



Tameside Safeguarding Children Partnership

Local Children’s Safeguarding Practice Review

Child Name:	Ellie
Date of Report	12 October 2022
Date of referral to Panel	03/08/2021

Agency
District Superintendent Police
Assistant Director Children’s Services
Youth Justice Service Operations Manager
Head of Service, Early Help, Early Years and Neighbourhoods
Specialist Nurse Advisor Hospital
Named Nurse Safeguarding Children
Head of Child Protection and Children in Need
Acting Head of Service Childrens
Designated Nurse Safeguarding CCG
Named Nurse Safeguarding Children (Mental Health)
Access Manager Education
Practice Improvement Manager Children’s
Detective Inspector Police
Administrator

1. Background

Ellie died whilst on holiday. Her brother, Tom, a young adult, has been found guilty of manslaughter.

Ellie and her family were known to various agencies since 2008. Concern related to parental mental health and the impact of this on the children. The family have experienced periods of difficulties for a majority of both children’s lives with ongoing and extensive service involvement throughout.

Services with involvement include: Children’s social care (CSC) ; Young Carers; Health visiting; Early help services; Youth Offending services; GP services; Hospital services; Healthy Young Minds ; Forensic Adolescent Mental Health services; Police; Education (Special Education Need) ; MST; Education Psychology; SALT (Speech & language therapy); BLIS (behaviour, learning & inclusion service); Consultant paediatrician; CLASS (communication, language & autistic spectrum support); Community mental health team.

Between 2009 and 2013, agencies recorded and shared concerns with CSC in respect of Tom's escalating violent and aggressive behaviours. The outcome of contacts was no further action from CSC.

An incident was referred to CSC in 2012 reporting that Tom had assaulted a member of staff at school and that Tom had become increasingly intimidating and aggressive at home, the target being his mother. At this time, the family were receiving support from the Young Carers Team. The outcome of the contact was for a CAF to be completed with School and Young Carers to lead. Tom had been presented at the Resolution Crime and Disorder Panel in response to the physical assault of his teacher and ongoing counselling was in place.

In 2014 an assessment was completed by CSC in relation to Tom's escalating behaviours that culminated in a period of Child in Need (CIN) support with the family. The CIN plan escalated to Child Protection Case Conference in April 2015 following an incident whereby Ellie was stabbed by Tom with scissors it was a Multi-Agency Decision that the children should be subject to Child Protection Plan (CP).

During the course of Child Protection planning professionals and parents considered the family living arrangements and how they could be safely managed to reduce their assessed risk of harm to both Ellie and her mum. Practitioners did not have a shared assessment of risk of harm which Tom posed to his family. His family have expressed that Tom had a positive relationship with his sister and his mother and the violence was part of his overall presentation of autism.

Mum made a decision to move out of the family home with Ellie, so that she and Ellie could live separately to Tom and Dad. This family separation occurred during 2017, and was identified by agencies involved as reducing the risk of future harm and was deemed effective at doing so. The case was subsequently stepped down from CP to CIN on 17th Oct 2017 and the case remained open to CSC until case closure in March 2018. Following the case closure there were no restrictions in place on for the family to work with or adhere to.

During the childhood and early adult life of Tom he had ongoing assessment for autism, A diagnosis of this condition was made when Tom was 17 years old. Although he was signposted to other services who may have been able to offer help and support to Tom, the uptake of these was minimal. His family say that this was because Tom had difficulty with reading and writing and did not always understand how such services may have helped to support him.

2. The child

Ellie has grown up in a family home where violence and aggressive behaviours have been present and where all family members have been physically harmed by Tom on many occasions. Both parents have suffered from poor mental health. Mother of Ellie pointed out that her low mood came after series of events in her life including bereavement and ill physical health. Mother of Ellie pointed out that she believed that professionals too often focused on violence within the home through a lens of domestic abuse rather than addressing violence as a response by Tom to frustration and anger, which were part of his autism. She also believed that Ellie and Tom enjoyed a positive sibling relationship and did not feel that any violent outbursts from Tom were directed at his sister.

It was confirmed by Midwifery services that Mum was treated for depression and prescribed medication whilst pregnant with Ellie. Ellie was delivered as a healthy baby and the Health Visitor worked intensively with mother due to mental health concerns.

When Ellie was 2 and a half years old Mum was sectioned under the Mental Health Act in 2008 (Section 2 assessment & Section 3 treatment) and remained involved with CMHT (Community Mental Health Team) until 2015. Mum had episodes of mental health inpatient stays leaving both Ellie and Tom in the care of their father. Assessments carried out at the time identified Dad, had mental health and past alcohol issues, and there was evidence that this has impacted on his ability to meet his children's emotional needs.

The family had limited support from extended family and friends with little offer for support in caring for the children. Home conditions were recorded as being of concern at times.

In addition to mental health needs, Mum has a chronic illness and has significant mobility difficulties requiring the use of crutches and a wheel chair. Ellie was identified as a young carer.

Ellie was referred to Young Carers to receive support in groups and have time away from responsibilities at home. Ellie attended group sessions on a regular basis until she went to high school. Ellie engaged in art activities and attended holiday activities but was always quiet and withdrawn. Her parents said that one reason for her attending these groups was to build her confidence. Ellie had one to one work completed with her around self-confidence, Ellie would not talk about her situation or feelings but was happy to draw these. School reported an improvement in her confidence after this work. Once Ellie attended high school and started to attend after school clubs, she chose to attend these rather than Young carers group. Her parents cite the reason for non-attendance at the Young Carers meetings was because the transport did not arrive on an occasion and this made her anxious. Ellie had additional support with numeracy and literacy.

Ellie had significant involvement with health services from the age of 7 years when she was referred for support in relation to low self-esteem and lack of confidence. A brief intervention was made. Ellie developed pains in heels and feet and was referred to Podiatry, physiotherapy and Orthopaedics. Ellie was assessed as having hyper-pronation of her foot and an infected in growing toe nail. Ellie was overweight in the latter part of her life. Her parents felt that she was very active and the family home had a number of photographs of Ellie undertaking activities. There was good compliance with health treatment for Ellie is documented.

Ellie had 9 A&E attendances, 3 being recorded as injuries but there were no safeguarding concerns evident, all attendances were appropriate and evidenced that parents met reactive health care. There were no suspicious injuries and one attendance led on to foot surgery related to ongoing podiatry issues. Referral to paediatrics for recurring headaches was investigated, thought to be tension headaches, and no treatment required. Ellie had various health issues relating to eyes, ears and feet, which she had relevant treatment for.

Concerns about Tom's problematic and aggressive behaviour started to emerge in 2009. Tom attended specialist education provision after he was permanently excluded in February 2011, when he was in Year 4. This was due to his persistent aggressive behaviour towards other children and adults. Tameside Youth Justice Service were involved with Tom and the family between 2013 and 2017 with Tom being subject to both voluntary and Court orders (5 separate interventions in total). Work completed throughout interventions focussed on Domestic Violence, emotional regulation, carrying knives and weapons and support for his mental Health and Speech and language needs. Tom's parents wished to point out that Tom did not normally carry knives and weapons but rather this was part of the overall

training programme he attended. There is evidence throughout of partnership working which in the main was positive. Many sessions were carried out with the support of school often physically carried out at school. Tom was diagnosed with Autism when he was 15 2 years from the point of referral for assessment. Tom was also registered as a young carer.

Throughout CIN and CP, planning professionals remained committed to attending meetings and overall appropriate support and services were identified to work with the family. Parents attended and engaged with parenting support packages, but it is evident that they were not always willing to fully commit to changes proposed, such as consistently contacting the police when Tom has been violent. The family of Ellie felt that it was inappropriate to contact the Police after violent events had taken place in the home. They believed that to take this action would have been to escalate interfamilial conflict further and that the focus which they would have liked services to have provided was guidance around interventions to help Tom take measures in anger management linked to his autism.

When Children's services involvement ended with the family Ellie was residing with her mother whilst Tom resided with his father. Records indicate that mother and Ellie continued to attend appointments with Tom rather than father and so perceived risks to Ellie remained despite parents separating with the children. No further referrals were made to CSC from closure in March 2018 to the death of Ellie in 2021.

The family expressed that although they recognise the problems within their family, they also wished to inform the Panel that they believed that their children had some positive experience of their childhoods including regular holidays and a family who cared and loved them.

3. Immediate Findings

Panel members felt that Ellie was not the focus of services throughout the family's various involvements with a large number of agencies.

There appears to have been lack of exploration around Ellie's daily lived experience during the initial periods of contacts made prior to CSC involvement, focus was on Tom and his mother's vulnerability. Physical harm to Ellie does not appear to have been fully risk assessed. There were missed opportunities from professionals in response to obesity and self-esteem as a safeguarding concern. The Panel felt that the multi-agency team did not fully understand the underlying root causes and factors in this family. The family have since confirmed that they also believed that there was a lack of understanding of the needs of the family and would have liked more interventions to have been available to address the underlying causes of Tom's violent behaviours.

At the time when professionals were initially raising contacts and expressing concerns to CSC in the period 2009 - 2013, the response from CSC was that there were already sufficient services involved with the family. The children's daily lived experiences appear to not have been fully considered and it is evident from records that there have been occasions when the children should have been seen.

Ellie had self-esteem and confidence issues at an early age and found it hard to talk about her home life. Some work was undertaken by the young carer's service and school nursing service but this does not appear to have been effective in the long term. There is evidence of non-verbal clues, there is some evidence of improvement in mood when initially separated from her brother and father but records detail that she misses them and her

behaviour becomes aggressive towards mum and children at school but this does not appear to have been assessed or appreciated at the time of the case closure.

When the case was closed in 2018 agencies recognised that the risk of abuse remained and the panel felt the risks posed by Tom were underestimated. There is evidence that parents rationalised and minimised the abuse experienced and assessments did not fully explore the vulnerabilities of the family nor appreciate the lived experience of Ellie. Panel members questioned the processes for tracking meaningful change in a whole family. Did we achieve meaningful change or in fact only a change in circumstances? Did parents have the capacity for change? There was little consideration of parental mental health in assessments and the impact of this on parents' ability to meet both their children's needs.

There was evidence that Tom's behaviour continued to cause concern recorded in various multi-disciplinary team records in the period 2018-2021. In sept 2018 Tom was seen by mental health services, he wasn't taking his medication and was identified as needing CSC input however there is no evidence this was actioned. The family emphasised that Tom stopped medication on the advice of his GP as he was experiencing side effects which were impacting on his daily living.

A further opportunity was missed in October 2019 when the Mental Health Liaison Team recorded they would refer Tom to adult and children services. Again there is no evidence that this was actioned. In October 2019 Greater Manchester Police had records of response to an allegation of sexual assault towards Tom from a peer at the education provision. The GP recorded in Feb 2020 that Mum reported that Tom was 'still hitting his father about 5-6 times per day. Tom denied this. There was no evidence that any of these concerns had been shared with CSC for further assessment /referral, the panel agreed that concerns should have been raised to secure multi-agency involvement.

The Panel discussed the effectiveness of the ASD pathways & process and the interface with CAMHS. It was apparent that there was considerable delay in identifying the need for an autism assessment and then subsequently a diagnosis for Tom, which may have affected access to appropriate support and provision for the family. The panel also considered the impact of this on the parents and professionals ability to meet Tom's social communication needs when they weren't fully understood. Practitioners spoke of the delay in reaching diagnosis and subsequent difficulties in offering a response to support people and their families, where diagnosis has been made. Work is ongoing in the area between commissioning and provider services to ensure that there is a diverse and appropriate range of services available to support families. The mother of Ellie reported that she believed that she had noticed an improvement in services locally.

Efforts were made to decriminalise Tom's behaviour. Tom had been presented at the Resolution Crime and Disorder Panel and worked with Tameside Youth Justice Service in the period 2013 - 2017. Following an incident in 2015 Tom was arrested and a decision made to charge him with the offences after YOT advised Tom had 'exhausted all pre-sentencing diversion work'. Tom was subject to both voluntary and Court orders. He was discussed at the Mentally Vulnerable Offenders Panel (MVOP) panel. There is evidence throughout of partnership working which in the main was positive however there was evidence to be a lack of accountability and tracking of recommendations. Panel members questioned why a therapeutic placement outside of the family home was not found despite being recommended at the time. Interventions needed clearer management oversight. Complex cases would now be subject to more regular assessment and review and Tom would meet the criteria to be managed in the multi-agency Complex Case Panel (High risk process).

4. Analysis Tree

EFFECTS:

Tom to serve custodial sentence

Parents lost daughter Ellie and impact of this on their own mental health and vulnerabilities

Community impact on Ellie's family

FOCAL POINT:

Ellie lost life due to Tom assaulting her

ROOT CAUSES:

Professional curiosity opportunities to ask those extra questions.

Failure to assess the impact of poor parental mental health on parent's ability to parent and protect their children.

History of Domestic Abuse, trauma causes by ACEs, disability, autism and mental

The risk posed by Tom was not responded to at the earliest opportunity

Lack of information sharing following key events in the last 3 years

Risks Tom posed to Ellie and parents, Ellie has not been the focus of services. VOC expressed in behaviours lack of communication.

5. What are we worried about?

The Panel were concerned the case was closed too soon (following change to living circumstances 2017) and there was an over reliance on the family reporting improvement, there was complacency among agencies that Tom's behaviour had 'settled'. The panel felt it would have been prudent to see sustained change over longer period prior to closing the case.

The Panel considered the quality of social work assessments. There was limited evidence that parental mental health was included in a holistic assessment of need considering broader factors that may have impacted on parenting ability and the impact that this had on the children. The family believed that the assessment focused on risk of harm from domestic violence rather than offering a service which could support family to intervene when Tom had violent outbursts.

The Panel questioned overall accountability for monitoring progress and information sharing in cases where there is no CSC involvement after step down. Many services continued to see the family after statutory intervention stopped however, this appeared to be in silo and there was a lack of lead agency monitoring progress. The Panel identified a number of missed opportunities over the last 3 years that warranted a referral for further assessment and/or support, this may have supported a more joined up approach and identified escalating risk. The panel acknowledge the impact of Covid restrictions and the lack of visibility of this family during the pandemic however it is not clear what prevented professionals from sharing concerns given the extensive history of CSC involvement.

There was evidence that police responded to some incidents in isolation and did not consider previous history and the impact on wider family members. Some of those incidents were not coded on police systems to indicate 'concern for child' therefore no Care Plans were raised for triage and consideration of safeguarding referral/s. Documentation and outcomes of strategy meetings was poor. The Panel considered if safeguarding was not considered due to Ellie and Mum living in separate accommodation.

The Panel were concerned that children are waiting too long for ASD pathway and diagnosis and this is affecting the ability to meet needs. The SEND code of practice clearly states children should not wait for service whilst awaiting diagnosis but it appears over reliance on a diagnosis to effectively meet need. There were several referrals made to CAMHS that weren't progressed, the panel questioned if these were these the right referrals. There is evidence that services did not understanding pathways for autism assessment and support with escalating behaviour and there was a lack of coordination of information sharing from CAMHS to wider multiagency to ensure when referrals were made key professionals are aware of waiting time and plan in interim. The panel were not clear what support and response is available for families who live with children who have social communication needs and present with aggressive behaviour, likewise what support is available for transition in to adulthood.

The effectiveness of EHCP reviews post 16 were unclear. There is no evidence a review of Tom needs had been reviewed. This factor may have influenced the absence of a multi-disciplinary approach to obtaining an up to date overview of the young person's holistic needs and the coordination required between services involved to identify the ongoing appropriateness of the current provision outlined within the EHCP.

The availability of therapeutic placements for children with challenging behaviour has been identified in other local reviews, the panel are satisfied that learning has been reflected in those action plans.

6. What worked well?

There is evidence of consistency in terms of the same professionals being involved in health and social care with the family. The children were well known and supported by their primary school. The family had a lot of support and input via a coordinated approach. The Neighbourhood Beat Officer offered consistent and multi-agency contact and support in place with good practice and partnership working.

7. Views of the Family

The author of the review met with the mother of Ellie and Tom. Mum described her daughter as a very kind and quiet person. Mum said that her daughter had been a good support to her and was greatly missed. Mum described a close relationship between them. Mum said that although the family had separated to two households, they still regularly got together and spent family time together. Mum had been pleased about the proximity of the two addresses. Mum visits Tom regularly in a custodial placement. .

Mum felt that mainly practitioners from services working with Tom had failed to understand how to respond to Tom's behaviours. She described that a response of punishment of Tom was often made, expulsion from school at a young age and contacting the Police were specifically mentioned. Mum believed that Tom was perceived as a naughty child rather than one with autism who became overwhelmed in situations and needed to have adults around him who had skills to help him overcome anxiety brought on by his distress. The involvement of CAMHS was also viewed by the family in this way. Mum believed that there was a reluctance to work with Tom until his diagnosis of autism was made.

Mum believed that his challenging behaviour and provision of support services to help him was not addressed by practitioners, although Mum believes that she has been able to see some learning especially from education in reviewing their response to children and young people who present with challenging behaviours. Mum believed that a change in approach of practitioners to people with autism would help to overcome some of the frustrations which they experience. Tom could barely read and write and so for practitioners to sign post him to services rather than making referral on his behalf was not effective in helping him to access services.

Involvement from services within the family appeared to focus on the level of physical abuse perpetrated by Tom. Services addressed managing the risk to the family through the accepted routes of multi- agency policy and procedure to manage domestic abuse rather than regarding Tom's behaviour as his inability to control emotions and hitting out as part of his autism diagnosis.

The model of perpetrator/victim as in adult relationships was used to address the violence within the home which Mum believed did not improve the situation in which the family were living. Because of the focus of practitioners on domestic abuse within the home the

opportunity to help Tom to learn techniques to cope with his challenging behaviours was missed.

Mum felt that the family's decision to separate was because she was afraid that she would lose her children. Mum believed that she did set out to minimise the violent incidents but believed that Tom needed to be helped. She believed that if the children had been removed from her it would have meant that Tom would have felt abandoned, which was one of his fears. This would have made the situation worse. After the separation of the family into two households a decision was made to close the case for the family. Mum believed that this action meant that any available help and support was no longer offered. The family were still in contact with each other so the risk of harm did not go away.

Mum also believed that at this time there are no services in Tameside to offer to those with a diagnosis of autism. Diagnosis is now being made but there does not appear to be any support available for individuals. Mum is supportive of developments in Tameside to address availability of therapeutic services for people with autism.

8. Further Learning - Practitioner Event

Key lines of enquiry were identified in the rapid review and further discussion and consideration was made of these at a Practitioner Event. These were as follows:

- How are children and young people assessed as suitable to be a young carer?
- Procedures to address domestic abuse in families where the child is a perpetrator of abuse
- How is capacity to parent a child assessed when mental ill health has been identified in the parent?
- How is the impact of parental mental ill health on the child assessed?
- Recognition and response to vulnerability in the adult who has parenting capacity
- Availability of help and support for a person who has a diagnosis of autism

Assessment of children and young people as young carers

Children as carers of an adult, very often a parent, is recognised within the UK. The Children's Society estimate that there are 800, 000 children in the UK who undertake this role and of those in the region of 30% of children report that they are unable to fully attend education or meet friends away from the home environment. Whilst other potential negative outcomes impacts of caring for an adult by a child has been well documented, the practice of children caring for their parents is accepted as necessary and every child has a right to carer's assessment. Support is offered to children to support them in such caring roles. This is balanced with provision of interventions to promote childhood activities so that children and young people are able to have positive experiences.

A local authority is required to carry out assessment of a young carer's needs if that child is deemed to have support needs. A young person or their parent may also request a carer's assessments from the local authority.

"Such an assessment must consider whether it is appropriate or excessive for the young carer to provide care for the person in question, in light of the young carer's needs and wishes.

"The Young Carers' (Needs Assessment) Regulations 2015/16 require local authorities to look at the needs of the whole family when carrying out a young carer's needs assessment. Young carers' assessments can be combined with assessments of adults in the household, with the agreement of the young carer and adults concerned." WTTSC 2018

Both Ellie and her brother had been assessed by practitioners for being young carers. The children were supporting their mother due to her physical difficulties.

Tom was assessed as his suitability to be a young carer at the age of 9 years old. The assessment identified that Tom was helping to bath his mother, to unload and load the washing machine and to generally *"fetch and carry"*.

Concerns had been raised about Tom's behaviour at school and these were known by the young carer's team at that time. Whether the demonstration of such behaviours were potentially reflective of any distress which Tom was feeling about the expectations of his life were not linked.

Ellie was referred to Young Carers by her mother when she was aged 8 years. Information shared at the Practitioner event described Ellie as making breakfast and sandwiches, helping her mother get in and out of the shower and if mother was upset she would comfort her.

The assessments of both children deemed them to have significant but not excessive caring responsibilities. The Young Carers team had been told by Ellie that she wished to carry out the care of her mother.

Whilst the concerns about Tom's behaviour was known by the team, the need to question how children who were already recognised as being in need of support and potential safeguards were able to carry out a caring function for an adult who had a key role in caring for them.

The impact which the residence of an adult family member living within the household may have on assessing whether it was appropriate for children to carry out roles as young carers is not always considered.

There was no evidence within the assessments of either child that the father's role in caring for his wife and family had been assessed. There was an assessment made that he was at work at that time but the service identifies that the presence of other adults who may be more suitably able to carry out the caring role within the family was not made. The children's father was not present at the time that either assessment of the children was carried out. It is unknown what role he played in caring for his wife within the home environment or how he supported his children in undertaking such support. This point highlights concerns which have been expressed in other reports such as *The Myth of Invisible Men* (National Panel 2021)

In addition the need for the appropriateness of referring the adult to other local services such as Adult Social Care to access care and support to meet their need was not considered. This point is considered in more detail later.

Procedures to address domestic abuse in families where the child is a perpetrator of abuse

A significant amount of work has been undertaken by agencies to address responses and support for domestic abuse nationally, regionally and locally. To date much work is to support victims of domestic abuse, although recently there has been increasing drive to work with perpetrators, alongside victims.

Support offered to domestic abuse victims who are adults still carries some gender bias with perceptions of female adults being victims and adult males being perpetrators. Whilst there is a wide range of literature which supports this view and statistical evidence would demonstrate an increased likelihood of the female victim, male perpetrator model, this sometimes impacts on the amount of support perceived to be necessary to support male victims or female perpetrators. Recent work within Tameside is increasingly addressing the needs of perpetrators. It remains focused, however on adult males as perpetrators. Tameside does commission child Independent Domestic violence Advocates (IDVA) but the role is focused on children as victims and witnesses of domestic abuse.

In addition legislation and guidance tends to focus on domestic abuse from an adult perspective. Whilst the Domestic Abuse Act 2021 has improved the need to support children as victims in their own right from witnessing such violence there is little literature which identifies the prevalence of children as perpetrators of domestic violence.

Tom had been identified as having increasingly violent behaviour as a child from a very early age. This was initially identified during his primary school education and had led to his expulsion from the school when he was 8 years old. MARAC referral had been undertaken in 2014, when Tom was 14 years old after a violent attack against his mother had occurred.

Practitioners described that Tom's mother often "played down" the seriousness of the violence and believed that she did so as she wished to prevent her son from being taken into care. They believed that she under reported incidents because of this concern.

Although practitioners suspected that Ellie was experiencing physical violence from her brother, on one occasion she had sustained a significant injury from him and practitioners described how Ellie had eluded to this in some conversations, there was no further action taken. There is no evidence that Ellie ever made direct disclosure to practitioners. Given that practitioners were seeing injuries to both mother and Ellie it is unclear why further action was not instigated without the need for direct disclosure. Mother of Ellie has denied that there was a risk of harm to Ellie from her sibling.

Practitioners did not appear to assess the violence which the father of Tom and Ellie was experiencing. When the family separated and Tom lived with his father no action was taken despite Tom's father reporting that it was "normal" for his son to be violent towards him about 5-6 times per day. After separation of the family Tom resided permanently with his father.

The focus of children social care assessments had been on safety of the family due to Tom's increasingly violent behaviour against his family. Other agencies, such as forensic psychology identified violence through their assessments. There appears to have been little work undertaken directly with Tom to establish any underlying reason for such behaviour or with Ellie to assess the impact which living in these circumstances was having. Some punitive measures were implemented early within the education settings without reviewing WHY such a young child was demonstrating such behaviours. There appeared to have been little intervention implemented to work with the family or Tom with the potential aim of reducing physical violence. An agreement for a therapeutic placement for Tom did not occur and practitioners expressed that this was a missed opportunity to potentially deescalate some of Tom's violent behaviours.

The family made decision to separate so that the risk of harm to Ellie and her mother could be reduced. Children's Social Care stepped down the level of intervention after this event with the belief that the risk of harm had been reduced and then closed the case. There is some evidence, however that the family, although being separated by address still continued to be in close contact with each other. They continued to function as a family unit so the risk of harm remained.

Whilst current local policy and national literature indicates that separation of perpetrators from victims does not reduce risk and indeed in some cases increases risk of harm to the victim, this is not always reflected in case management of domestic abuse by agencies. The risk of harm to the family from a child being the perpetrator of domestic abuse was assessed using current procedures and guidance based upon adults being perpetrators and victims.

It was difficult to find national or local guidance for practitioners as to steps to be taken when a child has been identified as a perpetrator of domestic abuse. There is evidence that practitioners did try to address through the existing procedures for responding to adult abuse. There is a need, however, for review of both the Tameside domestic abuse strategy

and procedures to include how to respond to children who are perpetrators of domestic abuse. At this time the Panel has been informed that such work is underway.

How is capacity of the adult to parent a child assessed when mental ill health has been identified in the parent?

Both parents of Ellie had suffered from significant mental ill health both prior to the time that they had children and for a significant time in the children's early lives. There is some evidence that the mother of Ellie had been so ill and this warranted inpatient mental health treatment. Some elements of mental ill health and chronic physical ill health of the adults in the household were prevalent throughout Ellie's life.

There is little evidence either from the rapid review undertaken or from the practitioner event that there is any formal assessment made, or that practitioners from any agency, except children's social care, question how parental ill health impacts on an adult's ability to parent their child or the impact which such ill health may have on the child. This appears to be assessed even less for a parent with chronic physical ill health.

The Practitioner event highlighted some concerns which practitioners believed on reflection to be significant. For example behaviours such as parents not accompanying Tom to his health appointments were a cause for concern. This was shared with Children's Social Care but there does not appear to have been any professional curiosity to ascertain why attendance was either not seen to be necessary or that there was some inability to attend.

Practitioners also discussed the difficulty in making assessment of parenting capacity and the impact on a child. Health professionals expressed that the number of people with mental health difficulties who presented to them was very common, with varying features of behaviours and levels of ill health. The impact with which chronic mental or physical health is having on the life of the individual and/or others for whom they care should be routine enquiry. It is very difficult to understand how the most relevant intervention to support the individual can be chosen.

In addition there was a perceived to be a high rate of non-engagement in assessments by parents for whom mental ill health has been identified. This did not appear to necessarily increase professional concerns about the impact of non- engagement on either their ability to provide suitable health pathways to support the child or the adult's ability to care for them.

Sharing of information about a parent with mental or physical chronic ill health was also identified. Education services illustrated that they have difficulties in their ability to respond to a child presenting with challenging behaviours which may be due to parental ill health. They believed that if this information was known then there would be opportunity to use alternative responses to support the family.

Recognition and response to vulnerability in the adult who has parenting capacity

The Practitioner event identified that on reflection both adults within the family ought to have been considered as vulnerable people who were had identified care and support needs (Care Act 2014). Mother of Ellie also has a degenerative physical health condition and there is some evidence that she was reliant on support from her children as young carers. Young carer's assessments do not include assessment as to whether referral for support to external agencies are preferable to children carrying out care of their parent. In addition when assessment was made of Ellie as a carer her mother had felt that the support of the children to undertake identified tasks helped her to cope without the need for external help.

There is evidence that after an assessment for made by Children's Social Care for the children in the household that a referral was made to adult social care. This was to gain some support for equipment to assist with mobility issues around the home.

Discussion occurred as to whether it was routine practice for separate referral to be made to other agencies to address needs of the adult. Practitioners discussed that some referrals are made to other services but usually for the purpose of supporting a parent to improve their ability to function as a parent. For some period in which the family were receiving support from agencies as "child in need" and then later being subject to child protection plan, there does not appear to have been any referral for the adults for support in their own right.

Availability of help and support for a person who has a diagnosis of autism

At the rapid review the panel discussed the effectiveness of the ASD pathways & process and the interface with CAMHS. It was apparent that there was considerable delay in identifying the need for an autism assessment and then subsequently a diagnosis for Tom, which may have affected access to appropriate support and provision for the family. The panel also considered the impact of this on the parents' and professionals' ability to meet Tom's social communication needs when they weren't fully understood.

At the practitioner event practitioners identified that that there is a two year period to make full assessment to formally diagnose autism.

Once diagnosis is made there appears to be little provision of care and support in Tameside for individuals to help them overcome difficulties in their behaviour caused by autism. Practitioners spoke especially in service provision available for young people who are in the 16 to 18 age group. Diagnosis is made but interventions are not provided unless there are other identified mental health needs. Although CAMHS continued to "*keep his case open*" due to the autism diagnosis there is currently no available service in Tameside until the person reaches their 18th birthday.

In addition there is no clear transition arrangements in place for young people with autism. Tom was closed to Children's Social Care at the age of 16 years and although some health work from CAMHS continued at that time, there was a significant risk that he may have been lost to receiving the support available once he reached 18 years of age.

Some services within other agencies did offer some interventions to Tom. These were education and vocational services. A trial of medication was also tried to assess whether this measure may reduce his level of aggression. This was unsuccessful and there was some difficulty in Tom engaging with these services.

Practitioners expressed their frustration that a diagnosis of autism for a child currently means that the child will need to continue to seek support required through availability of traditional services. There is a need to identify a service which would be able to respond to specific needs of children with an autism diagnosis rather than trying to make traditional services fit.

Practitioners also discussed that there is a clear gap in service in terms of support for autism within that age range, i.e. children's services stopping at 16 years old and adult

services starting at 18 years old. The exception to this was if there are significant concerns in relation to learning disabilities identified. Tom was not considered to have a learning disability. The learning from the practitioner event with respect to autism has been captured in the recent Ofsted SEND inspection for Tameside and work is being undertaken to address concerns raised. (2021)

8. Recommendations

- An all age task and finish group should be jointly initiated between adult and children's multi agency services to address transitional care between adult and children's services.
- Children's Social Care should provide evidence of robust procedures when closing cases, ensuring clear step processes are followed and that there is clear identification of the services continuing to support the child and family. This should be recorded in a closure case summary. Closure letters should be sent to parents and all agencies involved with the family as to facilitate ongoing multi-agency support outlining the agreed step down plan.
- CSC should provide evidence that demonstrates social work assessments include an effective consideration of history and parenting capacity that informs thorough analysis of risk and ensures that assessments are updated regularly to reflect children's changing needs and circumstances.
- Commissioners should provide assurance on plans to improve waiting lists for neuro developmental pathways timescale and update so that children do not wait too long for support and diagnosis.
- A working group should be established to review the availability of services & support available for families who are waiting an ASD diagnosis and post diagnostic support. The group should consider if pathways are clear for professionals and what supporting guidance is available to children and their families in understanding of ASD and social communication and interventions that help.
- Tameside Safeguarding Children Partnership to seek assurance on the effectiveness of interventions available for children with complex and challenging behaviours.
- The LA to provide assurance that ECHP reviews are carried out as a minimum every 12 months particularly for those in post 16 provision. There should be robust mechanisms in place to identify child & YP who have previous safeguarding concerns
- GMP to provide assurance there are robust systems for recording, identifying and referring child protection concerns.
- PCFT to provide assurance that children with complex needs who do not engage, are discussed with the MDT considering an impact assessment prior to discharging them.

Further actions were identified from the Practitioner event these are as follows:

- Assessments of children as young carers needs to capture the child's age, own development needs and their right to be parented.
- The potential of other adults living within the same household as a vulnerable adult needs to be assessed prior to the assessment of children as carers.
- The Tameside Domestic Abuse Strategy needs to include and identify pathways to recognise and respond to domestic abuse when children are perpetrators
- Multi agency routine enquiry should be made by practitioners about an individual's capacity to parent with adults for whom mental and physical ill health has been identified. This is to ensure relevant support can be offered to enhance parenting capacity and to minimise risk of harm to the child.