# Local Safeguarding Children Practice Review Report
# Finley

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## Executive Summary

This report sets out the findings and learning from the review of a serious incident which occurred in late 2021 in relation to Finley then aged 5 years.

The Review has evaluated whether the following key issues were appropriately considered and acted upon by local agencies:

1. Finley's lived experience and capture of his wishes and feelings
2. Accessing, responding to and sharing of information in a timely and appropriate manner
3. Appropriate and timely responses to changing risks and needs
4. Responding to a family where engagement was at times reluctant and sporadic and offers of support not taken
5. Organisational leadership within individual agencies and across the multi-agency partnership
6. Critical thinking, escalation and paramountcy

Finley was in the care of his father at the time of the incident. His father had been looking after him alone since 2017 with the support of his own parents who lived locally. Finley's mother has only had limited contact with him since he moved. Both Finley's parents have been described as having had a history of substance abuse and concerns having been raised about their mental health.

Throughout the period from 2017 to 2021, there had been recurring concerns about the safety and wellbeing of Finley because of his father's erratic behaviour and threats of suicide and threats to kill Finley. Thankfully, he did not succeed in taking either of these actions. However, Finley experienced trauma and insecure care from his father. As well as mental health concerns about father, he was challenged about his substance abuse when Finley was subject to a CP Plan. However, father totally denied substance abuse though there is now evidence that he was abusing substances for a long time and that this had an impact on his mental health. Therefore Finley was exposed to erratic behaviour and threats from his father as result of his substance abuse. Father's drug usage also meant there was no money to pay bills and to keep the heating on – all of which affected Finley. There is also evidence that Finley did not always receive the appropriate stimulation he needed resulting in developmental delay in his speech and motor skills.

A range of agencies were involved in seeking to keep Finley safe and to support his father to care for him. Finley was subject to a child in need plan and then a child protection plan till the end of 2018. The local Early Help service (Start Well) was also involved with the family as was the health visitor. However, Finley's father did not always fully cooperate with the services or allow access to Finley. After Finley started school, there were concerns about him and the school referred these appropriately. Father was supported by mental health services and at times took medication for his depressive symptoms.

There was some effective practice evidenced in this case with concerns about Finley's wellbeing being followed through. When concerns first arose about Finley's situation and father's capacity to care safely for him, a multi-agency child protection plan was put in place. The Early Help service (Start Well) tried to support father and, despite some early hesitation combined with father's resistance, to ensure he responded. The school was very concerned and passed on their concerns. They provided Finley with considerable support at

school and clearly knew him very well.

However, the practice overall in the case lacked sufficient focus on Finley as a vulnerable young child who was experiencing significant harm. His experience at home was not fully assessed or considered and the care being provided to him appears to have been assumed to be good enough without checking this out thoroughly.

There was insufficient professional questioning and curiosity about what was happening in Finley's home. Father's needs and his assumed mental health issues resulted in some professionals insufficiently considering what Finley's lived experience with his father was like and whether his father had the capacity to look after him. It was assumed that his paternal grandmother was covering any gaps in the care Finley was receiving.

When serious harm was threatened to Finley again after 2018, no strategy discussions were held and the case was considered appropriate for Early Help only. The home conditions were very poor with no heating. Father was not fully cooperative or open and he appears to have been preoccupied with his own worries and needs. Identified risks to Finley were not always fully investigated or considered and there was, it appears, an element of dismissal of issues and / or over-optimism about Father's repeated threats to harm Finley. This occurred even when family members were reporting concerns for Finley's safety and welfare.

Father is subject to a criminal investigation which is continuing. The Care Proceedings in relation to Finley have now concluded and he will be remaining in the care of the local authority. It is likely that he will need intensive therapeutic intervention for many years to come; this is the assessment of the psychologist who saw him as part of the court process.

There is important learning from this review which will need to be adopted in order to ensure that no other child experiences the same level of trauma and harm which Finley has suffered. More proactive, timely and challenging practice was required which truly focused on understanding and hearing Finley's day to life experience to protect him.

This young child's life has been very badly affected by the experiences of emotional harm and severe neglect he has suffered. After he was taken to hospital, Finley told the staff that he was asleep when the police arrived which may have meant that he had been rendered unconscious. He said that he *felt like it was the end of his life, which was not worth living because it was rubbish.*

## 1. Introduction and background to the review

### Introduction

Following a serious safeguarding incident relating to Finley, aged 5 years, in December 2021, a Rapid Review was carried out.

At the Rapid Review Meeting held in January 2022, it was agreed that a recommendation should be made to the tri-partite Safeguarding Children's Partnership and the National Panel that this case should progress to a Local Child Safeguarding Practice Review (LSCPR).

The tri-partite Safeguarding Children's Partnership agreed that the LSCPR should be initiated. The Rapid Review information was also shared with the National Panel which determined that the criteria for carrying out a LSCPR had been met.

### Background

Finley was living at the time of the incident with his father as sole carer.

At the end of 2021, Police attended the home after receiving a 999 call from a family member reporting that Finley's father appeared to be suicidal and was threatening to hang himself and that he had killed his 5 year old son (Finley) by strangling him.

The home was in total darkness, had no electricity, was cold, dirty, and littered with alcohol cans and general dirt. Finley was found upstairs with Father underneath the bed.

Finley was taken to hospital where he described his Father putting one hand around his throat and strangling him whilst covering his nose and mouth with the other. Finley was taken into Police Protection and placed with foster carers where he remains.

## 2. The Review Process and Methodology

### Methodology

The purpose of the review has been not just about gathering the narrative of what happened, but more importantly it has been to gain an understanding of the root cause and contributory factors of why those things happened in the context of a systems-learning model. The aim has been to understand why decisions were made and actions taken and to identify the key learning for individual agencies and multi-agency working both locally and nationally.

The review has been completed to learn lessons for future practice by examining the following key issues relevant to this case:

a. Recognising the circumstances in which professionals work together to safeguard children, without the bias of hindsight;
b. Understanding what information was known by agencies locally, and was sufficient action taken as a result
c. Provide a reflective analysis on both positive and negative issues, including expectations, identifying gaps in service and standards;
d. Consider and explore the effects of contextual safeguarding and relationships in respect of this family and wider networks.
e. Provide organisational information that may have impacted on a response to the family – high caseloads, sickness levels etc during the scope of review.
f. Identify any learning and development issues for the workforce

This LSCPR has drawn analysis from the detailed chronologies and the summary reports provided by each agency for the Rapid Review, as well as the discussions at the LSCPR Panel and the Practitioner Events which were held.

The Independent Reviewer has requested reports and information, as necessary, from the agencies involved to gather further insight or information. Finley's Guardian has provided a copy of her statement to the Court. The Reviewer has also considered this review in the light of findings from other reviews nationally but also locally.

The Review has sought to identify and acknowledge good and positive practice in the case as well as learning for further improvement.

**Time Period for the Review**

The LCSPR has covered the time period from January 2018 to April 2022 and has included consideration of any relevant information prior to that period.

**Parallel Investigations/Processes:**

There have been other parallel processes particularly the criminal investigation and potential court proceedings. The Reviewer has linked with the Police officer managing the case. The conduct of the Review and the publication date for the Review Report will be dependent upon the completion of the criminal proceedings.

There have also been Care Proceedings relating to Finley which concluded in July 2022.

**LSCP Reviewer and Panel**

A LSCPR Panel was established to support the Independent Reviewer.

Amy Weir was appointed as the Independent Reviewer and Report Author. She is an experienced safeguarding professional and reviewer who is a member of the National Panel's list of reviewers.

**Child's Voice and Experience**

This review has had particular regard to consideration of Finley's experience which is seen as essential to develop an understanding of what has happened and how agencies worked singly and together. Finley's views have been sought via his Guardian. This has informed the review further about Finley's experiences over the last few years as well as during the incident which led to him coming into care.

**Family Involvement**

- The review has sought to elicit the views of relevant family members particularly Finley's grandparents. The paternal grandparents were living close by and had regular contact with Finley. They have therefore been spoken to as part of this review.

- It has not been possible to speak to father given the parallel criminal proceedings. Full consultation with the Police has been required and it may not be possible to speak to him in the timescale for the completion of the review.

There has been some limited contact by others with his mother notably from the Guardian. It appears that mother's involvement has been very limited in caring for Finley directly particularly over the last two years. The reviewer considered writing to her but this has not taken place.

## 3. The Review's Scope

### The report includes:

- A brief report by the independent reviewer, focusing on learning rather than the events.
- A conclusion as to whether as a result of learning from this case, any changes are required to practice, policy or procedures by individual or collective agencies.
- Recommendations demonstrating the Case Issues, System Issues and Recommendation.

**The LCSPR has focused on the following key lines of enquiry:**

1. Finley's lived experience and capture of his wishes and feelings

2. Accessing, responding to and sharing of information in a timely and appropriate way
3. Appropriate and timely responses to changing risks and needs
4. Responding to a family where engagement was at times reluctant and sporadic and offers of support not taken up
5. Organisational leadership within individual agencies and across the multi-agency partnership
6. Critical thinking, escalation and paramountcy

## 4. Brief Family Background and History of the case

4.1 At the end of December 2021, Finley's grandfather contacted police to report that Finley's father was threatening to hang himself. Grandfather also stated that father was saying he had killed Finley by strangling him and that now he was going to kill himself. When Police entered the house they found Finley and father under a bed. The house was in total darkness and very cold. Finley was still alive but extremely distressed. He was taken into Police Protection and father was arrested.

4.2 Both of Finley's parents have had a history of substance abuse and concerns raised about their mental health. These issues were identified by the Health Visiting service in another area prior to Finley and his father moving to this authority in 2017. Finley's parent separated and from 2017, Finley and his father lived in this authority and the paternal grandparents, who live nearby, sought to support them.

4.3 There have been regular concerns about father's behaviour and his capacity to parent Finley safety given the threats to kill Finley which he made. Family members raised concerns on several occasions. The following is a list of the concerns:

4.4 In October 2017, concerns about father's erratic behaviour led to Finley being on a Child in Need Plan (CIN). In January 2018, father's brother contacted police to say that father was threatening to kill himself and Finley. A strategy meeting and Initial Child Protection Conference (ICPC) were held and Finley was made subject to a Child Protection Plan (CPP) for neglect. The Health Visitor identified that Finley was developmentally delayed and she felt this was the result of lack of parental stimulation.

4.5 In March 2018, paternal grandmother contacted police to say that father was threatening to hang himself and that Finley was with him. Father was calm when seen by police and denied thoughts of self-harm. Although Finley was subject to a CPP, no strategy meeting was held to consider this significant event and to review the level of risk with all agencies.

4.6 In August 2018, father's GP referred him to mental health services as he was expressing suicidal thoughts and making plans to hang himself. Finley was with his maternal grandmother. During his mental health assessment, father shared that in the past he had stated he planned to complete suicide

and kill Finley as well. Father described Finley as a protective factor. He denied any current substance misuse. This information was shared with Children and Young People's Services (CYPS). It appears that there was no strategy discussion held to review this new significant risk of harm to Finley. Father was not cooperating fully with CP Plan actions and was regularly missing health visiting appointments.

4.7 In mid-December 2018, the CPP was ended and the intervention with Finley was stepped down to a CIN Plan. This was despite there being some continuing concerns about Finley's development, father not having completed parenting work and father reported to being depressed about money according to paternal grandmother.

4.8 In January 2019, paternal grandmother contacted the GP saying she was worried about Finley's father – said to be shaky, having "funny turns". Father denied use of drugs or alcohol.

4.9 The case was closed to CYPS/CSC in April 2019 and Finley was no longer subject to CIN Plan.

4.10 In February 2020, there were two incidents when Police attended the home. Grandmother reported she had a text from Father saying, "help me help me help me ring the police". On the first occasion Finley was not seen. On the second he was when Father was said to be calm and Finley seemed to be alright.

4.11 In May 2020 father called the GP stating that he was anxious again and asked for medication to be restarted.

4.12 In June 2020 Father's brother called police saying Finley's father was depressed and suicidal. He was recorded as reportedly saying - "If I can't cope any more, I'll get rid of the fucking child and I'll kill myself." Refused Police entry. Grandmother came and reassured Police that Father was embarrassed about the untidiness of the house. Eventually, Father went voluntarily to a mental health service. Finley was seen by police appeared alright but very upset and he was taken to a neighbour's. Police referred to CYPS and Health. Strategy meeting not requested. Assessed as medium risk.

CYPS assessment was completed. Start Well involvement was recommended but Father refused this.

4.13 In May 2021 Finley told a teacher that his Dad had said he was going to kill himself. Grandmother was spoken to and said that "dad was not taking his medication and so she was going to ring his GP. She said she was also worried about social services being involved..

4.14 It appears that Finley's mother has had only limited care of him since that time and has led a rather transient, unsettled life. There is evidence that she has tried to maintain contact with Finley but his father has always seen this as detrimental to the child; it appears that Finley does not really have a relationship with his mother.

4.15 There are still criminal proceedings in progress in relation to this incident. Finley is now subject to a Care Order and he will be remaining in foster care.

## 5. Concise Chronology – Key Events – Harm to Finley

| Date | Event | Comments |
|---|---|---|
| **Oct 2017** | **Finley on CIN Plan** after Start Well concerns re Father's erratic behaviour and mental health. | |
| **Jan 2018** | 6/1//18 Father told HV that he had received an eviction notice.<br>6/1/18 Father's brother contacted Police; Father stating that he was going to kill himself and his baby son aged 1. | 8/1/18 Strategy Meeting held to have S47 and ICPC planned.<br>Paternal grandparents caring for Finley. |
| | **25/1/18 ICPC** | **Finley placed on CP Plan under neglect.** |
| **March 2018** | 23/3/18 Maternal *Grandparent contacted Police to say that Father was threatening to hang himself. Finley was in his care.* | Father was calm when seen. Denied thoughts of self-harm. Complained he was not being supported. Finley was asleep. No concerns noted but referral sent to CYPS and Health.<br>No Strategy Meeting considered though child on CP Plan |
| April 2018 | 20/4/18 Review CP conference held. | Finley remains subject to CP Plan. |
| July 2018 | 16/7/18 Review CP Conference. Father did not attend (unwell) but Mother did. | Finley remains subject to CP Plan. |
| **August 2018** | 21/8/22 Mental Health Assessment team informed by GP that Father, attended with his *father, was expressing suicidal thoughts and making plans to hang himself.* Son Finley was with his maternal grandmother and Finley had stayed with grandmother last night. | Face to face assessment completed with Finley's father-conclusion was to refer him to the Home treatment team and was prescribed medication. *Father voiced in the assessment that in the past he had stated he would look to complete suicide and kill Finley as well.* Father described Finley as a protective factor. Denied any current substance misuse. Info shared with CYPS. |
| | 29/8/22 Core Group. Father to continue with MH service | Stayed on CP Plan. Parenting and positive relationship work not completed. |
| Oct 2018 | 11/10/18 Review CPC – still concerns re motor skills and speech. | Finley remained subject to a Child Protection Plan under category of Neglect |
| | 31/10/18 Core Group. Father stated that Finley's behaviour deteriorating – biting and hitting other children - because of contact with mother. | Still outstanding parenting work. |
| **Nov 2018** | 14/11/18 Paternal grandmother telling nursery that *Father was becoming depressed due to money worries.* | |
| | **14/12/18 Review CPC.** | **End of CP Plan and step down to CIN Plan.** |
| **Jan 2019** | 10/1/19 Child in Need meeting. | Father said to be having disturbed sleep and starting to have seizures. Follow up unclear. |
| | 14/1/19 Paternal grandmother contacted GP – *worried re Father – shaky, having "funny turns".* | To go to GP – seen with grandmother and Finley. Having seizures. Denied use of drugs or alcohol. |
| | 15/1/19 Father attended hospital because of seizure. Discharged | |

| Date | Event | Comments |
|---|---|---|
| | himself. | |
| Feb 2019 | 12/2/19 CIN Meeting. Discussion re Finley's development. Apparent lack of reference to Father's health concerns. | Father wanted Finley to remain CIN. Said to be having housing arrears problems. |
| **April 2019** | 2/4/19 CIN Meeting<br>- Father stable<br>- -Father taking advice<br>**Case closed with CYPS / CSC** | SW and HV (who did not attend) in agreement about closing CIN Plan. SW said she saw no role for Start Well. |
| **July 2019** | 3/7/19 Nursery persuaded father to accept Start Well support. | |
| | **27/7/19 CYPS / CSC closed case.** | |
| **Feb 2020** | *22/2/20 Police attended the home. Grandmother reported had a text from Father saying, "help me help me help me ring the police".* | Police attended. It was second call in days from grandmother. Father's brother was there. Father was abusive to Police and would not let them in. Finley was seen and felt to be fine. No evidence of referral on? |
| May 2020 | 12/5/20 Tel call between Father and GP – father stated anxious again and asked for medication to be restarted. | Awaiting appointment with MH assessment Team on 20/5/20 – seen and given medication. No risk identified re Finley. |
| **June 2020** | 14/6/20 999 Call to Police by Father's brother. *Father depressed and suicidal. "If I can't cope any more, I'll get rid of the fucking child and I'll kill myself."* Refused Police entry. His mother came and reassured Police that Father was embarrassed about untidiness of the house. | Father was taken to mental health service with his mother . Finley was seen by police. Finley was very upset and was taken to a neighbour's. Police referred to CYPS and Health. Strategy meeting not requested. Assessed as medium risk.<br><br>CYPS assessment completed. Recommended Start Well involvement but Father refused. |
| Sept 2020 | Finley left nursery and started school. | |
| Jan 2021 | 14/1/21 Start Well contacted by school | Caseworker to be identified. |
| **May 2021** | 24/5/21 Finley told teacher *that dad said he was going to kill himself.* Nan said that "dad was not talking his medication and so she was going to ring his GP. Nan was also worried about social services". | Second referral made by school to CSC due to dad's poor mental health and the effect it is having on Child. Nan picked up Child from school |
| | 27/5/21 school checked in with nan. Finley stopped with nan last night. Dad was feeling better. | Nan said that if dad was feeling low, she would intervene and take Child. Dad was picking up tonight and grandma felt that dad was in a better place. Child would stay at dad's overnight but nan would have him over the weekend. |
| June 2021 | 3/6/21 CSC MAST – requesting information from MAST Nurse re Father's mental health and Finley's needs. | The MAST Nurse provided an overview of historical concerns, highlighted Finley's developmental delay, completion of SEND referral and reported "no recent mental health input" for father. |
| | 3/6/21 Grandmother contacted school to state that she had looked after Finley over the weekend due to a deterioration in Martin's mental | Start Well intervention was requested |

| Date | Event | Comments |
|---|---|---|
| | health. | |
| | 10/6/21 Contact form sent to Children's social care by DSL at school as a result of father saying he was going to kill himself | Triage in MAST to take place. |
| **July 2021** | 12/7/2 Outcome from referral of 24/05/21 by School informed by Start Well that after the referral they would now be supporting the family. | |
| Sept 2021 | 1/9/21 Start Well view is that Finley's basic needs are being met. | But - Home conditions cluttered – renovations ongoing by dad – advised to prioritise bedroom, kitchen and bathroom first. Paternal grandparents support parenting and Finley spends a lot of the time with them at their home. |
| Nov 2021 | 30/11/21 Start Well review – All actions met. **Start Well to close the case.** | All agencies agreed improvements and school and grandmother score 8 on signs of safety, dad scores 7. Finley's school attendance has improved from 89% to 93%. Dad and grandmother reported he is engaging with GP and advice given to register online for repeat prescriptions. |
| **Dec 2021** | 21/12/21 Start Well plan - Father will get an allocated worker from Wigan Well Being and that Finley is to stay at grandmothers home over Christmas so that he will not be affected by no utilities in dad's home. | Home visit same day to Grandmother's home to share the information discussed in supervision and advise Grandmother that Finley is to stay with her until the utilities are re connected after Christmas. No sign of conversation with Father. |
| | 29/12/21 999 *call to Police by paternal Grandfather. Father has threatened to hang himself. He stated that Father said he has killed his son by strangling him and that now he is going to kill himself.* | Police attended. The house was in total darkness and the door was locked. Entry was forced to the address. The house had no electricity and was freezing cold, the whole of the ground floor was littered with alcohol cans and general dirt. The kitchen was even worse and there was no surface or area that would have had the ability to prepare food. Other officers searched upstairs and both father and his Son Finley were found underneath the base of an ottoman bed. Finley was removed from the address. Whilst being checked over he told the ambulance service that his Dad had put one hand around his throat and strangled him whilst covering his nose and mouth with his other hand to cut off all air supply.<br>Finley said that he was asleep when the police arrived. He said that he felt like it was the end of his life, which was not worth living because it was rubbish.<br>At A and E, Finley was checked and they found spotting beneath his eye. It was thought this could be indicative of strangulation, but no marks on his neck. |

## 6. Summary and Analysis of agency involvement with Finley's Family.

In its annual report for 2020, the National Panel set out six key practice themes which were drawn as learning from recent reviews. Several of these apply in this case and I have considered those that apply alongside the key themes agreed for this review.

### 6.1 Finley's lived experience and capture of his wishes and feelings - Understanding what Finley's daily life was like

Although the health visitor, his school and nursery were well-tuned into how Finley was presenting to them. He even disclosed serious concerns at school about his father's care. The assessment of his needs and father's parenting lacked clarity and detail as far as what Finley's life was really like. His father's capacity to parent him was scantily considered and father's reassurance and good moments with Finley were seen as the whole picture.

Finley did talk about his father and his threats of suicide at school. He also told professionals that his father could be very difficult if challenged. It appears that in his father's care, Finley was anxious and probably watchful having to manage his behaviour according to how his father was presenting. However, even when these issues were referred to Children's Social Care, they were not immediately investigated and there was delay.

It was known that Finley's development particularly in motor skills and speech – was delayed. However, this does not seem to have influenced significantly the view taken of whether his father was able to meet his needs. Given that these areas of developmental delay were thought to relate to lack of parental stimulation, this should have raised concerns especially since father was not always reliable about being present for appointments with professionals.

Finley's experience was one of living with neglect with his substance misusing father. His substance abuse was denied by father but it was evidenced in the care proceedings. This resulted in Finley suffering significant harm which impact on his safety, health and overall development. There are several references to Finley suffering minor injuries and scratches sometime as a result of fighting at nursery and this may link to the neglect at home.

The physical environment at home for Finley was cluttered and untidy and not appropriate for a growing child. There were no heating or cooking facilities during 2021.However, these conditions did not result in the higher level of intervention which was required to consider all the concerns about the care Finley was receiving. In the social work assessments completed, Finley's views generally were insufficiently sought to inform analysis and assessment. The pattern of his experiences over the years were not fully evaluated and considered to decide on the level of support and intervention needed.

Too often in this case, the focus was mainly on Finley's father's needs and this impeded professionals' understanding of the risks faced by Finley. The impact on Finley of his living with neglect and a substance misusing parent whose mental health was of concern was not the main focus of intervention and the cumulative effect of this was not appreciated as it should have been.

Throughout, there is a lack of evidence that Finley's needs and vulnerabilities were identified and recorded. This is particularly lacking across adult services records with very little reflection of Finley's safety. Children's Social Care and Start Well records concerning father focus on his mental health and the belief that engagement with mental health services would mitigate that risk. Consideration of Finley's lived experience, wishes and feelings is very limited and is not the primary focus it should have

been.

### 6.2 Accessing, responding to and sharing of information in a timely and appropriate way - Sharing information in a timely and appropriate way

The agencies involved with the family were concerned about father's behaviour and his capacity to parent. Family, school, the GP, the health visitor and nursery shared concerns about Finley's safety and well-being. However, not all agencies were fully aware of the full family history. When Finley went to school, there was no information shared about the earlier difficulties and particularly that Finley had been subject to a CPP following his father's threats to kill him.

Mental health services, when involved, and the GP who supported father seemed to be working in isolation. There was a need to share with the whole network of services including those focussing on ensuring that Finley was safe. At the same time CSC did not really seek out information from mental health services and assumptions were made about the nature of father's mental health needs. His substance misuse and mental health concerns were therefor not fully explored or considered and this meant that the nature of risk to Finley was not fully understood or is recognised.

Generally the agencies involved were acting in isolation on the basis of some known but generally incomplete information. Whilst Finley was subject to a CPP or a CIN plan, there was more exchange of information. However, for the rest of the time there was no mechanism for sharing information or for exchanging professional views of what was happening in his family. It does not appear that for much of the time, there were team around the child / family support meetings to bring together all those involved.

Overall, and even at the point when the child protection processes were in place there was not a robust multi-agency approach either in practice or in the cycle of reviews attached to the CP processes or particularly in the seeking for and sharing of information. There is no evidence to suggest attendance by adult mental health team practitioners in the reviews of Finley's care and consideration of father's capacity to parent. It seems that on one occasion the mental health service involved sent apologies for a one child protection conference. This meant that there was no explicit discussion of or attention about managing the impact of father's mental health on Finley.

### 6.3 Appropriate and timely responses to changing risks and needs - Responding to changing risk and need

The risks identified to Finley from his father's worrying behaviour were considered in 2017 and he was subject to a CPP. However, when there were further episodes and concerns about father's threats to himself and Finley, it does not appear that the full impact of such risks continuing were considered and fully appreciated.

Father's reassurances about his substance abuse and mental health were not sufficiently challenged even when on several further occasions he made threats. It is now understood that father's mental health relates to anxiety and depression which are secondary to his drug dependence. This does not seem to have been fully identified when he was in contact with mental health services but may be the result of his inconsistent and limited engagement with those services.

Finley's grandparents were seen as protective factors but this was not really tested and again and again they called the police when there was a further crisis and father as not coping with his own needs or with caring for Finley.

Father was sporadically in touch with his GP and mental health services. However, it does not appear that the risks to his capacity to parent from his substance abuse were fully considered by agencies. The impact of the various crises and their affect on Finley's emotional well-being and development as a young child do not seem to have been taken into account.

The assessments of father by professionals during crisis (by mental health services and Police) appear to have been focussed on assessing the risk he presented to himself. There is a lack of evidence of any consideration of the impact that his mental health and substance abuse were having on his son. The explicit risks related to the threats he had made over the months / years to end Finley's life have never in themselves been responded to explicitly. They have been seen as symptomatic of father's mental health problems and substance abuse. Wider family re-assurances about his functioning have also been taken at face value.

As reviewer, I have been provided with other reviews completed recently in the same partnership. I would suggest that there is similar learning in the Child Y Serious Case Review (2021) regarding being assured of a 'child first' safeguarding approach when mental health services are assessing parents, and this case will feed into the ongoing action responses to that case.

Overall, when there were further serious concerns and risks to Finley, the previous risks were not reviewed and updated in response to changing and new circumstances or taken sufficient account. Each crisis episode seems to have been seen as separate and unrelated to the previous ones.

There was no holistic family assessment completed by CSC in the course of this case looking at father, Finley and the grandparents needs to take account of any changing risk factors. It seems likely that Father's behaviour and capacity to parent Finley safely was impaired throughout the time he was caring for Finley. CSC was over optimistic in seeing any progress by father in addressing Finley's needs and in accepting his reassurances.

There is very little information about, and insufficient consideration of, Finley's mother and her views in the records seen. The domestic violence by father she alleged was also not considered as a possible risk factor to Finley as well although the first social worker noted it. Father was negative about mother and always alleged that contact with her was detrimental. There is evidence that she has tried to be present for Finley but this has not been captured sufficiently in the practice in this case. As a result of this and father's negative appraisal of her which was not challenged, her relationship with Finley is now negatively impacted. It is to be hoped that she can commit to working with professionals to seek a reconciliation with him but this will of course have to be subject to the child's wishes and feelings.

When Finley was examined in hospital, a thorough process was undertaken. However, although it was requested, the clinician in charge of his care on the day was unable to arrange for photographs to be taken as he did not have parental consent and nor was a legal order in place which would have allowed the photographs to be taken. If a legal order had been in place then this time sensitive evidence could have been obtained.

### 6.4 Responding to a family where engagement was at times reluctant and sporadic and offers of support not taken up - The family's – particularly father's engagement with professionals was reluctant and sporadic and not all offers of support were taken up

Finley's father missed many appointments or cancelled visits particularly with the health visitor but also mental health services. These were all indications of avoidant behaviour and the health visitor, in particular chased these appointments up and informed Children's Social Care of her concerns about father's non-engagement.

In the 2018 Child Protection Plan, father was expected to undertake some work on his parenting but he was very reluctant to do this or to show any commitment to how he could improve his parenting. This attitude required more challenge than it received in the child protection process.

Family members reported each of the incidents when father made threats to kill himself or himself and Finley to the police. On each occasion, father then denied that he had made such statements and it appears that professionals accepted these denials at face value and then discounted the level of risk without focusing on what it could mean for Finley. In fact, following father's assertion that Finley could be considered as a protective factor with regards to his own self-harm and possible suicide, some professionals appear to have believed this to be the case without challenge or the required consideration of Finley's vulnerability as a very young child. Such extreme and repeated threats to a child are rare and it is unclear why these were not taken more seriously.

When the nursery recommended father should engage with Start Well, he eventually did but he also missed appointments and was unreliable in his contact with the service.

Although family members contacted the police on several occasions when there were further crises in father's mental health and capacity to care for Finley, it is not clear that the role of other agencies was fully accepted by the family. Grandmother did speak to school and the nursery and share some concerns. Her contact with Children's Social Care (CSC) seems to have been much less and she did say on one occasion that Finley's father was worried about contact with that agency. To be fair, CSC involvement was relatively limited and indirect only after 2018 so she may not have felt there was a useful link there.

The family's engagement with agencies appears to have been mixed. In the main it only occurred at times of crisis when there were concerns about how safe or potentially at risk Finley was in the care of his father.

Paternal grandmother and father have been seen as part of this review. They feel that it was the pressure of looking after Finley which led to their son's depression. They believe that Start Well and other support services should have carried on for longer. They did all they could to take the pressure off Finley's father. They said they were not concerned about their son caring for Finley but they now realise their son did not tell them everything that was going on.

### 6.5 Organisational leadership within individual agencies and across the multi-agency partnership

There were problems with the way muti-agency safeguarding practice worked in this case. Strategy meetings were not held on several occasions even when it was clear that Finley was suffering significant harm and agencies could and should have come together to discuss what should be done. CSC appears to have made decisions without this process and the case was not allocated to a social worker between 2018 and 2021 even though there were serious concerns about Finley's safety as well as his delays in development. Even though father was not fully cooperating with professionals and, it was decided that Early Help via Start Well could address the needs. as per the local policies, procedures and thresholds for intervention.

When the school made referrals to CSC, these were not responded to promptly even when one referral included the fact that Finley had told a teacher that his father had said he was going to kill him. It appears that the school had not been informed that had been previous threats of this kind. The school visited Finley when he was not in school and tried very hard to ensure that he was safe.

The Ofsted inspection of CSC completed in July 2022 has highlighted some of the same issues about

delays in the management of cases with high social work vacancy levels and problems with achieving enough staff in CSC. It is likely that this made it more difficult in the earlier period for practitioners to sustain the direct work on cases to make an impact with the required level of management oversight.

### 6.6 Critical thinking, escalation and paramountcy

Conversations with practitioners during this review demonstrated that there were frustrations about the lack of CSC 's timely response to concerns – particularly those concerns raised by the school. There has already been some learning about the need to exercise more challenge and to consider formal escalation to ensure that Finley was the primary focus of any agency involvement. Practitioners were able to discuss how they would invoke Escalation Protocols in the future if they were not content with the immediacy and level of response.

The health visitor sought to escalate her concerns about Finley's delayed development to the social worker. It is not clear whether she was able to have access to safeguarding advice within her own agency as at that time safeguarding supervision was provided when a child was subject to CPP. This may have supported her to get more urgent responses. Mental health services did not unfortunately make direct contact with services involved with Finley and it seems that there was insufficient consideration of the impact of father's behaviours, substance abuse and mental health on his capacity to parent and to keep Finley safe.

## 7. Findings

**7.1 There was some effective practice evidenced in this case.**
When concerns first arose about Finley's situation and father's capacity to care safely for him, an appropriate multi-agency child protection plan was put in place. The Early help service tried to support father and despite some early hesitation combined with father's resistance to ensure he responded, and the service was very involved later trying to provide financial and other practical support. The school was very concerned and passed on their concerns. They provided Finley with considerable support at school and clearly knew him very well.

7.2 **The practice in the case sometimes lacked sufficient focus on Finley** as a vulnerable young child who was experiencing significant harm. His experience at home was not fully assessed or considered and the care being provided to him appears to have been assumed to be good enough without checking this out thoroughly.

7.3 There was **an over-focus on Father's needs**, his vulnerability and his assumed mental health issues sometimes resulted in some professionals being less curious about considering what Finley's lived experience with his father was like. It was assumed that his paternal grandmother was covering any gaps in the care Finley was receiving. Unfortunately, when returned to his father's care after a few days, the level of care seems to have deteriorated and his grandmother does not seem to have identified how poor his circumstances were.

7.4 **There was a need for more focus on the quality of Finley's lived experience and on father's lack of openness and cooperation** in accepting the support offered to him by Early Help services.

7.5 **Identified risks to Finley were not always fully investigated or considered** and there was, it appears, an element of dismissal of issues and / or over-optimism about Father's repeated threats to harm Finley. This occurred even when family members were reporting concerns for Finley's safety and

welfare. When there was a further serious incident after Finley was no longer subject to a child protection plan, there should have been consideration of holding a strategy meeting but this did not happen.

7.6 **There was not a robust multi-agency approach in practice or in the child protection processes Early Help** attached to the CP processes nor also when Early Help services were involved. The CP Plans for Finley were not focused on better outcomes for him and were very limited. It is very difficult to understand how the decision to take him off a CPP was arrived at in December 2018 or to know what the supporting evidence was as there are no minutes of that meeting.

7.7 Although Finley was clearly a very vulnerable child, the **earlier concerns about his safety when he was subject to a child protection plan were not shared with his school.** This resulted in a significant gap in the school's understanding of Finley's history and about the potential for future significant harm to him.

7.8 The concerns about Finley's welfare and safety were shared particularly by his school and by family members but the action which followed was delayed and not robust. However, after the period when he was subject to a child protection plan, **there was no coordinating system or Lead Professional role in place for managing the concerns for Finley.** Individual agencies and notably the Health Visitor, Finley's school and Start Well worked hard to address Finley's needs and to support father to care for Finley but they tended to be acting in isolation without opportunities to reflect on what was happening and to act in concert.

7.9 The Care Proceedings in relation to Finley have now concluded. It should be noted that his Guardian in those proceedings has been highly critical of **the lack of assessment, planning and action** by the Local Authority's services to protect Finley over the last few years.

## 8. Conclusions and Summary

There is learning for all the agencies involved in this case. There are improvements required in the way children and their families are assessed and in the way agencies work together and share information in the best interests of children.

There was insufficient focus on Finley and his needs and experience of living with his father. The adults' agenda tended to be the main focus of intervention. Initially this related to the acrimony between his parents about mother's contact with Finley. This enabled father to deflect concerns about his substance abuse and behaviour towards Finley's mother. The involvement of paternal grandparents in support of father appeared to be positive though it is not clear that they were always open and honest about what was happening until there was a crisis.

It is positive that Finley survived the threats made by his father. However, he experienced significant harm over a long period in the care of his father which has resulted in him suffering developmental and emotional trauma of a long term nature. This has been confirmed by the psychologist who recently assessed him. It is likely that he will need long term therapeutic intervention.

### Summary view:

Many professionals sought to identify and address Finley's needs and to keep him safe. However, in this case the multi-agency safeguarding system did not work effectively to safeguard Finley for several years.

## 9. Recommendations for Wigan Safeguarding Partnership to consider and action

9.1 The Safeguarding Partnership should ensure that the learning from this review is shared widely with local professionals and workshops should be held for practitioners to be able to work together to understand how they can develop more effective joint working particularly between children's, mental health and GP services and between children's services and schools. This should include ensuring that practitioners are always child-centred when working with parents, aware of the affects which parental behaviour may have on a child, consider the impact of parental behaviours on the child and escalate if concerns about the impact of the parents' condition and presentation is resulting in harm to the child.

9.2 Joint Guidance should be commissioned to direct how children's and adult mental health services work together, to ensure that all the practice is child-centred and that professionals in each agency understand and are clear about their roles and expectations in terms of safeguarding. This should cover the whole range of early help and children's services as well as GP and mental health agencies.

9.3 The three statutory partners should ensure through updated Guidance that Strategy Meetings are always held within the statutory timescales when new and additional evidence of significant harm to a child has been reported, even when the child is already subject to a Child Protection Plan.

9.4 All Child Protection Conferences must be formally minuted. There must be robust evidence of the grounds for ending a Child Protection Plan and that all agencies attending the child protection conference are in agreement with this. There is a need to ensure that CP Plans are outcome focused and based on improved outcomes for and the safety of the child.

9.5 When children move from pre-school to primary school, there should be a system in place for ensuring that the safeguarding records of each child are transferred with them and shared with the school.

9.6 There is need for all agencies to ensure that when children have suffered significant harm, all evidence is collated in a timely way. This may including ensuring that appropriate authority is in place to consent to the taking of photographs or any other process required; this authority can either be from informed consent from a person with parental responsibility, a child or young person with sufficient age and understanding or other legal authorisation such as an Emergency Protection Order. In this case, no one with parental responsibility was in a position to consent, Finley was too young and he was not subject to an appropriate legal order till later on the day in question.

## 10. Next steps - Progress Report on Learning from this Review

In early December 2022, the Reviewer was provided by the safeguarding partners with information about the progress and updates relating to the recommendations of this Review. The Strategic Partnership Executive is keen to demonstrate the commitment to improvement and the progress which has been made already.

It is clear that there is a strong commitment in Wigan to learn from the findings of this Review and to ensure that the changes required to the local safeguarding practice system are made.

## Appendix A - Glossary of Abbreviations

| | |
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| CIN | Child in Need |
| CP | Child Protection |
| CSC / CYPS | Children & Young People's Service / Children's Social Care |
| ICPC | Initial Child Protection Conference |
| CPC | Child Protection Conference |
| CPP | Child Protection Plan |

**Appendix B - List of References**


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