North Tyneside
SAFEGUARDING
CHILDREN BOARD

NTSCB

Serious Case Review

Harry

Final Report

September 2019

Contents

Overview

Key:

Subject:	Harry (not his real name)
Mother of Harry	MH
Brother of Harry	Izsac (not his real name)

Agencies/Professionals known to or involved with the Family: Dec 2016 – August 2018

Primary SCH	SCH1
SENCO/Deputy Head	SEN1
Secondary School	SCH2
General Practitioner in first Practice	GP1
General Practitioner in second Practice	GP2
General Paediatrician	P1
General Paediatrician	P2
Dietician (Paediatrics)	D1
Community Mental Health Team	CMHT
Citizen Advice Bureau	CAB
Care and Connect worker	CC1
Employment Adviser	EA1
Emplyment Adviser 2	ES2
Talking Therapies, CBT therapist	TT1
Family Entrepeneur/Family Gateway	FGW1
Family Entrepreneur 2	FGW2
Social Worker who undertook Single Assessment	SW1
Team Manager who signed off the Single Assessment	TM1
SW inCSC who received escalation email from SCH2	CS 1
Team Manager who advised school to undertake Early Help Assessment	TM2
MASH Manager	MM1
Early Help Manager, MASH	EHM1
Early Help Coordinator (Locality) who attended 2nd TAF meeting	EHC1
Team Manager who attended 3rd TAF meeting	TM3
First Family Partner	FP1
Second Family Partner	FP2
Family Support worker , North Tynside Carers Centre	YC1
Family Support Worker, North Tyneside Carers Centre	YC2
Community Church	CH1
Acorns (referral only)	
Interpreter 1	
Interpreter 2	

Overview

Harry, his mother and younger brother moved to the UK from Hungary for 'a better life'. Harry was described as a quiet, polite, and thoughtful young person, who had lived in the UK for almost two years with his mother and younger brother before he died. Harry attended school regularly, he was bright and was thought of as a model pupil, picking up the English language quickly and immersing himself in school activities.
When not spending time with his friends, Harry would be out on his bike or at home playing on his Xbox. Both Harry and his younger brother, Izsac were aware that their mother suffered from mental ill health and did their best to care for her when she was stressed and struggling financially to provide for her family. Mum's understanding of English was poor, so Harry was often required to attend meetings and appointments and act as an interpreter and translator on her behalf.

The death of any child is always tragic. It is especially so, when a child decides they no longer wish to live and takes deliberate action to end their life. Harry took his own life and left an unaddressed note describing his intentions. Although many professionals who knew the family were concerned about the impact of mum's mental health and volatile behaviours on the emotional well-being on Harry and his younger brother, the review team was told there was no outward indication of Harry's distress or unhappiness.

This review has not identified a significant contravention or action by any professional that was a critical factor in what happened to Harry. There is evidence that both schools and FGW1 did all they could to support the family and voice their concerns about the needs of the children. There are however lessons to be learnt in terms of how agencies support migrant families who have no recourse to public funds and who, alongside other stressors, bring children to the attention of voluntary and statutory agencies.

Harry's sad and tragic death is also a stark reminder to all professionals about the importance of keeping work with a family child centred and being continually mindful of the wide range of factors that can lead to suicide in young people. The SCR particularly highlights the importance of practitioners and managers being attuned to the impact on children of living with a highly critical parent with poor mental ill health. The review also emphasises the importance of professionals keeping in mind the impact of cumulative adversities, which can lead to feelings of isolation and hopelessness in young people who feel they are without support.

1. Local Safeguarding Children Boards (LSCBs) and Serious Case Reviews

1.1. The main responsibilities of Local Safeguarding Children Boards (LSCBs)[1] at the time this SCR was commissioned were to co-ordinate and quality assure the work of partner agencies to safeguard children. The statutory guidance, which accompanies legislation and underpinned the work of LSCBs, set out its expectation that LSCBs should maintain a local learning and improvement framework so good practice can be identified and shared.

1.2. In situations where abuse or neglect of the child is known or suspected and children die or are harmed, local authorities and their partners are required to undertake a rigorous, objective analysis of what happened and why, to see if there are any lessons to be learnt which can be used to improve services in order to reduce any future risk of harm to children. There is an expectation that these processes known at the time of writing, as Serious Case Reviews (SCRs), are transparent with the findings shared publicly.

2. The circumstances which led to this SCR

2.1. MH moved to the UK from Hungary, in 2016 with Harry who was then aged 12 and his younger brother Iszac who was 8 years old. Over a 20-month period, professionals from different agencies raised concerns with Children's Social Care (CSC) about the impact of MH's volatile behaviours on the well-being of both her children and, towards the end of this period, Harry especially. Although several services were involved at different times with family during this period, there was never any statutory involvement and only one statutory assessment had been undertaken, fifteen months prior to Harry's death.

2.2. In August 2018, Harry took his own life. He was 15 years old and left an unaddressed note indicating feelings of hopelessness and despair. The note said, 'please read'.

2.3. Given the number of concerns held and shared with CSC by other agencies and the lack of any statutory involvement, especially during the four months prior to Harry's death, the independent chair of the North Tyneside Safeguarding Children Board agreed on 17 September 2018 that the circumstances of Harry's death met the criteria for a Serious Case Review.

3. The approach used

3.1. The Board appointed an independent lead reviewer who had no prior connections to any of the agencies involved, to lead the review process and to produce the SCR report. A review team of senior professionals, representing the agencies that had been involved with the family was established; their role being to provide strategic information about their agencies' involvement and to identify learning for their agency through the submission of an Agency Learning Report. This group met on four occasions and membership of the team is listed in Appendix 1.

3.2. Members of the review team identified frontline practitioners and first line managers who were known or had worked with Harry and his family. These professionals formed the 'Practitioner's Group' and offered useful insights to support learning. This group met on three occasions. FGW1

[1] *Children Act 2004, s14*

had already left her employment but took part in a telephone conversation with the lead reviewer.

3.3. At the start of the review, a time line of agency interventions was collated to illustrate multi-agency activity and who knew what and when. Each member of the review team completed an Agency Learning Report, which described and analysed practice within his or her own agency. These learning reports were presented to the review team for comment and challenge. Further data was provided through scrutiny of various assessments and agency records.

4. Scope and terms of reference

4.1. The review team agreed that the period under review would be from October 2016 when the family moved to the UK to August 2018 when Harry died.

4.2. The review team initially allowed key lines of enquiry to emerge as the review began to unfold. This approach allowed a wider exploration of events rather than a pre-determined focus on specific issues without the review team understanding what happened, when and why. After the second review team meeting and with the benefit of Agency Learning Reports and initial conversations with key practitioners, four key lines of enquiry (KLoE) emerged which the review team agreed should provide a framework for the review. These were:

KLoE 1: Harry and Iszac's lived experience
KLoE 2: The extent to which the children's vulnerabilities were recognised and addressed.
KLoE 3: The response of CSC to referrals and contacts from other agencies
KLoE 4: How well agencies communicated with each other and worked collaboratively.

5. Family Involvement

5.1. It was not possible to speak with MH about all that had happened since she came to live in the UK. After Harry's death, MH's mental health deteriorated, and she spent time in hospital. Izsac was placed with foster carers. The review team was informed that MH eventually returned home to Hungary where she is understood to be living with her mother. The lead reviewer wrote to MH; the letter was translated and forwarded by NTSCB Business Manager to an email address provided by MH's legal representative.

5.2. At the time of writing this report, MH has not made any direct contact with the lead reviewer or the Business Manager, nor was any communication received from MH's legal representative. The report does not therefore have the benefit of MH's views or include any insights she may have had about the services she did or did not receive whilst living with her children in the UK.

5.3. Iszak remains in the care of the local authority and is receiving support from counselling services.

6. Summary of key periods under review [2] *(figures in brackets refer to contacts with CSC)*

Period 1: October 2016 - January 2017– (aged 12)

6.1. The family arrived in the UK and according to various reports were initially supported for a week or two by friends who then returned to Hungary. MH registered the family with a GP and both boys were enrolled in local schools, Izsac at SCH1 and Harry at SCH2. The children presented as well dressed and polite and quickly settled with the support of extra language tuition. SCH1 and SCH2 frequently liaised as concerns began to emerge about MH's mental health and the family's lack of funds. In December 2016, SCH1 referred their concerns to Children's Social Care (CSC) (1) and were subsequently informed that the family had been referred to Care and Connect, a local authority service offering practical help to families who needed low-level support. SCH1 was also advised the family had been put in touch with the Welfare Benefits service. Following contact with the family, this service also raised their concerns about the family situation with CSC. (2)

6.2. In January 2017, Care and Connect allocated a worker (CC1) to support the family on a short-term basis with an agreement she would assist MH with practical help around benefits, employment and key appointments.

6.3. The local church community offered and continued to offer help to the family by providing food parcels and practical support to MH.

Period 2: February 2017 – July 2017 (aged 13)

6.4. CC1 continued to support the family with practical tasks including supporting MH with visits to the Job Centre where she was assessed as having no recourse to public funds (NRPF)[3]. This meant that MH was not automatically entitled to Job Seekers Allowance. Both boys were noted to have settled well, although there were continuing concerns about MH's behaviour when visiting SCH1, which was exacerbated by a language barrier, and MH's concern about not being able to find regular work.

6.5. MH, usually accompanied by Harry, had several visits to the GP practice during this period. Communication between the GP and MH was often difficult as was her behaviour in the surgery at times if she was kept waiting. On these occasions, MH expressed a view that she was being treated differently from other patients. Although prescribed anti-depressants by the GP, MH was reported to have told other professionals that she preferred natural remedies and would not take her medication. The GP was informed that Harry, at age 13 was still wetting the bed and that he was gluten sensitive. He was referred by the GP to a Paediatrician. (P1) and although he was not taken to the first appointment, he attended the second with MH and CC1. Records indicate that Harry saw his GP alone the following day and was advised to take the medication prescribed by P1. It later became apparent that MH often prevented Harry from taking his medication and his enuresis and occasional encopresis continued.

6.6. Two further contacts expressing concern by the Welfare Assistance team are contained in CSC records, which the review team was told were neither seen nor responded to at the time by CSC (3 and 4). SCH2 referred their concerns again to CSC (5) in May 2017 and in response, a Single

[2] *-Taken from agency records and from conversations with practitioners*

[3] *Many migrants in the UK have no recourse to public funds, which means that they cannot access mainstream benefits and housing assistance. The definition of a 'public fund' specifies precisely which benefits these are and it includes, for example, jobseekers' allowance, housing benefit and social housing.*

Assessment[4] was initiated. MH's visits to the GP continued usually accompanied by CC1 and occasionally Harry. Further information came to light through an interpreter commissioned by the medical practice, that, when living in Hungary, MH had received treatment for mental illness, depression, anxiety and, possibly, schizophrenia. The GP referred MH to the Community Mental Health Team (CMHT) for an assessment with a query as to whether she might have a Personality Disorder. In a conversation with the social worker, the GP shared the view that the children were not at risk from MH. MH cancelled the appointment she was sent from CMHT, so a duty officer visited MH at home. MH did not want to engage and insisted she did not need any mental health services. Harry's appointment set up by P1 with a Dietician (D1) was not kept. The involvement of CC1 ceased sometime towards the end of this period. With the help of SW1, MH received some funds from the father of the children which allowed her to pay her rent to avoid eviction.

Period 3: August 2017 – January 2018 (aged 13)

6.7. The Single Assessment was concluded with a recommended that the family's financial situation was insecure, and the needs of both children could best be supported under Child in Need provision. This is a consent-based service but MH would not agree to work with CSC, so the case was closed in August 2017. Harry and MH attended a follow appointment with P1 who noted Harry was well and that family circumstances had improved evidenced by the fact that CSC had 'closed the case'. MH provided 'a letter' confirming that matters were 'resolved'. P1 arranged to see Harry again 6 months later. Harry was not taken for the 3rd time to an appointment with D1 so he was discharged from that service and the GP was informed accordingly.

6.8. At the beginning of the autumn term MH appeared in SCH1 in a very distressed state with several demands for unpaid bills and told staff she was a risk of losing her rented property. Izsac told his teacher that he thought his '*mam needed help*'. It was agreed that SCH1 would refer the family to Family Gateway, a charity providing bespoke support to families with complex lives who need help. FGW1 was allocated to work with the family, initially for a 6-week period. MH missed another appointment with CMHT and was therefore discharged from the service. The GP was informed.

6.9. SCH2 began to note small incidents of negative behaviour from Harry and became aware, as did FGW1, of arguments in the home especially between MH and Harry. FGW1 told the review team that MH's behaviour towards Harry was very negative. On one occasion Harry called police to the home, where MH was found to be in a highly emotional and distressed state and indicated the children were not doing as they were told so she had thrown their Xbox out of the window. Police shared their concerns about MH's emotional state with CSC. (6). FGW1 attended GP appointments with MH who was again referred by the GP to CMHT for a mental health assessment.

Period 4: February 2018 – June 2018 (aged 14)

6.10. CMHT advised the GP that they would not accept the referral for MH as '*there was no escalation in her mental health needs'* since the last referral. CMHT suggested the GP should refer MH to Talking Therapies[5]. In response to Harry's absence from school, the Education Welfare Officer (EWO) made a home visit and was extremely concerned about the family's situation, MH's mental health and the fact that Harry was kept off school to look after MH, who had injured her hand at work. The

[4] *The Single Assessment is a detailed assessment to determine whether a child is In need, requires a protection plan, or requires immediate protection. The assessment also identifies the nature of any services, which may be required.*

[5] *North Tyneside Talking Therapies is a service funded by the NHS, which provides psychological assessment and treatment to adults who are suffering from mental health problems.*

EWO was also concerned that MH was being exploited by her employer and working long hours leaving Harry to look after Izsac. Concerns were shared with SCH1 and SCH2 and another referral (7) was made to CSC stressing that the situation was worsening and the impact on both boys becoming more evident.

6.11. CSC responded to the referral and advised SCH2 that they were taking no further action. SCH2 escalated their concern about this decision via email to what they thought was the Team Manager, (TM2) but later learnt the email had been sent to a social worker. The EWO also made a referral to Adult Services expressing concerns that MH may have been a victim of Modern-Day Slavery but no further action was taken.

6.12. In March, according to SCH1 records, MH disclosed that Izsac had threatened her with a knife after a heated argument and scratched her arm. Following discussions with SCH1 and SCH2 and FGW1, records indicate FGW1 again reported concerns to CSC (8). SCH2 were advised on the same day by TM2 that CSC were taking no action in respect of the referral and SCH2 should initiate an Early Help Assessment.[6]. MH did not take Harry for his appointment with P1, but she visited the GP in relation to her hand injury and was noted to be very upset about life in general.

6.13. In April, MH contacted the out of hours duty team saying, 'her life was broken' and she couldn't cope. The call led to a home visit where MH was found tearful and 'in need of support' (9) MH said she had an appointment with Talking Therapies later that month. Both children said they were happy. FGW1 was contacted by CSC and asked to visit.

6.14. MH had a telephone assessment with Talking Therapies. They concluded that her needs were such that they could not be met by that service. However, the therapist who spoke with MH contacted CSC expressing concerns (10) about MH's emotional presentation and financial difficulties and requesting support for the family.

6.15. In May 2018, SCH2 completed an Early Help Assessment with support from SCH1 and FGW1 who despite the 6-week initial contract was still involved with the family. The first Team around the Family (TAF) meeting was held and attended by MH, SCH1, SCH2, and FGW1. There were no health professionals at the meeting, although it would appear that the GP had been invited. It was agreed that a referral should be made to the North Tyneside Carers Centre (NTCC) for support for both children but especially Harry who was thought to be carrying a lot of adult responsibility. It was agreed that a referral should also be made to Acorns, a charity which supports young people who are living with or had lived with domestic abuse. MH agreed with these referrals. Notes from the TAF meeting indicate that boys when spoken to later, agreed to try harder to behave at home.

6.16. MH and Harry attended a rescheduled paediatric appointment and were seen by P2 who wrote to the GP expressing concern about MH and the family dynamics and requesting additional support for MH as P2 was worried about how she was coping. She also recommended individual counselling for both Harry and his mother. The letter was copied to CSC. FGW1 was reported to being increasingly concerned about what she saw as deterioration in MH's mental health and in family relationships and in early June she made another referral (11) to CSC to share her concerns. She was advised that the referral did not meet their threshold for intervention. FGW1 was advised by

[6] *The purpose of an EHA is an assessment that looks at the needs of the whole family to determine how best to help each family member. An EHA supports a meaningful conversation with the family about their strengths and challenges so the right people can be pulled in to provide support*

her manager to contact NSPCC and report her concern about the family which she did and was advised to contact the Young Carers to ensure Harry's needs were addressed. She was given a reference number and asked to get back in touch if she remained concerned.

6.17. A second TAF meeting took place in mid-June and the Early Help Coordinator (EHC) [7] from the locality was invited to attend so concerns about the family and the welfare of both Harry and Izsac could be shared. A proposal to EHC that a Family Partner[8] should work with the family was not thought appropriate as EHC advised that FGW1 was involved and their roles were very similar. It was agreed the situation would be monitored. EHC reported to the locality team and it was agreed that TM3 from the Early Help team would attend the next meeting.

Period 5: July 2018 – August 2018

6.18. Following a referral to NTCC in late June from SCH2, two practitioners from NTCC (YC1 and YC2) made contact with MH who agreed to their involvement and they subsequently made two home visits. MH advised that she had a social worker that visited but she did not know where she was from. YC1 eventually made contact with FGW1 who shared background information and her concerns and invited YC1 to attend the next TAF meeting in July. YC1, being aware of stresses in the family, discussed with MH whether she would allow the boys to take part in some activities and this was agreed.

6.19. At school, Harry typed '*I wanna die'* into his computer but assured the pastoral lead who spoke with him that he and his friends were just 'messing' about and no further action was taken. The following day, MH took a knife into the job centre and although records indicate this was to show staff how the injury to her hand prevented her from working, as a precautionary measure, the police were called, and MH appears to have told Police she was not coping. A Police notification was sent through to CSC. (12)

6.20. The July TAF meeting was attended by MH, FGW1, SCH1, SCH2, YC2, and TM3 from the locality team. Records indicate it was a difficult meeting as MH was highly emotional, difficult to understand or engage and talked negatively about Harry throughout most of the meeting. The meeting was brought to an early close by TM3 and MH left the meeting in a distressed state. TM3 advised that although she thought it unlikely that concerns reached the threshold for CSC intervention, she would nevertheless discuss the situation in the locality team. After the TAF meeting, FGW1 spoke with SCH1 and SCH2 and it was agreed that SCH1 would make another referral to CSC, which was done. (13). A Police notification was forwarded to CSC as per expected practice.

6.21. TM3 shared her experience of the TAF meeting with the MASH [9]manager (MM1) who agreed a MASH referral would be appropriate.

6.22. A discussion took place between MM1 and the Early Help Manager (EHM) and a decision was taken that a Family Partner (FP1) would be allocated to work with the family. Four visits were undertaken by FP1, between 19.7.18 and 30.7.18, two of which took place jointly with FGW1. After the first

[7] *Locality teams as the name implies are local officers from which services of commissioned and delivered.*
[8] *Family partners are employed by the local authority to work with families who need varying levels of support but whose needs do not meet the threshold for statutory intervention*
[9] *Multi-Agency Safeguarding Hub. MASH coordinates support and protection services for children and vulnerable adults in North Tyneside. It brings together professionals from across the Authority, Northumbria Police, Health agencies and the voluntary sector in one team to improve information sharing, identify safeguarding concerns quicker and manage cases more efficiently*

visit, FP1 raised her concerns about what was happening in the family but was advised to continue visits with FGW1 and do '*some joint work with Harry and Iszac separately'* so the children knew they were supported. FP1's concerns continued and on 30.7.18 these were shared with CSC. (14) Further discussions took place between MM1 and EHM and a decision was taken to keep the family in Early Help but to allocate a more experienced Family Partner (FP2) but '*not to do an assessment as MH didn't like professionals'*.

6.23. FP2 made three visits between 1.8.2018 and 10.8.2018 before going on annual leave. However, a plan to ensure the family had support during this time was agreed; FGW1 was to make two visits in week one and FP1 would visit the family twice in the second week. These arrangements were put in writing to all parties including MH who was also advised she could make contact if further support was needed.

6.24. In August, it was agreed by NTCC to allocate a worker to Harry but with a lack of information about MH's mental health and in the light of MH taking a knife to the Job Centre, it was agreed there would be no home visits until FP2 returned from leave at the beginning of September and a joint visit could then be undertaken. FGW1 records indicate that Harry went missing on two occasions around this time for several hours after a family argument but later returned home. His whereabouts were not recorded.

6.25. Both boys attended summer activities organised by North Tyneside Carers Centre, were observed to be having fun and joking with each other, although when Harry joined one activity with his peers, records indicated he appeared quiet and reserved. Both children also went surfing with FGW1 and FGW2 during this period.

6.26. At the end of August Harry took his own life, after an argument with MH.

7. Appraisal of Practice

7.1. The purpose of Serious Case Reviews is to support improvements in safeguarding practice. This means it is not enough just to describe professional activity in a case or to identify elements of practice that were problematic without seeking to understand why they occurred. The analysis needs to explore what systems were in place, which influenced professional activity and decision-making at key points in their work with the family.

7.2. It is important to be aware how much hindsight can distort judgment about the predictability of an adverse outcome. Once the death or a serious injury to a child is known it can become easy to look back and conclude that certain assessments or actions were critical in leading to that outcome. The review team was mindful of the dangers of hindsight bias but wanted.to understand why certain actions and decisions would have made sense at the time and importantly, what systemic factors in place then, might still be impacting upon practice in North Tyneside in 2019.

7.3. The analysis is structured around four key lines of enquiry (KLoE), which lead to the findings and identification of common thematic issues. The KLOE are listed below and an appraisal of practice under each key line of enquiry follows.

KLoE 1: Harry and Iszac's lived experiences
KLoE 2: The extent to which the children's vulnerabilities were recognized and addressed.
KLoE 3: The response of CSC to referrals and contacts from partner agencies

KLoE 4: How well agencies communicated and worked collaboratively.

7.4. **KLoE 1: Harry and Iszac's lived experiences**

7.4.1. Harry and Izsac were described in various records as polite and well-mannered children. They quickly settled down at school, formed friendships, and achieved academically. From initial agency records, there is clear evidence of MH's determination to make a new life for her and her children in the UK. Over the past few decades, migration has increased dramatically, fuelled not only by conflict but also by families seeking improved standards of living.[10] MH told professionals she came to England for a 'better life'.

7.4.2. For Iszac and Harry, there was nothing to suggest that either child was traumatised by the circumstances that brought them to the UK or by the mental health difficulties and stress experienced by their mother. As the boys became more settled however, staff in SCH1 and SCH2 became concerned about MH's behaviours and through some difficult conversations with MH began to suspect that she might suffer from mental ill health. In addition to direct parenting behaviours, untreated mental illness in parents is strongly associated with general family discord which is known to present additional risks to children's well-being. Both schools were right to be concerned and were diligent in their efforts to secure support for both children until Harry's death in August 2019.

7.4.3. Recordings from all agencies who visited the home or were in contact with the family refer in the main to MH and her behavior and it is her narrative that is clearly the focus in agency records. References to the needs and views of the children where they exist are slim in comparison with records pertaining to MH. There is, a striking difference in the assessment in May 2017, which describes the children as having a '*close bond*' with MH, with the information later shared by professionals acutely concerned about the negative and damaging attitude MH had towards Harry. However, these records refer to the perspective of professionals and the voices, wishes and feelings of Harry and Iszac are not evident to any considerable degree in agency records.

7.4.4. Whilst both SCH1 and SCH2 ensured that Harry and Iszac had access to the pastoral leads in school should they have wanted to talk, staff in school were cautious about placing additional pressures on the children to talk in any depth about family life, so conversations were usually kept 'general'.

7.4.5. Although the children, at various times, were asked by professionals about how well they enjoyed school and their life in England, there does not appear to have been any discussions amongst professionals about what support needs the children might have in their own right. Accepting that MH had undiagnosed mental health needs and knowing that the family had no support other than the church community, it would have been appropriate to explore how best the children could be supported and by whom, outside of the school environment.

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[10] UNICEF *Innocenti Research Children in Immigrant Families 2009*

7.4.6. Some practitioners in the review saw these types of conversations as being the responsibility of social workers but in fact any 'trusted adult', could have taken time to establish a rapport with either child and learnt a little more about their worries, hopes and feelings. What became apparent in discussions with professionals was that both children 'appeared well and relatively untroubled' which perhaps led to a degree of complacency and made it more likely that the focus was on MH's behaviour rather than how this impacted on the children.

7.4.7. In May 2018, both Harry and Iszac were each asked as part of the Early Help Assessment how things at home could be improved. Sadly, each child only offered ways in which their behaviour could change leaving them with a clear message that they were responsible for their mother's behaviour and state of mind. It would have been helpful at this stage if the children had been supported to better understand their mother's behaviour rather than being asked to help alleviate it. The feedback from those brief conversations with each child however highlighted a difficult home life and indicated Harry's emerging concern about the future.

7.4.8. The practitioners who were involved for lengthy periods with the family, for example, CC1, and FGW1 were not as child-focused as they should have been, but neither were, they supported by their respective managers to be so. Much of their work was centered on supporting MH yet, there is a wealth of evidence from children who highlight how much of a positive impact practitioners' can have when they find time to spend with the children they are helping and keeping a clear focus on their needs.

7.4.9. FGW1 told the lead reviewer that although she frequently challenged MH about her attitude towards Harry, she felt her concerns were never taken seriously or shared by CSC when she made contact. It is however important to acknowledge that other than formal referrals made by FGSW in March and June 2018, there are no records in either agency of these contacts.

7.4.10. The impact on Harry of his mother's behaviour was stated as a cause for concern by several professionals but there were no statutory assessments undertaken after May 2017 to determine exactly how, or indeed if, MH's behaviour was adversely affecting Harry and his brother. Some members of the review team were struck by the recording of the July TAF meeting, 19 months after the family arrived in the UK. The minutes of the meeting describe MH's repeatedly abusive, rejecting, and negative comments about Harry. The meeting was cut short by TM4 because the intensity of MH's emotions and distress meant that communication between the professionals and MH was not possible. Yet, Harry would have gone home after school to cope with the same barrage of accusations and emotions that professionals, as adults, had found so difficult to experience. Given previous concerns shared by other professionals, MH's emotional presentation at this meeting and its outcome, could usefully have led to a statutory assessment by CSC to gather information about Harry's needs and experiences and explore the possibility of emotional harm by MH towards Harry. This didn't happen and the review team was informed that services through Early Help provision were judged the best way forward for this family, which is why FP1 was allocated to work with the family.

7.4.11. Listening to the 'voice of the child' does not only refer to what children say directly, but to many other aspects of their presentation, how they look, how they behave and with whom; it essentially means seeing a child's experiences from their point of view. This meant acknowledging that if professionals struggled to cope with MH's behaviours in the short periods, they spent trying to engage with her, how much more stressful must it have been for the children

and especially Harry who she came to regard as being the cause of all her problems. The impact of MH's behavior on Harry was never explored directly with him; there is no reference other than the comment in the EHA as to what life felt like for him, nor are his wishes or feelings recorded in any agency record. Although FP1 was urged to undertake separate sessions with Harry and Iszac, these sessions did not take place as expected and although FP2 was able engage both boys in a family session where their feedback in front of MH was very positive, Harry's died before any one to one work could happen.

Finding 1*: Where concerns arise about the impact of parenting behaviours on children and interventions are deemed necessary, action should always be taken in to ensure that children are provided with carefully managed and purposefully created opportunities so their wishes and feelings can be explored and acknowledged.*

7.5. KLoE 2: The extent to which the children's vulnerabilities were recognised and addressed

7.5.1. The topic of a child's vulnerability is a long-standing and contested topic in work with children about whom there are concerns. It is, however, such a common concept that it is easy to underestimate its significance and allow the needs of the parents to be the focus of work as was the case with these two children.

7.5.2. Professionals were unable at the time to determine the exact details of what brought the family to the UK. Whatever the detail, even with limited information provided by the children, MH and the interpreters, it would appear that the children had at some time, received services from the authorities in Hungary in response to their mother's mental ill-health and had also witnessed family conflict and domestic abuse. Put simply, both children appeared to have experienced a number of adverse childhood experiences even before they moved to a new country without any financial support or family networks. In this respect, they were highly likely to be vulnerable despite their outward demeanour.

7.5.3. The review highlights the importance of professionals keeping in mind the impact of trauma arising through cumulative adversities, which can lead to feelings of isolation and hopelessness in young people who can feel they are without support. The review team considered the possibility that, paradoxically, had the impact of MH's behaviours on Harry or Iszac's behaviour led to them displaying more challenging, aggressive or destructive outward signs of behaviour, their vulnerabilities may have been more easily recognised and views taken that these were children in need, or possibly, even children in need of protection.

Harry as a young carer

7.5.4. Growing up with a parent who has mental health difficulties can lead to children feeling uncertain and anxious. There is evidence of this in school records when at different times, both Izsac and Harry expressed concern to school staff about MH – Izsac on one occasion wrote ' *I think it would be a good idea to get mam a bit of help'.* What can also happen is that children take on responsibilities beyond what should be expected of a child and this can easily lead to feelings of anger, abandonment, isolation, and low self-esteem. Harry was known to collect MH's medication at times, attend appointments and meetings with MH, to interpret and translate for her. Some of these appointments involved Harry hearing at first-hand about MH's problems, difficulties, and frustrations, information that was often inappropriate for Harry to hear. When MH was working long hours, Harry would look after Iszac and sort out meals. Despite the findings included in the Single Assessment in May 2017, it was not until May 2018, that the possibility of Harry being a

young carer was considered and it was not until one month later that a referral was submitted to North Tyneside Carers Centre for an assessment of his needs.

7.5.5. Young carers are children under 18 with caring responsibilities, and their rights to be assessed come mostly from the Children Act 1989 and the Children and Families Act 2014. If an adult is being 'cared for' by a child, then the local authority has a duty to consider the extent of that care and the consequent possible the actual or potential impact on that child. The local authority has a duty to assess '*on the appearance of need*' (i.e. without a 'request' having to be made).

7.5.6. There can be a common misconception that 'young carers' only do practical caring for disabled or incapacitated parents and this, the review team was told, possibly deterred professionals from, initially seeing Harry in that role. In addition to other tasks, the emotional support that Harry, specifically, gave and was expected to give to MH was considerable and this should have been recognised much earlier by the various professionals working with the family. A young carers assessment might not only have provided important information about what life at home was like for Harry and Izsac but may also have led to an invaluable source of support to address the emotional, psychological and practical support needs of both children.

7.5.7. Children can sometimes be viewed only in the capacity of risk and safeguarding concerns and some members of the review team considered this possibly explained why the May 2017 Single Assessment did not identify the need for a young carer's assessment, even though Harry's role in this respect was clearly identified. Caring roles taken on by children and young people can be a significant risk factor for their mental health and research[11] suggests that in national and local policies around children's mental health, the needs of young carers are not always been included. In the same research, young carers reported that, even when they had support, their caring role caused distress, tiredness, guilt, anger and isolation, all of which impacted on their mental health and emotional well-being.

7.5.8. Engaging hidden young carers can prove a challenge because very often children and families do not want to disclose caring responsibilities for fear of discrimination or statutory interventions. When there are cultural and language barriers, this task becomes all the more difficult but social care, health and education professionals have a crucial role in recognising young people who may be carers. The fact that this didn't happen until May 2018 suggests that more needs to be done to support practitioners in North Tyneside improve their understanding and awareness about young carers supporting the parents with mental health needs.

Finding 2: *Unless there is an increased awareness amongst professionals about how to recognise and respond to young carers, these children may not get access to the right support and their mental health needs will be missed. Early interventions are critical in ensuring that children do not take on inappropriate caring tasks. In addition, the need for children to provide care is increased when services to parents with mental ill-health are not in place and family-based interventions are not provided*

Working with Migrant families

[11] *The Lives of Young Carers in England. Omnibus report DFE (2017*)

7.5.9. When MH arrived with her children in the UK from Hungary, she lived in rented property initially paid for by friends, who soon after the family's arrival, moved back to Hungary. There is evidence that MH immediately began looking for work. By December records suggest that the family were relying on food parcels and help from the local church community and MH was struggling to find employment.

7.5.10. CSC's response to the referrals made by SCH1 in December 2016, was to refer the family to Care and Connect and to a Welfare Benefits Advisor for help with benefits. It is not clear from CSC records whether they were as aware as they should have been that MH was excluded from welfare benefits as she had 'no recourse to public funds' (NRPF)[12].

7.5.11. The legal framework that governs how a child or children in the UK with a migrant parent can access welfare benefits is complicated. MH had no recourse to public funds even though she was without work or access to any income. However, MH did however have two children who were at risk of being destitute and homeless and consequently there was clearly scope for financial assistance to be provided by the local authority under s17 of the Children Act 1989. This section places a duty on the local authority to assist a child in need if without that assistance, their health or well-being will be adversely affected. Parents who are subject to NRPF are not excluded from s17 support because the responsibility of local authorities under this section is to meet the needs of children within their families. A level of support therefore necessarily extends to their parents.

7.5.12. It is not clear why CSC did not consider the need to provide support in the form of accommodation and subsistence payments under s17 to this family in December 2016. If this support was considered, it is not documented. The review team was told by practitioners that North Tyneside continues to have a very small migrant population and issues around NRPF are not common and were even less so in 2017. The review team were unable to locate any policy or guidance documents to support practitioners whose work brings them into contact with migrant families or refugees.

***Finding 3**: Even with the relatively small number of migrant families arriving or living in North Tyneside, professionals should be acquainted with the ways in which immigration policy frames the conditions and pose barriers in the lives of the migrant families with whom they may come into contact. Without this awareness, some children in migrant families may be left vulnerable.*

7.5.13. MH struggle to understand English and found it especially difficult to make herself understood when she was distressed or agitated. Migrant families face many cultural barriers accessing support, but the language barrier must be particularly challenging when trying to understand and gain access to health and welfare services.

7.5.14. It is not possible to determine how well MH fully understood the child in need process. Certainly, several practitioners recall MH being concerned about government interference and stating she thought she was being 'spied' upon by the government. This may well have impacted upon her willingness to accept help from 'official' channels. The review team were not able to determine how or in what detail the child in need process was explained to MH and how much she understood its purpose, even though an interpreter was used to aid communication between

[12] *The term 'public funds' refers to a collection of specific welfare benefits which are set out in Section 115 of the Immigration and Asylum Act 1999 and Paragraph 6 of the Immigration Rules*

the parties. Research[13] suggests that individuals from ethnic minority backgrounds can struggle to understand the language spoken by professionals and when practitioners do not speak the language of the parent, misunderstandings and frustrations easily occur.

7.5.15. Whilst there is no legal duty for social care providers to provide translation and interpreting services and no definitive national guidelines about how and when to commission these, the review team was informed that the local authority does have access to such services and a translator was appropriately used when the Single Assessment was undertaken in May 2017. For health professionals, principles and guidelines for best practice are captured in a guidance document produced by NHS England. [14]

7.5.16. The review team noted how few times interpreters seemed to be used in conversations with MH, but this was explained in terms of cost and availability of skilled individuals who could translate MH's language and dialect. MH did not always book her GP appointments well enough in advance to ensure a translator was available in person, but the GPs did occasionally use a Language Line, a telephone service which offers interpreting services over the phone. The review team did have a sense, identified in the Agency Learning Report, that MH's experience when she attended the surgery was not always as positive and reassuring as it could have been, and contacts were often frustrating for both MH and the GP. Whilst patients must be able to access primary care services in a way that ensures their language and communication needs do not prevent them receiving the same quality of healthcare as others, it was clearly not always possible to ensure an interpreter was present when MH attended the surgery or even that she would agree to communicate through that individual.

7.5.17. The review team found no evidence to suggest that any formal letters, documents, or minutes of meetings were ever translated for MH. In the absence of any information to the contrary, it was assumed, that communication was always in English and was, where necessary translated or explained by Harry. Realistically, translating all paperwork was clearly not possible but the review team was curious as to how agencies were assured, with, or without the presence of translating services that MH fully understood what was being said and what was agreed.

7.5.18. What emerged from conversations with some practitioners was that, notwithstanding her emotional state, with enough time and often twice as long as English-speaking families, communication with MH was possible, and usually but not always MH would ensure Harry was present. The review team could find no evidence in agency records that his presence at these meetings/appointments was unwelcome or considered inappropriate even though he was often hearing adult information and MH's anxieties and this in itself would have impacted on his own emotional health.

7.5.19. Practitioners from health and social care did highlight the difficulties they experienced in finding not only interpreters with the right language skills but also interpreters who could be relied upon to turn up for planned appointments. It would seem this is a common issue in the North East, which the review team was told is regularly highlighted with commissioners. The review team learnt that MH often argued with the interpreters when they were present and that some had refused to accept the work when they knew they would be working with her. This information

[13] *Social work in a multicultural society: New challenges and needs for competence Sage 2014*

[14] *Guidance for commissioners: Interpreting and Translation Services in Primary Care NHS England 2017 revised 2018*

is however anecdotal and there is no record of any complaints being made to the service provider in this respect. Clearly, there were frustrations for all professionals trying to communicate with MH and understand her perspective and this made it all the more difficult to establish a meaningful working relationship in which a focus on the needs of the children could be assured.

Finding 4: *Unless there are multiple and more innovative ways to communicate with migrant families which help them absorb and digest information, the dynamics, and intricacies in family life may be less well understood and children may be left vulnerable.*

7.5.20. Like all families, migrant families are diverse, complex, and have their strengths and challenges. The process of leaving one's home country and migrating to another will to a greater or lesser degree be traumatic for all family members. Research[15] suggests that once in the UK, migrant children adapt to the culture and learn English much more quickly than their parents and this in itself can create stressors that can bring the family to the attention of statutory and voluntary agencies. Mental health is also understood differently across cultures, many of which have systems of assessing and treating health problems, which are very different to the approaches in the UK. In addition, the manner in which distress and frustration is openly expressed can be different but if not understood can be interpreted as aggressive or threatening.

7.5.21. Life must have been difficult for MH, the constant search for employment to bring money into the family, the sheer number of professionals with whom she had to liaise, the frustration of not being able to make herself understood and the ever-present concern that without enough funds she and her children might have to return to Hungary. It became evident that MH's experiences in her home country, whatever they were, had left her deeply distrustful of authority figures and impacted on her ability to work with professionals in the UK, when it would have been helpful and in the interests of the children for her to do so. As the boys settled and began to mix with their peers, MH tried to keep her children 'close' to their own culture. This inevitably created tension and ultimately conflict between MH and the two children who clearly wanted to 'fit in' with their friends.

The issue of MH's mental health

7.5.22. After Harry's death, an independent social work report was commissioned by CSC to find out more about Isaac's history and the family background and some significant information emerged in relation to MH's mental ill-health. However, during the period under review and at the time of the Single Assessment in May 2017, this information was not available. What was known was gathered from MH's own reports of her mental health and her history and observations by professionals of her extreme emotional states and impulsive and negative behaviours towards her children and others. There are numerous complexities associated with diagnosing mental illness and although views were expressed by many professional that MH suffered from mental ill health, her mental health needs were never formally assessed in the UK. Regardless of any diagnosis however, MH's behaviours were such as to warrant concern about the impact of these on her children.

7.5.23. Following completion of the assessment, SW1 concluded that the family's financial situation was precarious, MH's mental health needs were unassessed and social work involvement under child in need provision would best support the children's stability, security and safety. MH would not

however agree to work with the local authority; she advised that she had found employment, so no further assistance was offered, and the case was closed. It would have been helpful if the assessment had considered in greater depth the implications for the children if MH's mental health needs remained unassessed, but as a 'medical' view had been given to SW1 by the GP that MH was suffering from a Borderline Personality Disorder[16] and the children were not at risk, and MH refused to engage with the Community Mental Health Team (CMHT), no further enquiries were made in this respect.

7.5.24. Understanding the extent to which mental ill-health problems may be affecting parenting capacity in a family does require an understanding of the nature of the mental health problem, the extent to which other factors may be impairing parenting capacity and the actual impact on the children.

7.5.25. The challenge for social workers undertaking assessments is that if there is no mental health diagnosis, the task of determining impact and risk has to then be based on observed and reported parental behaviours and the shared views of other professionals. Whilst descriptions of MH's behaviours were described in detail by some professionals they were not as explicit in agency records as might be expected and the term mental ill-health was frequently used as a catch all description. However, the detailed descriptions of MH's behaviours towards Harry should have given rise to greater concern, regardless of whether they occurred as a result of parental mental health difficulties or poor parenting. Regardless of the state of their home environment or their educational attainment, children in families where parental mental health difficulties are seen to exist are at increased vulnerability due to numerous factors and assumptions should not be made about the health and wellbeing of these children based on standard assessment models.

Finding 5: *An over-emphasis on the physical wellbeing and general demeanour of children who live with parents with mental health difficulties can displace the need to think about potential psychological vulnerabilities which may exist in children*

7.6. KLoE 3: The response of CSC to referrals and contacts from partner agencies

7.6.1. The family was first referred to CSC in December 2016 by SCH1 who expressed concerns about the family's financial circumstances and MH's mental health. CSC advised SCH1 that they would take no further action, but they had contacted Care and Connect, a local authority service, who would offer support to the family and a referral had also been made to Welfare Rights to help with the family's financial situation. The report has already commented on why there was no recourse to s17 to help the family at that point.

7.6.2. A second referral was submitted to CSC by SCH2 in May 2017 and a Single Assessment was undertaken. Although the assessment states that Iszac was seen alone, it is not clear if Harry too was seen alone. Conversations took place with SCH1 and SCH2 who shared concerns about MH but also acknowledged that the children were doing well at school. It would appear that conversations were also held with the GP who offered a view about MH's mental health difficulties but stated that in her view the children were not at risk. There does not however

[16] *Borderline personality disorder is a mental illness marked by an ongoing pattern of varying moods, self-image, and behaviour. These symptoms often result in impulsive actions and problems in relationships. (National Institute of Mental Health*

appear to have been a conversation with any other health professional, including P1. This was a missed opportunity to gather additional information about Harry's medical condition and determine if his health needs were being properly addressed by MH.

7.6.3. At the time of the assessment, the family were in danger of being evicted for non-payment of rent but the deposit in MH's bank of almost £3,000, presumed to be from her ex-husband, offered temporary relief and MH was advised by SW1 to use most of this money to make advance payments on her rent, which she did.

7.6.4. The assessment appropriately sought to address some key questions and contained a wealth of information, some of which was acquired with the aid of a translator and CC1. It is clear that the social worker (SW1) and her manager, (TM1), were reassured by the observed strengths in the family which focused on the 'warmth' of relationships, the evidence of positive of care within the family and the fact the children were described as 'doing well' and were happy at school. There were however concerns about the impact of the family's precarious financial situation and the extent to which MH's mental health needs, which were not being addressed by MH, were impacting and could impact upon the welfare of both Harry and Iszac. The assessment concluded with a recommendation that there should be ongoing social work with the family through 'child in need' provision. There were however, no contingency arrangements noted to determine what, if anything, should happen if MH, as she did, refused to work with family support services or seek help for her mental-health difficulties.

7.6.5. As 'child in need' is a consent-based service, CSC closed the case in August 2017. The review team have not had sight of any closure summary to indicate whether the implications of MH's refusal to engage with 'child in need provision' were thought to have led to any increased risks for the children and how these should be managed if they arose in the future. Both schools continued to support the family and on learning there would be no social work involvement appropriately commissioned Family Gateway to work with the family. FGW1 was introduced to the family in September 2017. It would have been helpful if at that stage, an assessment of the family's needs had been undertaken and a SMART work plan created, so there was clarity around the role of FGW1 and the means by which her intervention could be measured, and progress reviewed. The review team was given to understand that such assessments are now routinely undertaken, and plans are subject to regular management review.

7.6.6. Between December 2016 and August 2018, there were 14-recorded contacts made by various agencies to CSC through their Front Door[17] expressing concerns about MH and the welfare of the children, particularly Harry. Eight of these contacts were made between March and August 2018. Despite the initial view in 2017 that the children needed ongoing social work involvement to ensure their security, stability and safety, the number of ongoing concerns raised by different agencies in 2018 and MH's still unassessed mental health needs, did not generate any professional curiosity about what might be happening in the family.

7.6.7. The review team was informed that all the concerns were assessed but that they *'did not meet the required threshold'* for statutory intervention so no further action was taken. It seems each concern or referral was considered and assessed as a single and separate episode and the

[17] The Front Door service provides access to all services for children and families in North Tyneside. If concerns arise about the safety or welfare of a child in North Tyneside the Front Door Service is the first point of contact for professionals and the public.

pattern of ongoing and escalating concerns was not recognised nor picked up through managerial oversight. The 'Start Again' syndrome[18] is an error that commonly occurs in the assessment process whereby practitioners view each incident, contact or referral with 'fresh eyes' and this can result in a poor or absent analysis of history and parenting capacity.

7.6.8. Professional curiosity is the capacity of professionals to be inquisitive and not take things at face value. The number of concerns raised by professionals working or coming into contact with this family between March and July 2018 should have generated a degree of uncertainty and curiosity about why professionals were so concerned, but feedback from some professional suggested that the involvement of FGW1 was seen as a protective factor.

Finding 6: *If when CSC are assessing referrals, the volume and nature of previous and recent contacts by other agencies are not taken into consideration, escalating concerns and risks to children may not be emerge or be recognised and they will be left vulnerable.*

7.6.9. In May 2018, CSC suggested to SCH 2 that they complete an Early Help Assessment (EHA) which they reluctantly agreed to do. Both schools indicated to the lead reviewer that they believed this was the only way to secure the involvement of CSC, a point referred to later in this report.

7.6.10. Following another referral from SCH1 in July 2018 a MASH referral (known by agencies as referrals) was made following the intervention of TM4 who had attended a TAF meeting. The review team was told that at the time, the process in MASH was that all contacts (known to agency partners as referrals) were triaged by the MASH Social Care Team Manager into three categories of Red, Amber or Green depending on the presenting risk to the child and likely complexity of the case. Green indicated that no social work assessment was required, Red, that it was necessary and Amber, that multi-agency information should be gathered by the MASH to determine whether or not a social work assessment was required.

7.6.11. According to police records, the MASH contact in July 2018 was graded Amber. Following a discussion between MM1 and EM1, a decision was taken to allocate a Family Partner (FP1) from Early Help to work with the family. FP1 visited the family on 4 occasions within a 10-day period. After her first visit, FP1 discussed in supervision that she believed the children were suffering emotional abuse. She also shared information that Iszac had threatened to stab a girl at school '*27 times*.' It is unclear from the supervision records or case recordings whether this was said to FP1 or told to FP1 by MH. Either way, this information was not included in the subsequent referral to MASH, an issue which should be addressed by managers in the Early Help team.

7.6.12. FP1's concerns continued and after her 4th visit, records indicate that she believed Harry's presentation was deteriorating and that he was spending most of his time in his bedroom under covers. These concerns were again reported into MASH and a second discussion between MM1 and EHM, led to a decision to keep the family within Early Help because according to agency records '*support was needed rather than an assessment…. and mum dislikes professionals*.' The family was allocated a more experienced practitioner (FP2) with FP1 acting as the buddy.

7.6.13. At the time, the MASH process had been in place for almost 12 months and was well established. The referral into MASH should have led to a multi-agency discussion involving health and police

[18] *Brandon, M., Beldersone, P., Warren, C. Howe, D. Gardner, R., Dodsworth, J. and Black, J. (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn: a biennial analysis of serious case reviews*

colleagues but instead the decision as to what action was needed was discussed only between MM1 and EHM whose service was already involved with the family. This was a missed opportunity to discuss professional concerns about the needs of the children in a wider context and, specifically, draw on expertise from health professionals. It is unclear why a more experienced practitioner was allocated to the family rather than progressing FP1's concerns to a social work assessment. It would appear that EHM was not made aware at the time of Iszac's' remark about stabbing a girl at school but even so the deterioration in Harry's behaviour observed by FP1 was a worrying sign which certainly, given what was known about the family, warranted a social work assessment.

7.6.14. It remained difficult for some members of the review team to understand why, *given the numerous contacts received from other agencies and the concerns expressed by FP1*, it made sense at that time to introduce a more experienced worker to offer 'support' to the family but not to undertake an assessment. Assessments matter; they provide the means which the best interventions can be identified so that good outcomes for children can be secured and they ensure that the best decisions are made on the basis of information which has been purposefully collected and well analysed. An assessment would have usefully sought a health perspective on Harry's mental and physical wellbeing and secured perhaps a better understanding of MH's own mental health difficulties and how these were impacting on the children's well-being.

7.6.15. There is a substantial body of research evidence[19] that identifies the tendency for 'early evidence bias' in human decision-making – that is, a first summing up of a situation, which strongly influences the analysis of subsequent or new information. Fish[20] suggests '*one of the most common, problematic tendencies in human cognition. … . Is our failure to review judgements and plans – once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture*.'

7.6.16. Some members of the review team alongside the lead reviewer considered this might have been a factor in the decision taken to continue working with the family under Early Help provision and not to progress to a social work assessment. This, coupled with the introduction to the family of a more experienced worker and with what might be described as an overly positive interpretation of what might be happening in the family, continuing to work in the same way with the family may well have seemed to have made sense to those managers at the time. Whilst professional judgement has an important place in the decision- making process, drawing as it does on professional wisdom and practice knowledge, it is prone to bias, not necessarily reliable, and may sometimes lead to premature judgments as seemed to be the case with this family.

7.6.17. Health professionals who attended the review team meetings suggested that it was possible that had information known to EHM and MM1 been presented to a multi-disciplinary team as would be expected for referrals graded Amber, Harry's physical and mental health needs would have been flagged as significant by health colleagues in MASH team.

7.6.18. Concerns were expressed by some members of the review team that the MASH process did not appear to have been followed and it was not possible to determine exactly why this was so. It

[19] *The Munro Review of Child Protection: A child-centred system (2011)*

[20] *Brandon, M., Beldersone, P., Warren, C. Howe, D. Gardner, R., Dodsworth, J. and Black, J. (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn: a biennial analysis of serious case reviews*

became clear from discussions in the review team that the MASH process itself was not well understood by some agencies.

Finding 7*: A review by Ofsted of the MASH in 2018 commended the process in North Tyneside suggesting that the system was working well. It would be of benefit for the Board to seek assurance that all key agencies are knowledgeable about MASH processes and that all contacts are triaged effectively.*

7.6.19. Several practitioners, including two adults from the Church community, told the lead reviewer of the times they had tried, unsuccessfully, to pass on their concerns to CSC, yet there was not always evidence in agency records that these conversations had occurred. There is considerable learning here about the importance of robust recording processes, even when calls to CSC are 'just' about seeking advice, it is vitally important that records in all agencies are scrupulously maintained. The detail offered to the lead reviewer by FGW1 highlighted the considerable support she offered to the family and she painted a very clear picture of the family dynamics which caused concern, but this information was not well captured in records and only emerged later in the review process. The review team was informed that recording practices in the organisation have now been improved and are regularly reviewed but there is learning to for all agencies to ensure that where safeguarding concerns arise records are purposefully created and carefully maintained.

7.6.20. Following Harry's death, MH was sectioned under the Section 2 of the Mental Health Act 1983 *21* and CSC undertook another assessment in relation to Iszac, the contents of which highlight many of the concerns raised by staff in the five months before Harry's death, but which later, and with the benefit of hindsight, carried far more significance than had been considered at the time.

7.6.21. The communication of concerns from referring agencies is an important step in initiating a response from CSC. The review team found that some professionals believed they were making a referral for action by CSC when in fact the information they were providing was being logged by CSC as a 'contact only' and did not lead to any further action. The review team was told by some agencies that they are not always provided with feedback about their concerns, or why action was not considered appropriate, but some agencies also acknowledged they did not always follow this through and get back to CSC when feedback did not happen.

7.6.22. Despite concerns made to the review team about MH's mental health and the concerning impact this has on the children, the detail in some referrals and in TAF meetings did not equate with the detailed concerns and descriptions shared in meetings with professionals and in one to one conversations with some practitioners. The review team was left to consider whether some referrals and minutes held euphemistic language because MH was present at the meetings or because some referring agencies were trying to provide a 'balanced' analysis of their concerns. There can be an assumption by these agencies that simply describing a family situation or stating that a parent has mental health difficulties that CSC will automatically 'connect the dots' and understand why agencies are concerned. This is not so and referring agencies need to be explicit

[21] Section 2 provides for someone to be detained in hospital under a legal framework for an assessment and treatment of their mental disorder.

about what they see, what they have been told and exactly what they are worried about and why.

7.6.23. The referral by SCH2 in May 2017 however clearly described school concerns and expressed worries about emotional abuse and the fact that because of Harry's medical condition, he had to occasionally wear nappies. It was this referral, which led to the 2017 Single Assessment.

7.6.24. The language used by professionals in referrals provides a medium for describing perceptions and therefore has an extraordinary capacity to influence the way professionals think[22]. The use of the term 'concerned about mum's mental health' – which was used many times by different professionals does not carry the same weight as '*MH was seen to scream and shout at Harry telling him he was useless; she would tear her hair and sob uncontrollably telling the children she will kill herself*'. Parental mental illness has a range of influences, which may impact on child development and behaviour and at its most extreme, poses significant harm and death to children. Assessments need to balance the rights and needs of the child and the needs and rights of the parent but before any decisions are taken about what to do, the exact nature and extent of parental mental health difficulties must be well understood. In this respect, it is important to ensure that referrals, reports, and minutes are crystal clear about what exactly professionals are worried about and the actual or potential impact on the child.

Finding 8: *Unless professionals who refer their concerns to CSC are clear and specific about what it is, they are worried about and use their skills to clearly convey why they are worried, appropriate referrals requiring statutory intervention might not be recognised as such.*

7.6.25. The review team was of the view that the extent of MH's behaviors in the home and the impact these had, or had the potential to have, on the emotional development of the children were not as well understood by CSC as they might have been. There was no input from, and not enough communication with, health professionals and there were no purposeful pro-active opportunities created to talk to the children whilst acknowledging the significant pressure they were under to affirm that all was well. The fact that children were 'doing well' and were displaying no outwards signs or symptoms of distress offered a false reassurance that they were OK, despite the escalating concerns shared by other agencies.

7.7. KLoE 4: How well agencies communicated and worked together.

Understanding roles and responsibilities

7.7.1. There is a plethora of research, which highlights the importance of professionals from all agencies working collaboratively, sharing knowledge and expertise. By its very nature, joint working brings together professionals with different roles and responsibilities as well as divergent professional cultures, which can both, support, and hinder effective joint working.

7.7.2. Understanding the roles and responsibilities of colleagues from different disciplines and respecting their expertise is critical to the success of effective multi-agency work. Practitioners who contributed to the SCR process and even some members of the review team acknowledged that they were not well informed about the role and function of all the professionals or agencies

[22] *This is sometimes called the Sapir-Whorf hypothesis. 'Language may indeed influence thought' Jordan Slatev and Johann Blomberg. Phil Papers October 2015*

that at different times were in contact with MH. The list of these professionals listed on page 3 of this report is daunting - for MH, Harry, and Iszac, it may have been overwhelming.

7.7.3. It must have been difficult for MH to understand who came in and out of her life, who they were, and why they were visiting, with each offering where they could, assurances of how they could help. Not many of the conversations had the advantage of an interpreter and MH's high emotional state, together with her struggle to make herself understood clearly caused frustration on both sides.

7.7.4. At various times throughout the time the family lived in the UK, MH was involved with the local church community who offered practical support and occasional financial help at times. Churches and faith-based groups play a vital role in the lives of many children, young people, and adults. People who contribute to the life of faith-based communities and places of worship also have an important role to play in keeping children and adults safe. For faith-based organisations and communities, getting this right can be challenging.

7.7.5. The review team learnt that whilst individuals in MH's church were concerned about the family, they were at times unsure as to how best to raise their concerns and with whom, especially when MH could be adamant, she did not want [government] interference in her life. It may have been helpful for there to have been greater connectivity between the schools and the church community, but any such arrangements were, it seems, often compromised by MH 'falling out' with people in the community. At the time of the TAF meetings in 2018, MH no longer attended the church.

7.7.6. Despite the concerns expressed by the Church Pastor about the family, there are no records to suggest that any referrals were made to CSC. The review team would urge the church to review its safeguarding policy and procedure so lay individuals are confident they know what to do if they are concerned in any way about any member of the church community.

7.7.7. CC1 met with SCH1 and SCH2 in January 2017 to introduce herself as an early help practitioner whose role was to provide practical support to MH for a limited period. Care and Connect was a local authority service set up originally within Adult Social Care for practitioners who were known as 'community navigators', in that their role was to signpost individuals or families to local resources when low-level support/advice was needed on a short-term basis.

7.7.8. Until May 2017 when the Care and Connect service was fully adopted by Children's Services, CC1 was supervised by a manager in adult services. There was no managerial oversight from anyone in children's services, although the family, it seems, did have an allocated social worker with whom CC1 occasionally liaised.

7.7.9. Helping the review team understand the role and involvement of CC1, it became clear that managerial oversight of the work being undertaken by CC1 was not as robust as it should have been; the input from CC1 focused solely on practical tasks to support MH despite, according to Early Help records, there being an implicit expectation that 'one to one' work would be undertaken with the children. However, the review team could locate no plan of work or supervision notes, which made this expectation clear.

7.7.10. CC1 was in regular contact with the family but agency records indicate that she was often unable to engage with MH and her contact appears to have ended sometime in July 2017 around the

time the Single Assessment was coming to an end. There was no closure summary and no indication of what had changed for the family. Believing support was still required and knowing that CSC would not be intervening, SCH2 referred the family to Family Gateway and FGW1 was allocated to work with the family for an initial six-week period. In effect, she continued to work with the family from September 2017 until Harry's death in August 2018.

7.7.11. What emerged from the SCR process was that the roles of CC1 and FGW1 were not well understood by other agencies and at various times these practitioners were viewed by others almost as social workers or lead professionals. In fact, they were neither, but their presence clearly afforded reassurance for some professionals that 'someone' was involved with the family.

Finding 9*: Some professionals, in North Tyneside are not as knowledgeable as they could be about the range of services available to families and how these services work in practice.*

Finding 10: *Information sharing between professionals also means that professionals in voluntary, statutory and faith-based organisations, working or in contact with families where there are concerns about children's welfare, should always seek consent of the parent to find out who is involved with the family, their role and remit and their contact details.*

Multi-Agency working

7.7.12. The key agencies having regular contact with the family were SCH1 and SCH2 and after September 2017, Family Gateway. Whilst professionals from these agencies met regularly and shared concerns, there was little contact with the GPs in the medical practice attended by MH. Neither was there any contact with P1 or P2. It would perhaps be more accurate to describe these arrangements not as multi-agency but as joint working in that they involved primarily only two agencies: Education and Family Gateway.

7.7.13. There were in fact no 'multi-agency' meetings undertaken during the period of this review, yet multi-agency meetings remain the key mechanism for implementing and progressing plans to promote a child's wellbeing, safety, and welfare. Like other local authorities, North Tyneside work with a range of families with complex needs who are at risk of statutory intervention but fall below existing service thresholds. For these families, as with MH, North Tyneside operates a Team Around the Family (TAF) approach, where professionals and families meet to set targets/goals, identify additional support, and monitor and review progress. Where the approach is delivered most effectively, the TAF is multidisciplinary in nature, drawing on support from a range of professionals who work collaboratively to undertake an Early Help Assessment which informs the subsequent action plans.

7.7.14. The EHA competed in May 2018 was based around the signs of safety approach which supported the identification of concerns and strengths and actions to be taken. The subsequent TAF plans were, however, not SMART and were focused largely on the behaviour of the children rather than addressing parenting issues. The review team obtained copies of the minutes from the three TAF meetings, which took place in May, June, and July 2018. The first two meetings were chaired by SEN1 who told the review team that she did not regard herself as the 'lead professional' she just 'chaired the meetings'. An, Early Help Coordinator. EHC attended the second meeting and TM3 from the Early Help team, chaired the third. MH, schools, and FGW1 attended all the meetings. The last meeting was also attended by a professional from NTCC.

7.7.15. The presence of the EHC at the second meeting and TM4 at the third was well advised. Whilst the TAF process might helpfully have been introduced earlier in work with this family, the lack of engagement with key health professionals and the poor quality of the multi-agency plan, which remained largely focused on MH behaviour and the children's response to it, actually in this case, curbed the effectiveness of the process.

7.7.16. The review team was advised that the work of the Early Help and Coordination team has, since then, further developed, and matured. The Early Help and Coordination (EHC) team continue to support other professionals working with families, but practice standards have been reviewed and clarified with a specific emphasis on ensuring that all work with families include recorded and individual sessions with children so their 'voice' can be heard. Case consultancy is also available to support lead professionals and the quality of EHAs, action plans and reviews are monitored with timescales and outcomes still being measured. Where progress in work with a family is not evident, the Early Help Coordinators support the intervention of social workers or family partners. A range of other initiatives were introduced in 2018 including more training for family partners and a new practice-learning tool to help promote learning and case reflection.

7.7.17. The review team was informed by SCH2 that the role of Early Help Coordinators is very much welcomed and used to good effect in schools although it remains the case that the lead professional role usually sits within education for most children about whom there are concerns and this continues to remain a challenge for many schools.

Working with Health colleagues

7.7.18. At no time in work with this family was the involvement of the school nursing services considered as a support option for the children. Harry's medical needs would have justified their involvement, as would P1 and P2's view that his enuresis could well be linked to emotional distress. Within the review team, the value of introducing a school nurse to support Harry was clearly identified and yet it was never considered as an option. Views were expressed that had there been more liaison in general with health professionals, the value of Harry being referred to school nursing services may have been encouraged.

7.7.19. Exploring this issue further, it appears that the significant changes in the remit and function of school nurses together with an overwhelming demand for their service has left some professionals less clear about their role and their remit. Ofsted in their 2017 report, 'Growing Up Neglected' also noted that the limited capacity of the school nursing service in some areas was actually limiting the quality and breadth of work that school nurses were able to provide.

7.7.20. The review team was told that in North Tyneside, work is currently underway within the 0-19 Healthy Child Programme service to look at how the school nursing service can be more proactive and target the most vulnerable children and young people. A proposal to collaborate far more closely with partners in Early Help is currently being explored. This would ensure that interventions would be delivered at a much earlier stage and make good use of the skills of the school nurse to detect and respond to mental health concerns of older children, like Harry. This is a move to be welcomed.

7.7.21. MH was treated by her GP for anxiety and depression. Although the GP considered that MH's behaviours were symptomatic of a Borderline Personality Disorder[23], there was never a formal assessment or diagnosis of MH's mental health needs as she refused to engage with CMHT. The implication of this for the children could have been more robustly addressed by the GP and CMHT especially as the initial referral highlighted there were safeguarding concerns. A discussion between the GP and the CMHT could usefully have explored what impact MH's refusal could have on the children. Harry's medical problems of enuresis and encopresis were already thought to have a psychological rather than a medical basis and, in this respect, MH's mental health, her refusal to engage with CMHT and Harry's continued missed appointments with the dietician was clear evidence of his increased vulnerabilities. The GP was also unaware that at the time MH was not taking her prescribed medication.

7.7.22. There were several missed opportunities when GP concerns might have usefully been shared with other agencies, possibly brought together via a 'supporting families' meeting - an approach regularly used by the practice. The view expressed to the SW1 in June 2017 that the children were not a risk was unhelpful and not based on any risk assessment, yet it was included as a professional opinion in the Single Assessment in 2017.

7.7.23. There are well-established links between parental mental disorder and poor outcomes in children but assessments which measure the potential or actual impact of mental health on parenting, the parent/child relationship and the child, as well as the impact of parenting on the adult's mental health are essential before it can be concluded that children are 'not at risk'. There were also occasions when the GP may have referred concerns directly to CSC, when for example MH did not engage with CMHT, which left a diagnosis of mental ill-health undetermined. Whilst, the review team were advised that the presence of CC1 and later of FGW1 at GP appointments gave the impression, confirmed by MH, that there was social work involvement, this does not detract the responsibility for all professionals to share information which relates to the wellbeing of children.

7.7.24. In May 2018, P2 recommended via a letter to the GP that Harry and MH would benefit from individual counselling sessions. The letter was copied to CSC. This action was not however progressed by either the GP or CSC and P2 did not follow up whether her recommendation had been actioned. The letter, seen by the review team, was clear in its expression of concern about the family dynamics but did not specifically request the GP to refer either Harry or MH for counselling. The review team was told that without a specific action for the GP and given the letter had been forwarded to CSC, the GP assumed the matter would be picked up by that agency and consequently took no action. A simple telephone call by either practitioner to the other might have highlighted the need for contact with CSC.

7.7.25. Given there was no CSC involvement at the time; the letter sent by P2 to CSC did not prompt any action. P2 could have made contact with CSC directly to share her concerns but as a new paediatrician to the area, it appears she was not well acquainted with service provision in the area and was of the view that the GP would make the necessary arrangements, highlighting again the dangers of unchecked assumptions.

[23] *A person with borderline personality disorder (one of the most common types) tends to have disturbed ways of thinking, impulsive behaviour and problems controlling their emotions. Someone with a personality disorder may also have other mental health problems, such as depression and anxiety*

7.7.26. There were examples of some professionals communicating with each other at different times, sharing information via emails and phone calls. Both schools regularly liaised and worked closely with FGW1. These communications, important as they are, are not the same as multi-agency collaboration. When important and relevant information related to a child becomes known it is important that professionals take the next step of exploring within a multi-agency context what this means and why significance is attached to certain issues and not others. The lack of any liaison with or by health professionals, when most of the concerns about MH centred on her mental health and the children's emotional development meant that important information was not discussed or shared in a multi-agency setting and was effectively lost.

Finding 11: *Where concerns arise about parental mental health, health professionals, including mental health specialists, have a key role in considering, and advising on, to what extent an undiagnosed and /or untreated condition can impact on parenting capacity. This information should be appropriately shared with other key professionals where potential risks to children are identified.*

7.7.27. SCH2 undertook an Early Help Assessment (EHA) because they had been told to, even though they believed that their concerns met a much higher threshold and a statutory assessment was required. The review team was told by SCH1 and SCH2 was that undertaking an Early Help Assessment seemed to be the only way they and FGW1 could highlight their concerns about the children in the family. Whilst some practitioners spoke of the difficulty in challenging 'expert opinion', few of the agencies involved in the SCR were aware of the escalation procedures designed specifically to support and address professional disagreements.

7.7.28. Further discussions with practitioners and the review team highlighted that these procedures are neither well understood nor well known. Practitioners told the review team of their perceived difficulty in not only getting referrals accepted by CSC but the difficulty they had at times when challenging CSC advice. Issues were raised about thresholds between services with professionals during the SCR process, being concerned that in this case, the number of different agencies raising concerns did not in itself warrant further investigation by CSC and the professional expertise of colleagues was not acknowledged.

Finding 12: *Agencies clearly disagreed with CSC about the level of risk in this family and although such disagreements are common, divergent views need to be adequately explored though professional conversations which seek to build on and acknowledge the expertise of all those involved. If escalation procedures are not known or well utilised professional relationships and multi-agency working will be less effective.*

7.7.29. The sad and tragic death of Harry has, understandably had a significant impact on many professionals who knew or worked with the family, leaving some practitioners with mixed emotions - grief, sadness, anger at others for seemingly not doing more and in some cases guilt for believing they could have done more themselves to prevent Harry's death. These emotions are natural and are part of being human and doing a challenging job in difficult circumstances. The lead reviewer noted that not all professionals received support or the opportunity to talk about how they felt after Harry's death. Agencies in the voluntary and statutory sectors and those in faith settings should be attuned to the impact a child's death can have on professionals tasked with the job of looking out for that child's welfare.

7.8. Concluding Comments

7.8.1. In the UK, suicide is the leading cause of death in young people accounting for 14% of deaths in 10-19-year olds. Whilst, the UK has a relatively low rate of suicide by children and young people compared to other countries, according to Office of National Statistics, (ONP) the number of teenage suicides in the UK increased by 67% between 2010 and 2017 reversing a decline over the previous 10 years. Suicide in young people is rarely caused by one thing; it usually follows a combination of cumulative adverse experiences, which combine over time to increase risk, until suicide occurs in a crisis triggered often by a significant event or crisis.[24]

7.8.2. Various research studies refer to ten common themes found in a previous study of suicide by children and young people up to 20 years of age. One of the most important in considering suicidal behaviour in adolescents is the family context in which young people live or have grown up. Several risk factors concerning family structure and processes have been linked to suicide behaviour in numerous studies. It is estimated that in 50% of youth suicide cases, family factors are present with parental mental ill health also being a key determinant.

7.8.3. Health, social care, education, and other agencies that work with young people, as well as families and young people themselves, need good insight into the risk factors contributing to suicidal behaviour in young people. Professionals can contribute to suicide prevention through greater awareness of the range of factors that may add to risk and of the "final straw" stresses that can lead to suicide. This requires agencies to work together and jointly unravel the complex interplay of the risk factors acknowledging that clear evidence of harm and stress may not always be visible.

Finding 13: Youth suicide is referenced in the updated North Tyneside Local Transformation Plan 'Promoting, Protecting and Improving Mental Health and Wellbeing of Children and Young People in North Tyneside' and there is a multi-agency local suicide prevention strategic group and action plan in place which addresses risks around CYP. However, the remit of this group was not as well known amongst professionals involved in this SCR as might be expected. This is an issue which needs to be further explored.

7.8.4. This review has not identified a significant contravention or action by any professional that was a critical factor in what happened to Harry. There are however lessons to be learnt in terms of how agencies support migrant families who have no recourse to public funds and who, alongside other stressors, bring children to the attention of voluntary and statutory agencies.

7.8.5. Harry's sad and tragic death is also a stark reminder to all professionals about the importance of keeping work with a family child centred and being continually mindful of the wide range of factors that can lead to suicide in young people. The SCR particularly highlights the importance of practitioners and managers being attuned to the impact on children of living with a highly critical parent with poor mental ill health. The review also emphasises the importance of professionals keeping in mind the impact of cumulative adversities, which can lead to feelings of isolation and hopelessness in young people who feel they are without support.

[24] *Suicide in Children: A Systematic Review. 2015 Soole R, Kõlves K, De Leo D Arch Suicide Res. 2015;*

7.9. Summary of Findings under themes

Management of Systems – Contacts and referrals

Finding 8: Unless professionals who refer their concerns to CSC are clear about what it is they are worried about and use their skills to clearly convey why they are worried, appropriate referrals requiring statutory intervention might not be recognised as such.

Finding 6: If when CSC are assessing referrals, the volume and nature of previous and recent contacts by other agencies are not flagged and taken into consideration, escalating concerns and risks to children may not emerge or be recognised and children may be left vulnerable.

Management of Systems – Assessments

Finding 5: An over-emphasis on the physical wellbeing and general demeanour of children who live with parents with mental health difficulties can displace the need to consider potential psychological vulnerabilities in children.

Finding 7: A review by Ofsted of the MASH in 2018 commended the process suggesting that the system has improved since 2017. It may however be of benefit for the Board to seek assurance that all key agencies are knowledgeable about MASH processes and that all contacts are triaged effectively.

Finding 2: Unless there is an increased awareness amongst professionals about how to recognise and respond to young carers, these children may not get access to the right support and their mental health needs will be missed. Early interventions are critical in ensuring that children do not take on inappropriate caring tasks; the need for children to provide care is increased when services to parents with mental ill-health are not in place and when family-based interventions are not provided.

Work with Families

Finding 1: Where concerns arise about the impact of parenting behaviours on children and interventions are deemed necessary, action should always be taken in to ensure that children are provided with carefully managed and purposefully created opportunities so their wishes and feelings can be explored and acknowledged.

Finding 3: Even with the relatively small number of migrant families arriving or living in North Tyneside, professionals should be acquainted with the ways in which immigration policy frames the conditions and pose barriers in the lives of the migrant families with whom they may come into contact. Without this awareness, some children in migrant families may be left vulnerable.

Finding 4: Unless there are multiple and more innovative ways to communicate with migrant families which help them absorb and digest information, the dynamics, and intricacies in family life may be less well understood and children may be left vulnerable

Finding 9: Some professionals, in North Tyneside are not as knowledgeable as they could be about the range of services available to families and how these services work in practice**.**

Multi-Agency Work

Finding 10: Information- sharing between professionals also means that professionals in voluntary, statutory and faith-based organisations, working or in contact with families where there are concerns about children's welfare, should always seek consent of the parent to find out who is involved with the family, their role and remit and their contact details.

Finding 11: Where concerns arise about parental mental ill- health, health professionals, including mental health specialists, have a key role in considering, and advising, to what extent an undiagnosed and /or untreated condition can impact on parenting capacity. This information should be appropriately shared with other key professionals where potential risks to children are identified.

Finding 12: Agencies clearly disagreed with CSC about the level of risk in this family and although such disagreements are common, divergent views need to be adequately explored though professional conversations which seek to build on and acknowledge the expertise of all those involved. If escalation procedures are not known or well utilised professional relationships and multi-agency working will be less effective.

Finding 13: Youth suicide is referenced in the updated North Tyneside Local Transformation Plan 'Promoting, Protecting and Improving Mental Health and Wellbeing of Children and Young People in North Tyneside' and there is a multi-agency local suicide prevention strategic group and action plan in place which addresses risks around CYP. However, the remit of this group was not as well known amongst professionals involved in this SCR as might be expected. This is an issue which needs to be further explored.

Appendix 1

Agencies involved in the Serious Case Review Team

Role	Organisation
Designated Nurse, and Chair of the Review Team	North Tyneside CCG
Linda Richardson	Independent Reviewer
Designated Doctor	Northumbria Healthcare Foundation Trust
Named GP	North Tyneside Clinical Commissioning Group
Senior Manager Safeguarding Children	North Tyneside Childrens Social Care
Senior Manager, Early Help	North Tyneside Children's Social Care
Acting Named Nurse	Northumbria Healthcare Foundation Trust
Senior Manager 0-19 Service	North Tyneside Council
Det Chief Inspector - Safeguarding	Northumbria Police
Chief Executive	North Tyneside carers Centre
Head Teacher	School 1
Programme Manager	Family Gateway
Consultant Child and Adolescent Psychiatrist/ Clinical Lead	Northumbria Healthcare Foundation Trust
LSCB Business Manager	NTSCB

NOTES: