order (December 2019)

7.2.1 The decision to discharge the Care Order in December 2019 appears to have been made without all relevant material being considered. Social Care and the IRO believed that there was no indication that Mother had not remained stable in her mental health and this belief was held despite numerous reports of erratic behaviour during the earlier 2018 investigation into suspected FII. Additionally, information from North East Ambulance Service (NEAS) that described two occasions of self-harm by Mother was not considered, nor was a referral to Stockton Affective Team for issues relating to self-harm (cutting), OCD and a potential eating disorder. Collectively, these factors should once again have acted as a red flag to agencies that Mother's mental health was less than stable and that she was struggling to cope.

7.2.2 There is no evidence that any robust, inter-agency examination of Mother's mental health took place before an application was made to court to discharge the care order. If this had occurred, it is likely that it would have led to a far greater understanding of the risk represented by Mother's fragile mental health condition. Any future attempt by a local authority to discharge a care order should be preceded by a thorough and comprehensive inter-agency discussion that includes the exchange of information relating to a carer's mental health history. If this had taken place and all information was properly considered, it may have prompted discussion around the merits of taking Child T and sibling into local authority care rather than applying to discharge the existing care order. Failure to do this represents the seventh occasion when agencies might have reasonably chosen to remove the children from Mother to protect them. Instead, the local authority chose to apply for discharge of the existing care order that resulted a lessening of supervision in place around Mother.

Recommendation
Prior to any local authority application to discharge a care order in favour of a parent or carer, an inter-agency discussion should take place and agencies should exchange information to ensure that they are fully sighted on relevant facts, including the mental health history of parents or carers.

7.2.3 Some professionals were involved in the management of the case for an extended period of time including in some cases, for a number of years. Views gathered during the course of this review, indicated that this provided an element of continuity which was a positive in allowing a productive working relationship to develop between the professional and Mother. While the concept of continuity within social care case management can bring many positives, agencies should guard against a comfortable familiarity developing between professional and client.

This case exhibits some features of this phenomenon and an examination of material gathered during the course of this review included comments made by professionals, relating to their period of involvement in the case. These comments include the observation that *"Mother had a loving and proud relationship with her sons, and they had a close and loving relationship with her. The concept of harming the children is not one ... would have considered her capable of"*. Given that the professional making those comments was fully sighted on the circumstances of the case, including the 2016 Finding of Fact Hearing which confirmed that Mother was responsible for breaking the Child T's femur, it is extraordinary that they were not able to conceive of a scenario when Mother might be capable of harming her children. This does lead to the belief that some of the decision making at this time, lacked sufficient professional objectivity. To guard against this, agencies should ensure intrusive supervision of professionals working with clients for an extended period of time, to confirm that professional curiosity is maintained, and an objective view is taken when making decisions.

Chapter 8 - Step Down of Services

8.1 Step Down of Services (April 2020)

8.1.1 Daisy Chain is a charity that supports families who have children diagnosed with autism. From December 2019 – June 2020, Mother became a heavy user of the Daisy Chain project following a self-referral. Despite Child T still having no diagnosis of autism, Daisy Chain provided resources and strategies to Mother that she might better manage Child T's needs and behaviours. In total, there were 48 separate points of contact between Mother and staff from Daisy Chain in the period from January 2020 until June 2020. This included numerous telephone contacts during the lock-down period that resulted from the Covid-19 pandemic. The frequency of contact from Mother increased significantly from the start of April 2020 and eventually grew to contact every 1-2 days. A feature of the contact was Mother relaying behaviours exhibited by Child T, such as not drinking from a cup, poor toilet habits and numerous screaming tantrums. By June 2020, Mother was reporting to support workers that she was struggling to cope and continued to receive telephone support from the charity.

8.1.2 A telephone call from Mother was received by Harrogate and District Foundation Trust in early February 2020 advising that Health Visitor support would not be needed in the future. Mother stated that the previous care orders had been discharged (which was true) and that she had also been discharged from social care (which was not true). No further contact was received by that agency from Mother, other than a request in May 2020 for a continence referral for Child T as he was still not able to use a potty.

8.1.3 On 10 February 2020, Child and Adolescent Mental Health Services (CAMHS) received a referral for an autism assessment of Child T. An initial assessment was conducted with Mother and a social worker on 27 February 2020. During this meeting, Mother disclosed that she suffered from severe OCD and received support from mental health services. Mother stated that her concerns around Child T's behaviour had led to her seeking a referral for an autism assessment. Mother also stated that Social Care were intending discharging her and that she had begged them to keep the case open. From March 2020, Mother's GP surgery noted a marked increase in contact from Mother, most of which related to her concerns around the health of Child T.

8.1.4 During this period, the relationship between Mother and the childrens' school began to deteriorate with the school noting that Mother would only engage with certain teachers and would complain about the conduct of others. The school became aware that Mother was posting material on Facebook suggesting that Child T was suffering from Covid-19 and that the school should be closed down. This information was shared with Social Care and Mother was known to have expressed unhappiness that the school had shared that information. During the period of the lockdown, Mother was offered the option of allowing Child T and sibling to continue attending school. Mother refused this offer and in lieu of the children attending school, telephone contact was maintained with Mother three times each week. During these calls, Mother advised school staff that all was well with herself and the children.

8.1.5 On 7 April 2020, following requests from Mother, North Tees Hospital Foundation Trust (NTHFT) referred Child T to the Sunflower Sensory Programme which is an initiative aimed at children displaying autistic related sensory behaviours. However, due to the Covid-19 pandemic, Child T could not be offered a place on the programme and was placed on a waiting list. Mother stated at this point that she was concerned about having been discharged from social care, although it should be noted that the local authority do not record Mother has having been discharged until the following day.

8.1.6 On the 8 April 2020, the decision was taken to end Childrens Social Care involvement in the case and step down to Early Help. By late April 2020, Mother was stating to agencies including CAMHS that she was struggling with the Covid-19 situation and that she also had her own health concerns following a cancer scare. Mother was given support during the course of telephone calls and was signposted towards other services that might provide additional support for any issues related to Child T. CAMHS ensured at this time, that the Stockton Affective Team were updated regarding details of the contact received from Mother as it was their assessment that the Covid-19 situation was having an impact upon her mental health.

8.2 Analysis of decision to Step Down services (April 2020)

8.2.1 During the course of this review, information emerged that suggested that Health Visitors had been aware of Mother attempting self-harm by taking an overdose of lactulose in February 2020. Health Visitors were unaware at that time of Mother taking any medication and Social Care were unaware of Mother's episodes of self-harm. This amounts to a failure in communication between the hospital that treated Mother, the Health Visitor team, and Social Care. It is clear that Mother was anxious that medical information that might have disclosed about her mental health status, should not be shared with agencies that were involved in child protection. It is likely that some concerns around patient confidentiality may have been driving the failure to share relevant information (as alluded to earlier in this report), though it may equally be due to systemic failure. Once again, it is vital that agencies share information that might potentially safeguard children. This is especially relevant when that information relates to the mental health of a parent or carer.

8.2.2 The decision of Social Care on 8 February 2020, to step down services to Early Help was made without the benefit of any multi-agency discussion. Professionals from some agencies found out that the decision had been taken to step down services from Mother herself and were never officially notified by Social Care. This amounted to a serious failing on the part of Social Care and served to ensure that potentially vital, up to date information concerning Mother's mental health was never discussed by professionals with an understanding of the case. During some interactions with professionals, Mother was very clear in stating her opposition to any proposed step down, and if a multi-agency meeting had been held, this information might have been better understood by Social Care. However, it should also be acknowledged that Mother did have a history of making contradictory and untrue statements to professionals and the possibility that this was done deliberately to manipulate situations for her own purposes, cannot be discounted.

8.2.3 Analysis confirms the view that that the step down of Social Care services to Early Help was managed very poorly in this case. No risk assessment of any kind was conducted prior to the step down of services and no hand over of the case to Early Help was conducted. The social worker responsible for the case was managing a high case load and it is thought that this led to them resigning their position at the time of step down. Due to a (now resolved) issue with Social Care IT systems, the electronic referral to Early Help did not arrive and the case was lost within the system. In future cases, professionals must ensure that handovers from one service to another are properly completed and that confirmation is obtained that the receiving agency is in receipt of any referral and all associated case material.

8.2.4 Given the extensive history associated with the case, at the very least, Social Care should have called a multi-agency meeting to ensure that all was well from the perspective of each partner agency. It is clear that opportunities to exchange relevant information were missed and that communication between Social Care and other agencies was extremely poor. A picture is painted of Mother as a person living a relatively socially isolated lifestyle, apparently without the support of family, while attempting to cope with two young children. This situation was undoubtedly exacerbated by the effects of the Covid-19 pandemic when agencies tended to withdraw face to face services and replace them with telephone contact. As society embraced social isolation as a necessary response to the pandemic, it is feasible that becoming further distanced from other adult contact, may have hastened Mother's declining mental health situation.

8.2.5 Given the background to this case and in particular, the 2018 suspicions of FII, it is clear that Mother's renewed determination to pursue a diagnosis of autism for Child T, together with social media claims of illness and objectionable behaviour towards professionals, should have acted as an early warning to agencies that all was not well. At the very least, these facts should have elicited a multi-agency response to establish if the previous FII suspected behaviours were beginning to re-surface. In future, cases with similar levels of complexity to those seen in this case, the scheduling of regular Care Team meetings would be helpful in acting as a multi-agency group, already well placed to exchange information and consider the appropriate point for a formal step down of services.

Recommendation
In complex cases, regular multi-agency meetings should be held to exchange information and ensure that all agencies are fully sighted on changing circumstances. This group should also consider and agree the appropriate point for formal step down of services.

8.2.6 In taking the decision to step down services, social workers made a number of assumptions around the stability of Mother's mental health. While a full psychiatric and psychological assessment of Mother was made in 2016, there was an assumption made that her Emotionally Unstable Personality Disorder remained as under control in 2020, as medical professionals thought it to have been in 2016. This assumption was dangerous and, in all likelihood incorrect. Where extensive mental health history exists in carers with responsibility for children, agencies should ensure that up to date mental health assessments are completed before the step down of services are considered.

Recommendation
Where extensive mental health history exists in carers with responsibility for children, agencies should ensure that up to date mental health assessments are completed before the step down of services are considered.

8.2.7 Examination of the facts associated with the step down of services by Social Care indicate poor supervision of the case. A failure by supervisors to robustly examine those decisions made by practitioners together with an absence of involvement in what amounted to an extremely challenging case are all evident. It is essential that supervisors from all those agencies involved in safeguarding, support frontline practitioners and provide scrutiny and oversight to the professional conduct of cases. In especially complex cases such as this, multi-agency supervision and scrutiny is desirable and would assist in ensuring that agencies make the right decisions.

Recommendation
In complex safeguarding cases, stakeholders should create multi-agency supervision panels to scrutinise decision making and ensure effective case management.

8.2.8 Social Care had no policy or guidance relating to the step-down of services that was available to practitioners as a point of reference. Definitive policy or guidance documents can drive consistency in decision making and act as a valuable resource to inexperienced practitioners.

Recommendation
The Local Authority should develop clearly defined policy and guidance around the step-down of social care services and make it readily available to practitioners.

Chapter 9 – Terms of Reference Questions

9.1 Whether the injury to Child T's femur in 2016 was a precursor to the attempted murder of Child T in 2020?

9.1.1 While it is impossible to definitively state whether the injury to Child T's femur was a precursor to the later offence of attempted murder perpetrated against him, all available evidence indicates that it was. The injury to Child T's femur was almost certainly caused by Mother and indicates her capacity to cause serious physical harm to an infant. Mother's criminal and mental health history, together with the erratic behaviours displayed during the years following the broken femur should have caused agencies to act decisively in protecting Child T by removing him from the domestic setting where both the broken femur and the attempted murder took place.

9.1.2 How did information around parental mental health, Mother's historical information (LAC child), parental behaviours and support networks inform decision-making in relation to the non-accidental injury in 2016?

9.1.3 Information regarding Mother's previous criminal and mental health history was known to agencies at an early stage during the case. The police, health and social care all exchanged information and this information was also later made available to the Family Court. It was initially thought that Mother possessed a strong support network of friends and neighbours and in the early stages of the case, that network was utilised to care for sibling and to later supervise Mother. Subsequently, these arrangements were found to be ineffective and called into question the effectiveness of Mother's support network. There is no evidence that any of these factors particularly influenced decision making following the presentation of Child T at hospital with the broken femur injury. Despite understanding Mother's criminal and mental health history, neither social care nor the police saw fit to remove Child T and sibling from the family home and instead allowed Mother to return home with both children (following medical treatment to Child T) under extremely lax supervision arrangements. There is no evidence that any formal risk assessment was completed at this time and little evidence of the joint investigation that was agreed at a Strategy Meeting, ever taking place.

9.1.4 How did information-sharing between Social Care (finding of fact) and Police inform decision-making?

9.1.5 Information regarding the Finding of Fact judgement that Mother broke Child T's femur did not inform decision making. Social Care did not communicate the judgement to the police and the police remained unaware of the judgement in the critical early months of the case. This failure is addressed within Recommendation 2.

9.2 Was decision-making appropriate in relation to the Courts decision to grant joint parental responsibility to the LA and Mother, versus the Local Authority plan for adoption in 2016?

9.2.1 In responding to this question, it should be acknowledged that the review was not able to reflect upon the full range of material considered by the court during its involvement with the case. Without this, it is difficult to definitively state whether the court's decision making was appropriate or not. What is known is that the court received various practitioner reports and that they seem to have informed subsequent decision-making. However, these reports recommended that Mother and her children should be kept together while failing to identify any significant risks associated with Mother's mental

health. This led the court to adopt a position that was at odds with Local Authority attempts to safeguard the children by removing them from Mother.

9.2.2 What information went to court to inform court decision-making?

9.2.3 The court was provided with details of Mother's criminal and mental health background as well as detail on her troubled upbringing which included episodes of sexual abuse. The court was also sighted on the history of non-compliance with supervision arrangements in the period following discovery of the broken femur, as well as her confrontational behaviour towards supervisory staff. Additionally, the court was provided with several medical reports including one which detailed the spiral fracture to Child T's femur as well psychiatric and psychological reports assessments of Mother that were completed during her stay at the Mother and Baby Assessment Centre (Chrysalis). The court was also able to consider comprehensive reports from the Childrens' Guardian and the IRO detailing their opposition to the local Authority plan for adoption.

9.2.4 What was the multi-agency view of the court's decision and how was this challenged?

9.2.5 The multi-agency view of the court's decision was mixed with some practitioners viewing the court's decision making as appropriate while others were left feeling deeply uncomfortable. Ultimately, those practitioners who disagreed with the court's decision did not feel empowered to register their opposition to the plan and were not aware of any mechanism that would have enabled them to do so. This issue is specifically addressed within Recommendation 3. While the Local Authority did make separate attempts to place the children into foster care and later to have them adopted, the court indicated opposition to those applications. The Local Authority could have explored legal mechanisms to challenge court's decisions but failed to do so.

9.2.6 Was the outcome of the decision shared with the multi-agency partnership? If so, what was the response of the multi-agency partners?

9.2.7 The outcome of the court's decision was not escalated to the Hartlepool and Stockton-on-Tees Safeguarding Children Partnership (HSSCP). It is unfortunate that this did not happen as the senior professionals who comprise the partnership would have been better placed to instigate any challenge to the court's decision, than frontline agency practitioners.

9.3 Was decision-making around FII appropriate?

9.3.1 During the course of multi-agency discussions into the potential case of FII, there were two separate risk assessments conducted. The first of these rightly indicated that a heightened level of risk existed and that the matter should be escalated to an Initial Child Protection Conference (ICPC). However, following the later ICPC (which was attended by Mother), professionals judged that the level of risk was significantly reduced. This assessment appears to have been made purely on the strength of verbal explanations provided by Mother during the ICPC in response to challenges around her behaviour. Taking these explanations at face value displayed a lack of professional curiosity while also risking the possibility that Mother may have been untruthful or attempting to manipulate professionals.

9.3.2 The medical opinion that was provided to the ICPC stated that Mother's behaviours lay within Example 2 of the FII matrix that is used to guide medical professionals. Following review, it is clear that many of the behaviours displayed by Mother were characteristic of Example 3 on the matrix. However, the consultant paediatrician offering that opinion provided clarity to this review and indicated that this was not a true case of FII as Mother had not actively sought to induce illness in child T. On that basis, the decision made by the ICPC around FII was ultimately led by the medical evidence and was appropriate. However, while not a case of true FII, the behaviours exhibited by Mother may well have amounted to emotional abuse of Child T and the ICPC should have intervened to ensure that Child T was protected from further harm. The partners present decided that no further intervention was necessary, and this decision was not appropriate.

9.3.3 What information was shared from all agencies? How was this understood?

9.3.4 Information sharing did eventually take place during the two multi-agency meetings that were held to address the suspected case of FII. However, there is some evidence that information was not shared effectively in the months leading up to these meetings. It is known that the consultant paediatrician who provided medical opinion was not previously sighted on Mother's mental health history and this is symptomatic of a failure by agencies to properly exchange relevant information. While the wider case history was known to professionals who considered the FII issue, there is no evidence that they arrived at any assessment of risk having considered the full history of the case from 2016, rather than only the immediate behaviours that led to FII being suspected. This issue is addressed within Recommendation 5.

9.3.5 What was the multi-agency response to FII at that time?

9.3.6 The multi-agency response to the suspected case of FII was good with all relevant agencies eventually sharing information to address the behaviours that were being displayed. However, it is reasonable to assume that if those behaviours had been considered as part of a wider examination of all known case facts, a more comprehensive safeguarding response might have been implemented.

9.4 Was there a deterioration in Mother's mental health leading up to the incident and, if so, was this risk-assessed in terms of impact upon the children and appropriately communicated with professionals working with the family?

9.4.1 All available evidence indicates that Mother did suffer a deterioration in her mental health leading to the incident. Some information was shared between agencies but crucially, Social Care were not in receipt of relevant information when important decisions were made about the conduct of the case. This was the situation when the decision to step-down was made in April 2020 and was also the situation when the earlier decision to apply for revocation of the care order (sharing joint parental authority of Child T and sibling between Mother and the Local Authority) was made in December 2019.

9.4.2 What did the decision-making look like in relation to the step-down and were all relevant agencies involved / informed?

9.4.3 The decision to step-down was taken unilaterally by Social Care without the involvement of other agencies. This represents a significant failing on the part of Social Care and Recommendations 7 and 8 relate to the step-down process.

9.4.4 What information had been taken into account when the decision to step down was made?

9.4.5 It is reasonable to assume that existing Social Care records detailing the history of the case might have been referred to as part of the decision to step-down in April 2020. However, there is no evidence to substantiate this view and there is no evidence that any multi-agency information was considered at this time. No records detailing the rationale behind the decision to step-down were made by Social Care.

9.4.6 Did this include relevant information from all services, particularly MH services?

9.4.7 There is no evidence to suggest that information from other agencies (including mental health services) was either sought or considered by Social Care during the decision-making process.

9.4.8 What risk-assessment was undertaken at that time and were all historical factors taken into account alongside current circumstances?

9.4.9 No risk assessment was undertaken as part of the decision making into the step-down of services by Social Care. It is believed unlikely that any historical factors influenced the decision-making process, though the lack of any documented risk assessment makes it impossible to categorically confirm this view.

9.4.10 Did workload pressures impact upon decision-making?

9.4.11 There is some evidence to suggest that workload pressures may have contributed towards organisational failings relating to the step-down of services that have been identified during this review. The social worker who made the step-down decision resigned her position around the time that the decision was made, citing workload pressures associated with a high case load. Managers from Social Care confirm that staffing pressures were exacerbated during the Covid-19 pandemic lock-down, with many staff absent from work. It is therefore reasonable to assume that some workload pressures may have contributed towards the absence of practitioner thoroughness and lack of supervisory scrutiny that was applied to this decision.

9.4.12 What difference would any added information have made to the decision and potential challenge around this?

9.4.13 If all additional relevant information including details of Mother’s deteriorating mental health and recent episodes of attempted self-harm had been in the possession of Social Care and considered, it is likely that the decision to step-down would not have been made. As detailed in Recommendations 7 and 9, regular multi-agency Care Team discussions and multi-agency supervision of the case would have ensured appropriate risk-based decision making.

Chapter 10 – The lived experience of Child T

10.1 In attempting to assess what life was like for Child T during the time period reviewed, a number of difficulties exist. Ideally, the review would have included the opportunity for the reviewer to meet Child T and to ask him about his home life. Unfortunately, Child T is still only four years old (at the time of writing) and while this should not discount him from being given an opportunity to speak, further difficulties are presented by the fact that Child T does not have the speech and language skills to allow this. Further obstacles to communication with Child T and his family were represented by the ongoing (at the time of writing) government Covid-19 restrictions on social interaction and movement.

10.2 Ideally, the review would have also spoken to Mother during the initial stages of the review. However, given the criminal prosecution which was then being undertaken against her, the advice of the Crown Prosecution Service was that Mother should not be approached until criminal proceedings were finalised. Following the conclusion of those proceedings and subsequent conviction, Mother was spoken to and afforded the opportunity to contribute towards the review. Mother insisted that she had never caused any harm to either of her two children and that she had provided a happy home for them. Mother stated that during the lock-down period, she continued to take the children to a local park where they were able to play and enjoy outdoor activity. Mother also claimed that Child T did not exhibit any challenging behaviours at home during this period, and that he liked to play with the dogs that were kept as pets within the home. Mother stated that she had a good relationship with the children's school, though she chose not to allow sibling and Child T to attend school during the lock-down period due to her fear that they might contract the Covid-19 virus. Mother did acknowledge that her mental health began to decline during 2019 and continued to deteriorate to such an extent that she was unable to remember the incident that led to her arrest in June 2020, and subsequent conviction.

10.3 It is possible to gain some further understanding of what life was like for Child T by examining the evidence that exists concerning his home conditions. Several references are made to the house being messy and cluttered within documents recording visits by social workers. Those reports are usually focussed less on the condition of the home and more on the interaction between Mother and her children. Other social care reports contain little more than a record of the date and time that a visit was conducted with no other detail recorded. Records of visits conducted by Health Visitors to the home address also frequently failed to properly describe home conditions. Ideally, these reports would have painted a far more comprehensive picture of living conditions so that a more informed picture could be built up as to their suitability. In future cases, social workers and health visitors must ensure that records of visits made to the homes of vulnerable children, contain descriptions of living conditions so that a consistent picture of suitability (or otherwise) can be developed.

10.4 It is known is that at times, up to nine dogs were kept within the family's home address, living alongside Mother, Child T and sibling. While Social Care reports make little or no reference to the impact upon the children of sharing their home with so many animals, some insight was provided in 2018 by the unusually detailed observations of a Health Visitor. At that time, it was noted that the house was messy, contained seven dogs and had a strong odour of dogs and cooking. The kitchen was observed to be dirty and both children were seen to have dirty feet. Unfortunately, these observations were not shared during an initial multi-agency meeting that was held later the same month to discuss FII concerns.

10.5 During one of the learning events held as part of this review, the police disclosed that in 2016, it was noted that rat poison was found on the floor of one of the bedrooms within the home address. The police were not able to describe whether that information was ever passed to Social Care. In January 2018, the police received a report that a stray dog had bitten two members of the public. A call from a member of the public suggested that Mother had taken the dog to her home address and that they were concerned that a dangerous dog was being taken into a house containing two small children. The police took no action to follow-up this report and also failed to share the information with Social Care.

10.6 In June 2017, Child T was found to have a bite injury to his arm that was later found to have been caused by a child under the age of six. Sibling, who as well as being two years older than Child T was known to be far more physically robust, was believed to have been responsible for biting Child T. Later that year in August 2017, a letter of concern was received from a member of the public who was concerned about Child T and sibling. The letter stated that there were large numbers of dogs within the family home, and that the children were sick and neglected. It was also alleged that one of the dogs had died as it had eaten some of Mother's medication that had been left where the children could have accessed it. It was also alleged that Mother hides dogs if she knows that social workers are attending her home address and that it was terrible how Mother treated her children. It is not believed that receipt of this letter elicited any specific response from Social Care to the allegations made. In June 2020, following police attendance at the family home after the attempted murder of Child T, it was noted that the house was untidy with mess scattered all over the floor. The house was dirty, and a number of dogs and other animals were being kept in the kitchen.

10.7 While acknowledging that any assessment of the suitability of home conditions by professionals involves an element of subjectivity, a mechanism should be provided to practitioners that assists them in making an assessment. During the course of this review, professionals indicated that a system of Graded Care Profiles were being introduced to assist Health Visitors in making consistent assessments of home conditions. This is a positive development and should be fully embedded within health services and shared with partners to encourage cross-agency consistency.

Recommendation
A system of Graded Care Profiles should be introduced to assist professionals in making consistent assessments of home conditions. Ideally, this system should be adopted by all agencies involved in safeguarding children to encourage cross-agency consistency.

10.8 In making an assessment of the lived experience of Child T, this review found that he was allowed to live in unsuitable and potentially dangerous home conditions. While there is evidence from professionals that under their gaze, Mother exhibited a warm and loving attitude towards Child T, within the home he was subjected to harm on a consistent basis. This harm ranged from serious assaults perpetrated by Mother, living in unsanitary conditions, potentially being exposed to dangerous animals and substances, being bitten by his sibling, as well as exposure to the emotionally abusive behaviour of Mother during the suspected FII episode. It is significant that the latest information provided by professionals to this review suggests that both Child T and sibling have thrived since being placed in foster care in June 2020.

Chapter 11 - Conclusion

11.1 In this case, the review process involved engagement with a great many practitioners, managers and senior leaders from the agencies involved. All of the professionals consulted, fully embraced the review process, displaying admirable openness and honesty in their contributions. The majority of those professionals acknowledged failings in the management of the case and that represents a welcome and encouraging starting point, from which the process of improvement must begin.

11.2 Ultimately, the case discloses a number of concerning failures by agencies in their attempts to safeguard Child T and highlights areas of learning for all agencies involved in child safeguarding. This learning will be relevant for agencies within the Hartlepool and Stockton-on-Tees areas, and beyond.

11.3 Agencies involved in child safeguarding must prioritise the protection of children beyond all other considerations. Child T first came to the attention of agencies as a four-week-old infant who had sustained a serious, non-accidental injury. Child T was extremely vulnerable and in need of protection against further harm. The safest and most definitive way of providing Child T with the protection to which he was entitled, would have been to have removed him from the environment where he was exposed to the risk of further harm. Opportunities to take this course of action were considered a number of times but were never taken. Whatever the peripheral considerations in the case, agencies should have maintained a determined focus on safeguarding Child T and his older sibling. Sadly, they did not, and Child T was exposed to further harm over the course of the following four years.

11.4 A culture of risk-based and documented decision making by professionals should be encouraged among those involved in safeguarding. Upon review of this case, critical decisions were made that were not based on risk and were not documented, thus preventing subsequent scrutiny. To guard against similar mistakes being made in the future, robust supervision of cases must be applied by managers in all cases and especially so in cases that involve extreme vulnerability or serious injury. This case exhibited both elements and Child T deserved a better response than that which he received from some of the agencies involved.

11.5 Over a four-year period from 2016-2020, a number of opportunities were presented to professionals to consider the case in its entirety. As various incidents occurred, this should have allowed an opportunity for professionals to reflect upon all relevant risk factors. There is little evidence that this approach was taken by professionals. Given the large amount of information that was available to professionals and whatever their initial stance towards Mother and the risk she potentially represented, eventually a tipping point should have been reached when decisive action was taken to safeguard Child T. Professionals managed incidents such as the suspected case of FII as a single issue of concern rather than applying a wider view and considering the escalating cumulative risk associated with the case.

11.6 As with many other previous cases, failures in the prompt exchange of relevant information between agencies is a feature of this case. The criminal and mental health history of parents and carers can contain important indicators of risk and the exchange of this information should be prioritised where child safeguarding concerns exist. Exchanges of information between agencies regarding Mother's ongoing mental health happened sporadically and did not contribute towards a comprehensive understanding of the escalating level of risk in this case.

Far closer monitoring of a parent or carer's ongoing mental health is required in the future should they have responsibility for the care of children.

11.7 The later part of the case covers the period of lockdown which was implemented by the government in response to the Covid-19 pandemic in Spring 2020. While this extraordinary event caused additional pressure to fall upon safeguarding agencies, most were able to maintain services by switching from face to face, to telephone contact. During the weeks leading up to the attempted murder of Child T, Mother was still accessing high levels of contact and support with the voluntary sector in the form of Daisy Chain, providing a particularly strong response. While it is impossible to determine whether the pandemic lockdown ultimately contributed towards Mother's deteriorating mental health, it cannot be discounted that social distancing and the lack of face-to-face adult contact may have contributed towards a sense of isolation. Despite the best efforts of professionals attempting to provide support during this period, this may have been one of the factors that led Mother to act as she did in attempting to cause serious injury to Child T, though this view is entirely speculative.

Chapter 12 - Recommendations

1. In the spirit of true partnership working to protect children, agencies should feel empowered and be encouraged to provide professional challenge to one another regarding actions taken and rationale for decisions made. To facilitate this process, a structure to provide challenge opportunities should be incorporated into multi-agency child protection meetings.

2. Social Care and the court should develop a mechanism that provides updates to the police when Finding of Fact judgments are made by Family Courts in child protection cases.

3. Agencies should develop CPD for their staff that informs them of the mechanism to register their objection to court decisions and encourages them to do so, if in their professional opinion, the court's decision is wrong and fails to sufficiently protect children.

4. Agencies should ensure that risk assessments are conducted before making critical care decisions that may result in children being returned to home environments that have previously represented (or might yet represent) a risk to their physical or mental health. This process should include a record of the rationale behind any decisions that are made.

5. Agencies should take a risk-based approach to safeguarding and consider the cumulative effect of known factors in a case rather than treating separate episodes of concern as individual incidents, managed in isolation.

6. Prior to any local authority application to discharge a care order in favour of a parent or carer, an inter-agency discussion should take place and agencies should exchange information to ensure that they are fully sighted on relevant facts, including the mental health history of parents or carers.

7. In complex cases, regular multi-agency meetings should be held to exchange information and ensure that all agencies are fully sighted on changing circumstances. This group should also consider and agree the appropriate point for formal step down of services.

8. Where extensive mental health history exists in carers with responsibility for children, agencies should ensure that up to date mental health assessments are completed before the step down of services is considered.

9. In complex safeguarding cases, stakeholders should create multi-agency supervision panels to scrutinise decision making and ensure effective case management.

10. The Local Authority should develop clearly defined policy and guidance around the step-down of social care services and make it readily available to practitioners.

11. A system of Graded Care Profiles should be introduced to assist professionals in making consistent assessments of home conditions. Ideally, this system should be adopted by all agencies involved in safeguarding children to encourage cross-agency consistency.