Serious Case Review

Family HJ

OVERVIEW REPORT

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1  **Summary of the Learning**

1.1 This Serious Case Review (SCR) is in respect of a family where neglect and emotional abuse was evident over a period of years. The extent of the neglect has led to the health and development of a number of the children being compromised, which is likely to have a lasting impact.

1.2 A number of learning points for the individual agencies involved and for the Local Safeguarding Children Board (LSCB) have been identified. This report provides information, in the analysis section, on the learning gained from the detailed consideration of the involvement of partner agencies with this family. More general learning has also been identified when considering this case as part of the wider system, and from this several key themes have emerged. These can be summarised as:

**Identification of neglect and children with disabilities**

- The overall most significant finding from this review is that professionals need to understand and consider the complexities presented by culture, diversity, neglect and disability when working with families.
- All professionals undertaking assessments of children with disabilities need to distinguish between features which are or are not part of a child’s disability, in order to identify signs of neglect. Specific medical advice should be sought to clarify if concerns (such as bruising or developmental delay) are part of a child’s underlying condition.
- Consistency is required to ensure that when children with disabilities are assessed their particular needs and limitations but also their increased vulnerability is taken into consideration.

**Lack of cooperation / inability of professionals to engage with the family**

- It is difficult for professionals who are involved with a family to differentiate between those parents who are overwhelmed with the amount of appointments and demands of caring for children with special educational needs and disability, and those who are unwilling to engage and/or show disguised compliance. Professionals need to be encouraged to state ‘I am struggling to engage.’ The use of supervision and peer challenge to identify these issues is crucial.
- Families require specific support and approaches when facing a safeguarding intervention. Contact should be characterised by sincerity, politeness, and respectful assertiveness, acknowledging the anxiety that professional involvement can cause.
- When a family is told there are concerns about their children/parenting, there must be a maintained level of contact with that family to ensure they are aware of what needs to change and what support they will receive to achieve this, as part of a clear child in need or child protection plan.
- When parents are oppositional it is sometimes difficult for professionals to see the children and to gain their views. There is also a risk that children will be silenced. This should be seen as an additional risk when undertaking assessments.
Drift and changes of professionals

- The lack of a consistent and coordinated group of professionals and managers working in key positions with the family led to drift and delay in the identification and acknowledgement of significant harm and in the plan to safeguard the children.

Multi-agency meetings (includes the clarity of meeting being held, what is the purpose, and how they fit within LSCB procedures)

- When arranging, chairing, attending and recording any multi-agency meetings there must be clarity about the purpose and status of the meeting, who needs to attend, why they are there, and what the expected outcome of the meeting needs to be. Those involved should challenge the chair if the meeting is not addressing the concerns, should be clear about what is expected next, and should inform others if anything changes between meetings.

Consideration of each child individually

- In families with a number of children, each child must have an individual assessment, should be seen separately, and should have their needs considered, this should include a consideration of the impact of their siblings needs on them.
- In large families with complex needs, consideration should be given to compiling a multi-agency chronology. It should include ALL of the children, ALL of the agencies, and ALL of the history.

Internal and external escalation/professional disagreements

- When it is necessary to commission a child sex abuse medical, staff require clarity about the process including the importance of timeliness for the preservation of forensic evidence.
- Every formal escalation/professional disagreement should receive a response. The process for escalating and responding must be transparent, timely and clearly communicated.
- As well as escalations of concern about decision making or planning being promoted across the single and multi-agency workforce, the learning from escalations should be considered and embedded to ensure there are improvements beyond a single case.

Specialist social work provision and legal processes

- The notion of ‘high support, high challenge’ should be the aim of engagement with families. It is a complex and difficult balance when working with all families, but particularly so when engaging with minority or ‘hard to reach’ groups. To do this well requires skilled practitioners, relevant cultural support, reflective practice, and effective supervision.
- The use of a specialist worker to provide advocacy and support to families in specific circumstances, for example, for families from different cultures/families where the
parents have learning disabilities, is helpful and should be available in specific cases as appropriate.

- Staff working in specialist roles with disabled children require appropriate experience, supervision and support to ensure they are able to undertake the full range of child protection work.
- Legal advice and planning needs to enable the safety of children to be secured promptly and at the earliest opportunity.
- When children with complex health needs are the subject of a Legal Gateway Meeting, it is good practice to have a health professional involved in the meeting to provide information and advice.
- Effective child protection relies on sufficient qualified and experienced professionals across a range of disciplines, including legal, social care, and paediatrics. All organisations need to ensure that they are reporting to the Safeguarding Children Board where there are shortfalls in workforce capacity and capability.
- The Public Law Outline should always be utilised in neglect cases that meet the threshold for care proceedings to ensure that parents are completely aware of the concerns about their children, how serious those concerns are, and to ensure they receive early and appropriate legal advice. Consideration should be given at an early stage to the ability of the parents to meaningfully understand the concerns and the complex legal processes.

2 Introduction to the Significant Incident Learning Process (SILP)

2.1 The LSCB agreed that this Serious Case Review (SCR) should be undertaken using the SILP methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted in a certain way at the time. The completion of Agency Reports, where agencies are asked to consider and analyse the practice and systemic issues, and learning from the case within their agency, is followed by a large number of practitioners, managers and agency safeguarding leads coming together for a Learning Event. All Agency Reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued. The same group then comes together again to study and debate the first draft of the Overview Report. Later drafts are also commented on by all of those involved, who make an invaluable contribution to the learning and conclusions of the review.

2.2 It is stated in Working Together 2015 that SCRs should be conducted in a way that;

- recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

This review has achieved these objectives.
2.3 The LSCB recognised the potential to learn lessons from this review regarding the way that agencies work together to safeguard children where neglect is a concern. It will:

- Identify improvements in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice.
- Clearly identify what lessons are to be learned both within and between agencies and within what timescale they will be acted on and what is expected to change as a result.  

3 Introduction to the Case

3.1 The subjects of this review are a sibling group to be known as Family HJ. There had been involvement with the children beyond the universal services for a number of years, and there were concerns particularly about the neglect and possible physical abuse of a number of the younger children. This review was agreed due to disquiet that the abuse and neglect had not been identified or responded to as would be expected and that the children suffered significant harm for a number of years while in the care of their parents. The neglect that the children suffered is believed to have a negative impact on their longer term health and development.

3.2 The wider context of the work undertaken on this case is also considered. Of particular concern was the fact that the Local Authority was under significant pressure at this time in regards to the number of children and families requiring a statutory intervention and difficulties in recruiting and maintaining staff and managers.

4 Family Structure

4.1 There were a number of children in the family. This report will not specify the exact number and genders of the children to protect their identities.

4.2 The children share the same mother, but not all of them have the same father. This report will refer to the adults involved as Mother and Father as they were a consistent couple and were providing the parenting to the children during the time considered by this review.

4.3 The children and parents are from a minority community. The family speaks both English and a second language. A number of the children in the family have disabilities. One child has mobility and learning difficulties. Another of the children has sight and learning difficulties, and a third child also has health challenges.

4.4 Both parents have cognitive functioning limitations. This was not identified until the later stages of the work with the family that is being considered by this review.

5 Terms of Reference

5.1 It was agreed that the scope of this review would be from 1 October 2010, to the 28 February 2015. It is in this timeframe that potential child protection concerns emerged.

5.2 Relevant information prior to these dates was also considered as required.

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6 **Process**

6.1 The family was visited by the Lead Reviewer and a support worker during the course of this review. The purpose of engaging with the family is to inform them of the review, to discuss publication of the overview report, and to see if there is any additional learning to be established from their experience of the professional interventions at the time being considered. The Lead Reviewer thanks the parents for agreeing to meet with her. The eldest child was unwell when the visit was undertaken so has not yet engaged with the process.

6.2 The Department for Education (DfE) expects full publication of SCR overview reports, unless there are particular serious reasons why this would not be appropriate. Working to that requirement, some confidential historical family information and case detail will not be disclosed in this report. It is written in the anticipation that it will be published, and contains all of the information that is relevant to the learning established during this review. The family will be contacted prior to publication to ensure they are aware of the conclusions of the review.

6.3 The decision to undertake an SCR was made by the Chair of the LSCB on 17 October 2015. The case was first considered by the SCR subgroup in 2014 after a number of the children had come into care, but initially it was considered that the criteria for a SCR were not met. The relevant agencies agreed to undertake a reflective learning review to see what lessons could be learned from the case. It was during this review that the criteria and threshold for an independently chaired and authored SCR were reconsidered and the LSCB Chair initiated the SCR.

6.4 A lead reviewer was appointed in November 2015. The terms of reference for the SCR were agreed, and agency reports were requested, along with a chronology of agency involvement. A briefing meeting for agency report authors was held on 16 November 2015 to clarify expectations. The SILP model requires engagement with staff involved at the time, and therefore two events were held to enable the Lead Reviewer to engage with staff. A Learning Event was held on 26 January 2016, and a Recall Event was held on 22 March 2016. Practitioners and first line managers attended and engaged in both events and received all reports. The Overview Report was presented to the LSCB 18 May 2016.

6.5 Lead Reviewer in this case is Nicki Pettitt, an independent social work manager and child protection consultant who is an experienced chair and author of SCRs, and a SILP associate reviewer. She is entirely independent of the LSCB and its partner agencies.

7 **The background prior to the scoped period**

7.1 Universal health services had not identified any concerns about Mother’s parenting after the birth of the eldest child. She was a single parent at the time and had support from her own parents. The family were first known to children’s social care (CSC) and the police (for child related issues) when a referral was received from Council staff in 2007 about the eldest child having unexplained bruises and being tied to a chair. This was investigated but no further action was taken, as no non-accidental injury was evident.
7.2 The second child was born with complex health needs. In the months that followed it appears that the parents cooperated inconsistently with the multiple health appointments. During the first year of life the child had to attend a large number of specialist health appointments both locally and at a regional hospital.

7.3 In the year following the second child’s birth concerns about the child’s care were raised by a hospital, and they made a referral to CSC about the child’s poor hygiene. Checks were undertaken with the health visitor but there is no evidence of any further action by CSC. The family's cooperation with health appointments for this child appeared to improve in the year that followed. There were no identified concerns about the eldest child.

7.4 The mother then gave birth to a third child, and no concerns were identified at birth. A CAFTAC\(^2\) had been put in place for the second child earlier that year; the siblings were not included in the plan made. The issues emerging for the second child at that time were that they were not putting on weight, development delay and missed appointments including speech therapy and occupational therapy.

8. **Key Episodes**

8.1 The time under review has been divided into 5 Key Episodes, which are periods of intervention that are judged to be significant to understanding the work undertaken with a child/ren and their families. They are key from a practice perspective rather than to the history of the child/ren. They do not form a complete history of the case but represent the key activities that occurred, and include the information that is thought to be most helpful in informing the review. When considering a period of five years, as we are in this case, it is essential to ensure the case history is summarised.

**Key Episode 1: (2010-11)**

8.2 This episode will look at 2010 – 2011 when the CAFTAC was in place for the second child. The CAF was instigated by a Portage\(^3\) worker because of the child’s disability and not because of any wider concerns for the child or the siblings.

8.3 During this period another of the siblings, who was suffering from sight impairments and delayed development was missing a number of appointments and there was limited professional contact with them.

8.4 The second child had started school on a part time basis, and concerns emerged about hygiene. The child was also hospitalised with severe dehydration at one point. Neither at the time, nor with hindsight, were any safeguarding concerns evident in regards to this incident.

8.5 Low level concerns were evident throughout this key episode, with over-crowded housing, the children not being taken for immunisations, one child having small unexplained bruises noted by the school, concerns about hygiene and dental care, and

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\(^2\) Common assessment framework and team around the child. The common assessment framework provides a tool for assessing the needs of children and young people to support earlier intervention and to improve joint working and communication between practitioners.

\(^3\) A home visiting service for pre-school children with developmental or learning difficulties, physical disabilities or other special needs. They help parents to encourage their children's development by suggesting activities and daily routines to make learning fun.
Mother cancelling or not attending appointments. The diet of one of the children was also a concern as they were not putting on weight as expected. Mother was asked to keep a food diary but did not cooperate. The concerns were not specifically identified by or addressed by the CAF.

8.6 It was noted at nursery that one of the children habitually pulled their hair out, and nursery staff were concerned at the extent of the habit, but there were no other concerns. Checks were undertaken with the eldest child’s school by CSC and there continued to be no concerns.

8.7 An anonymous referral was made to CSC via the NSPCC that stated the children never went out and that the home conditions were poor. The police have no record and there is no evidence this was investigated or recorded by CSC, or that the information was discussed with the agencies and professionals working with the family.

**Key Episode 2: (2012 – October 13)**

8.8 In September 2012 the CAF was closed as the ‘team around the child’ stated they had achieved their objectives for the second child and the only outstanding issue was a larger house being required by the family. The meeting that decided to close the CAF was only attended by two professionals however and there is no evidence that others working with the family were consulted. The information noted in paragraphs 8.7 above was not available to this meeting. The family told the review that they had been promised respite care for this child at this time, but this had never materialised. Their memory of this time was that no support was offered at all.

8.9 In early 2013 this same child had a large bruise to their face which was said to be accidental and the paediatrician felt the explanation was consistent with the injury and noted that the child was making ‘pleasing’ developmental progress.

8.10 Later in 2013 Mother requested that one of the children’s statutory educational needs assessment be cancelled. She stated that they did not want the child to go to school and wanted to keep them at home. The same month CSC received a referral via the MASH from the school about another of the siblings highlighting concerns about behaviour and physical appearance of the child. There is evidence that the case was opened to CSC at this time, but no work was undertaken.

**Key Episode 3: (Oct - December 2013)**

8.11 A further MASH referral using the MARF was made by this child’s school in October 2013. The child had a potentially non-accidental injury to the palm of their left hand and had said ‘Daddy hit me’. A strategy meeting was held but the school was not included or informed. There is no evidence of a subsequent S47 investigation, child protection medical, or a record of why these things did not take place. The school received no update despite chasing for information.

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4 Multi-Agency Safeguarding Hub.
5 Multi-agency referral form
8.12 It was evident at this point that another of the children had special needs due to physical disabilities. Numerous medical appointments were arranged for the next few weeks. Mother attended a number of orthopaedic appointments at hospital but avoided the health visitor. The child was not weighed and measured and no immunisations were undertaken.

8.13 After the health visitor had a supervision session on 15 November 2013 an escalation was made to the social worker and their team manager requesting a strategy meeting. The health visitor was clear at the Learning Event that she had stated that a S47 child protection investigation was required. No response was received and the health visitor and her supervisor had to follow up the escalation. They received information on 13 December 2013 stating that a professionals meeting was to be held on 19 December 2013. It was not clear what status this meeting had.

8.14 On 13 December 2013 the school took advice from the education safeguarding lead in the MASH regarding the case. They were frustrated that there had been no response to the referral they had made in October about the injury to the hand of one of the children. They were advised to escalate their concerns at the meeting to be held on 19 December.

8.15 A social worker went to the family home as part of the core assessment and recorded there were no concerns. The day before the professionals meeting one of the children was seen by at a planned paediatric clinic and their weight was noted to have dropped below the 0.4th centile.

8.16 At the ‘professionals meeting’ the health visitor and staff from both schools expressed concerns about multiple missed appointments and poor engagement. One of the sibling’s school were concerned about physical abuse in the home, as the child had said they were hit and a number of small injuries have been evident. Concerns about speech and language delay, weight loss (or lack of expected growth,) lack of toilet training, hair loss, and toileting delay were also shared by those professionals who were present. The plan from the meeting was not explicit and those who attended thought that a CiN plan was now in place, but were not clear what this would involve. It was also noted that the hand injury to the child remained un-investigated. Responsibility for the children’s social work input transferred to the children with disability social work team but in the weeks that followed there was little action taken and drift was again evident.

Key Episode 4: (January - October 2014)

8.17 From January 2014 the health visitor continued to be unable to see Mother, and Mother became abusive and threatening, telling the health visitor she knew where she lived. Threats were also made to the housing officer involved at the time. The youngest child’s weight was faltering and Mother was avoiding the child being weighed. In February 2014 CSC received a referral from another of the children’s schools. The child had bruising

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6 Children Act 1989. Where the Local Authority has ‘reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child’s welfare.’
above the armpit and an enlarged middle finger. They had blamed a number of the siblings and said that the bruise was caused by a door, raising concerns about the level of supervision in the home. Checks were undertaken by the social worker who noted that the consultant paediatrician involved with the child had stated that she had seen a large bruise on the child’s forehead approximately a year previously and on that occasion the child had also blamed a door. The paediatrician had commented and advised that there should be a relatively low threshold of suspicion for this child due to them being particularly vulnerable. The doctor stated that she felt the child is ‘always miserable’ when seen in clinic. The Social Worker visited as a result of the referral and noted that the child had ‘black teeth’.

8.18 In the following month blood was found in the same child’s underwear pad (nappy). The school made a referral to CSC at 9.45 a.m. but a strategy meeting was not held until fairly late in the day, and the child was not spoken to until 3.45 p.m. The family were then told that the child would need to be placed into foster care overnight until a child protection medical could be planned the next day. This lead to an angry exchange from the parents, with an extended family member making threats to school staff. In the learning section below an explanation for the delay is identified and explored. No disclosures were made by the child and the medical showed no evidence of sexual abuse, however it was not ruled out. A potential explanation offered was that the child had long finger nails and the blood may be the result of the child or someone else scratching in the genital area.

8.19 The results of the medical were discussed at a further strategy meeting and an Initial Child Protection Conference (ICPC) was agreed due to on-going concerns about neglect and the identification of disguised compliance to the parents. The conference was held in timescales and a number of the children were made the subjects of Child Protection Plans (CPP) under the category of neglect. One other child was made the subject of a Child in Need (CIN) plan at that stage (but subsequently made subject of a CP Plan at a later conference.) The ICPC took 4 hours due to the complexity of the children’s needs and the number of children.

8.20 Once the children became subjects of CP plans there was evidence of a number of visits to the family home by the social worker and by a family support worker (FSW). Concerns continued. The FSW wrote on 15 May 2014 that Mother was not showing any commitment to the work being undertaken with her. Mother was avoiding talking about routines, times of feeds, time that one of the children spent out of the cot, and she was unable to explain when the children ate their main meal, where they sat, or how she managed to support them with their very specific needs. The FSW reported Mother avoided making specific arrangements for forthcoming visits.

8.21 At a Core Group Meeting held in May 2014, the health visitor shared concerns about the youngest child whose weight had dropped and whose physical development was considered to be increasingly delayed. There were concerns about the other children missing appointments such as physiotherapy, and some school attendance issues.

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7 ‘Disguised compliance’ is a term that can be attributed to Peter Reder, Sylvia Duncan and Moira Gray in ‘Beyond blame: child abuse tragedies revisited’ (1993). It involves a parent or carer giving the appearance of cooperating with agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.
8.22 Concerns were raised by the school in respect of one of the children, who was making statements that appeared to be sexual in nature. A police officer and a social worker saw that child at school, and no further action was taken. There is no record that the parents were aware of this intervention or that S47 procedures were followed.

8.23 Concerns continued about engagement with both family support and medical support services. For example, in June 2014 the physiotherapist for one of the children visited the family and was concerned that Mother and Father were not following advice to ensure the child’s expected recovery from a recent operation. There were a large number of appointments that the family were expected to attend due to the complex issues faced by a number of the children. Consideration was given at the time to the difficulties this presented and attempts were made to coordinate appointments and help the family, who claimed at the time that they did not require assistance. When spoken to by the lead reviewer the family stated they received no help and support with attending appointments, and that they would have cooperated if it had been offered.

8.24 As a result of the child protection plan a number of the children had medcals to gain a paediatrician’s opinion on whether there were physical signs of neglect. Concerns about the reports written following the medcals were raised by CSC as the reports did not clarify that one of the children’s developmental delay was not related to their disability. This is good practice. A review followed by a Consultant Paediatrician and the reports were amended. The Consultant Paediatrician used the opportunity to state that in her opinion the child’s “developmental delay is likely to result from severe neglect of their developmental needs from infancy.” It should be noted however that at this time the various children were under the care of eight different paediatricians and there were differing and conflicting opinions regarding the children’s needs and their care.

8.25 The social worker undertook regular visits at this time. Whilst there were no concerns identified about the home conditions, the lack of opportunity for play and stimulation was noted. On occasion the children were described by the social worker and FSW as being pale and ‘grubby and unkempt’. The health visitor reported that the home was tidy but that there was a strong smell of body odour and urine.

8.26 In July 2014 a strategy meeting was held. It was chaired by a CSC Head of Service following an escalation of concern by health professionals. At the meeting the professionals shared that they found the parents very hard to work with, and that this had an impact on the children. At this stage there was a lack of suitable assessments and no co-ordinated plan. The other issues identified were dental decay, extreme hair loss, wetting, and occasional soiling. It was agreed that a legal planning meeting should be held. There was however considerable delay in the legal processes that were required, with little evidence of pre-proceedings work being undertaken under the Public Law Outline prior to the first application to the court which was made in October 2014.

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8 Under the Public Law Outline (2014) and the Children and Families Act 2014, there is a 26-week time limit for the completion of care and supervision proceedings. This places an increased emphasis on pre-proceedings work and the quality of Assessments.
Over the coming months parental cooperation was limited. Mother told the school she would remove the children from their schools because of what the school professionals had shared at the Review Child Protection Conference. Dehydration, poor diet and apparent weight loss was still evident amongst a number of the siblings. Concerns were also emerging about the parents' attitude towards the children. For example, when one child said a relative had dropped them, Mother called the child "a liar".

The RCPC was held in two parts over two dates as Mother could not make the first meeting. At the conferences the youngest child’s continued failure to thrive and mounting concern about their health and development was discussed. The second of the two RCPC’s was a difficult conference with a family friend who attended to support them stating that the family were being discriminated against and that the children’s special needs were not being taken into consideration. A consultant paediatrician was in attendance and was clear that the issues were due to neglect and that medical challenges two of the children suffered from should not have an impact on their development and growth. The Designated Doctor was contacted after the conference and they suggested that an urgent growth assessment was required for the youngest child, who was admitted to hospital that day.

The conference chair subsequently completed a red alert⁹ on the case, due to concerns about drift in the Child Protection Plan. They noted that no core groups had been recorded despite the conference chair being informed that two had taken place. They also noted that social work visits had not been adequately recorded despite the children being the subject of CP plans for over 6 months. The Conference Chair stated it was “very hit and miss” which children were seen and that the child protection plan had not been progressed. At the time the social work responsibility for the children was held in the children with disabilities social work team. It was a small team of 3 social workers with responsibility for 140 children initially, but at this time was expanding to serve over 200 children with 5 social workers. At the learning events it was stated that the team were not aware of all the cases they were overseeing, there was no proper management oversight as the team manager was constantly acting down and doing case work, and they ‘worked in chaos.’

The youngest child was admitted to hospital, and a week later CSC met with the parents and negotiated that the child would be placed in foster care due to concerns about being neglected at home. A S47 strategy meeting was held, which included a locum Local Authority Solicitor who gave incorrect advice about the threshold required by the court for care proceedings on this child. The solicitor’s view was not challenged. The Police initially considered the case as a potential criminal matter but decided there would be no further investigation regarding neglect due to the complex issues associated with the child’s health needs. At the SCR events it was agreed amongst those involved at the time that hospital may not have been the best place for the child at this time, and that a referral for an immediate outpatient appointment with a growth specialist may have been preferable.

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⁹ Quality Assurance system used by child protection conference chairs and independent reviewing officers in the authority.
Key Episode 5: (October 2014 – February 2015)

8.31 After a visit to the family home following the youngest child’s admission into foster care, where it was evident that the concerns identified about the care of the other children had not improved, care proceedings were started on all but one of the children. Care Orders were refused by the court however, partly because the application was made incorrectly by the Local Authority and the youngest child was returned to the parent’s care. Social Care staff attending the Learning Event believed this was due to the lack, at this stage, of clear evidence from a paediatrician that the children’s failure to thrive was due to neglect not their health issues.

8.32 In November 2014 the court issued an interim care order in respect of the youngest child and they moved into foster care where they quickly began to put on weight and improve developmentally. After the next RCPC CSC requested that a support worker provide advocacy to the family, and this was a successful relationship for the remaining child and the parents in the months that followed. Around a week later one child stated that Father had hit another of the children for getting out of bed. There were no injuries, the child did not make an allegation when spoken to by a police officer and the social worker, and the parents denied it, so no further action was taken.

8.33 During the care proceedings a psychologist report indicated that both Mother and Father had low IQs (69 and 71) but had the capacity to instruct their solicitors. The parents did not attend the first two court ordered parenting assessment sessions. It was clear at the Learning Events that the professionals involved prior to the care proceedings had not previously identified or suspected the limitations of either parent’s cognitive capacity.

8.34 The care proceedings continued in 2015, with all of the children but one living at home. PAMS\textsuperscript{10} assessments were undertaken. The social worker who had instigated the care proceedings was removed from the case after the parents made serious threats to them. It was not until 27 February 2015 that the court made a decision to remove other children from their parents and made orders for them to live away from the family home. This was following a change of CAFCASS Children’s Guardian, who undertook a thorough review of the case, spoke to the professionals involved, met with the parents and children, and observed contact between the child already in care and the parents. The Guardian went on to support the Local Authority’s plan to remove all of the children except one from the care of the parents on interim care orders. This was identified in this review as a thorough and good piece of work.

8.35 There have been issues identified regarding the level of contact the children were having with their parents following them coming into the care of the local authority. During a medical in March 2015 Mother was thought to be silencing one of the children, and this led the Paediatrician to advise CSC that contact should be reduced. It is alleged that Father has made a number of serious threats to staff across agencies since the children have been in foster care.

\textsuperscript{10} Parent Assessment Training Manual (PAMS) was developed by Dr Sue McGaw a Clinical Psychologist in the field of working with parents with learning disabilities.
9 Analysis by Theme

9.1 From the information deduced from the agency reports, from the discussions at the Learning Events, and from the meeting with the family, several key themes have emerged. These can be summarised as:

- Identification of neglect and children with disabilities
- Lack of cooperation / inability of professionals to engage with the family
- Drift and changes of professionals
- Multi-agency meetings (includes the clarity of meeting being held, what is the purpose, and how they fit within LSCB procedures)
- Consideration of each child individually
- Internal and external escalation/professional disagreements
- Specialist social work provision and legal processes

Each theme will be considered below, with any learning clearly identified.

Identification of neglect and children with disabilities

9.2 In this case there were a number of complexities and these appear to have led to a delay in the identification of neglect. The complexities include; a lack of historical concerns about the eldest child; the complex health needs of a number of the children; the family’s crowded living conditions; the support of the maternal extended family; the limitations of the parents (although the extent of the parents’ learning difficulties were not clear until the care proceedings); the home being relatively well cared for; and the parents’ inconsistent cooperation. There were also issues within the system, such as; the allocation of the case within the children with disabilities social work team; the large number of appointments the family had to attend; and concerns about the need to respect the cultural heritage of the family. All of these complexities led to the focus of the work with the family being support without adequate challenge.

9.3 Concerns about neglect were evident, and these included:

- Refusal of immunisations followed by inconsistent agreement then avoidance
- Missed hospital appointments
- Other missed appointments such as occupational therapy and physiotherapy
- Developmental delay not related to medical issues.
- A number of episodes of blood in one child’s underwear pad, the cause of which has not been identified
- Inconsistent completion of the requested food diaries for a number of the children
- Over-grown and dirty finger and toe nails
- The children’s poor hygiene
- Lack of toys and age appropriate stimulation in the family home
- Regular disengagement with services by parents e.g the CAF, physiotherapy, etc
- Children gaining most of their calories from formula milk (also a denial of developmental progress)
• Tooth decay
• Unexplained bruising
• Not using mobility aids
• Not using spectacles
• Emotional difficulties evidenced by hair pulling

However, the children’s clothes and the home were often described as ‘pristine’ by a number of the agencies involved, and the children were certainly not seen as ‘classic’ neglected children. At the time there were conflicting views and opinions from health professionals which was difficult for non-medical staff.

9.4 It appears that the care of the children was inconsistent over time, and that on occasion they did receive care that was adequate and appropriate, however they also had periods were their needs were neglected. The incidents and impact of neglect appear to have increased as the number of children, particularly children with special needs, increased.

9.5 One of the most vulnerable groups in terms of safeguarding is disabled children. The evidence that disabled children are at increased risk of being abused and neglected is extensive. There is also evidence that they are less likely to become the subject of child protection plans.11 The special needs of a number of the children meant that they had to rely on their parents to provide good care in regards to their health, their personal care needs and their emotional wellbeing. For KE5, the court ruled that the care received was not good enough and that the children had suffered significant harm.

9.6 All children are vulnerable to neglect, physical, emotional and sexual abuse. For disabled children and those with complex health needs there are likely to be additional vulnerabilities, such as the failure of the parents or carer to follow professional and medical advice which is considered to be in the child’s best interests or being denied access to appropriate education, play and leisure opportunities.12 When professionals focus on providing support, they may not always notice that parental care is neglectful.

9.7 While disabled children should be considered as no different from other children, simultaneously it has to be acknowledged that they also have additional needs and particular vulnerabilities. Kennedy and Wonnacott stated in 2005 that an ‘important message for practitioners is that they need to apply the same care to assessing developmental needs in all domains and consider whether the children are attaining their potential’. The 2003 National Working Group on Child Protection and Disability found there were barriers to the identification of child protection concerns for children with special needs. They stipulated lack of holistic child-focused assessments; reluctance to challenge parents/carers; reluctance to challenge professional colleagues; a skills gap; and resource constraints.

9.8 In their 2014 report for the NSPCC Miller and Brown13 note that there is little research specifically in relation to minority ethnic disabled children and safeguarding, although research shows that families from minority ethnic groups experience additional disadvantage and discrimination in caring for a disabled child. The family told the Lead

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11 Kennedy and Wonnacott (2005)
12 Miller and Brown 2014 NSPCC
13 ‘We have the right to be safe’ Protecting Disabled Children from Abuse. Miller and Brown 2014 NSPCC
Reviewer that they would have wanted to manage things within their family as much as possible, as they were wary of professionals.

9.9 The limitations to the parents’ understanding was not identified until the case was in care proceedings, and questions must therefore be asked about the expectations of the parents (and particularly Mother as she was left with the bulk of the child care responsibilities in the household) to manage the complexities involved in the children’s care.

9.10 The identified learning:

- All professionals undertaking assessments of children with disabilities need to distinguish between features which are or are not part of a child’s disability, in order to identify signs of neglect. Specific medical advice should be sought to clarify if concerns (such as bruising or developmental delay) are part of a child’s underlying condition. Consistency is required to ensure that when children with disabilities are assessed their particular needs and limitations but also their increased vulnerability is taken into consideration.

**Lack of cooperation and the family’s culture:**

9.11 Lack of engagement between professionals and the family led to an absence of relevant assessments, and limited the impact of the support offered. While it appears that the parents were happy to accept some professional support, for example with housing, this had to be on their own terms. When their behaviour was questioned or challenged they would avoid appointments and on occasion would be abusive to professionals. This increased after the children became the subject of child protection plans. However, it should be noted that insufficient attention was given at the time to the impact of the parents’ cognitive limitations on their understanding and acknowledgement of the children’s needs.

9.12 There were a number of indicators that the parents were resistant to professionals. There was some acceptance of this as those involved understood that the culture of the family would have an impact on how much professional intervention they would want in their lives. Mother was thought to have a genuine fear of professional involvement. The community nurse who had significant relationship with Mother and was visiting weekly during the first key episode recorded that Mother was very upset about the CAF, that she found it intrusive, and that she did not want people interfering in her raising of her children. This appears to have influenced the early stages of the CAF, where the professionals were keen to keep Mother engaged so did not talk about areas of concern with her, and were not as candid as they could have been about the impact on the children of those concerns.

9.13 Those in the helping professions are often inclined towards positive interpretations of what is going on, and are likely to see the best in those they are working with. The ‘rule of optimism’ in safeguarding decision-making was first identified by Dingwall, Ekeelaar and Murray in 1983. In this case the parents tended to cooperate with professionals just enough to reassure them that they were compliant. This was mostly disguised compliance however. A number of agencies found Mother to be largely engaged and appropriate. However, others often found the parents to be dismissive and hard to engage, such as

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the health visitors, a number of the paediatricians and the FSW. This review has found, however, that until the involvement of the support worker in the later stages of the case, the parents received very little support to understand child protection processes and acknowledge the potential seriousness of the situation.

9.14 The parents did not respond well to challenge, and a number of examples of them being threatening to staff were discussed at the learning events. As time went on and there was more pressure being put on the family by professionals because of concerns about their care of the children, the more the parents got angry and threatening. Anxiety about challenging the service user may stop the recognition or exploration of difficult issues by professionals, this may have been exacerbated by concern from staff that they should not discriminate and should understand the family’s reluctance to accept too much professional intervention in their lives. However, a number of the professionals involved acknowledged their own fears and used examples of the parents’ unreasonable behaviour to stress their ongoing concerns about the children. In KE4 the health visitor was threatened by Mother and this information was used to raise further concerns with CSC. It is noted that during their engagement as part of this review, both parents denied ever threatening staff.

9.15 Information was shared and concerns were voiced by a number of professionals throughout KE3 and 4, some of those involved at the time shared their frustration at not feeling listened to. They also felt that it was implied at the time that they were picking on the family. Escalations of professional disagreements were made, but were ineffective. There was also continued delay in agreeing the identification of significant harm to the children, and they remained in a damaging situation for up to another year before the case was made to and accepted by the court. The lack of response to the escalations, the lack of firm management of the case, and the delay also gave the parents a mixed message about the severity of the concerns which was unfair and insensitive.

9.16 When agencies fail to engage with parents’ where it has been identified that this engagement is necessary to promote the well-being of the children, the impact on a child’s outcomes can be profound. Missed appointments and the resultant work can also cause pressure on over-stretched agencies. There are a number of examples of the services not be able to engage with these parents. These include missed physiotherapy sessions, missed health visiting appointments, and missed sessions with the FSW. Dealing with the impact of a lack of engagement with services is frustrating and time consuming for professionals, and can take the attention away from the needs of children. The Biennial Review of Serious Case Reviews\(^\text{15}\) highlighted the extent of parental resistance and its negative impact on improving children’s outcomes.

9.17 In order to ensure that professionals are given help and support to enable positive engagement with parents who use anger and aggression to avoid professional challenge, and to work in partnership with all families, there needs to be a multi-agency culture of supervision, support and peer challenge. In this case there were examples of a good supervision system and practice, such as that provided to the health visitors, who also worked in a supportive team environment where case discussions were frequently held. In the case of CSC the social workers reported a situation where there was limited management oversight and limited supervision available at a time of staff shortages and lack of experienced managers. This had an impact on the outcomes for the children in this case, and on the breakdown of the relationship with the parents.

\(^{15}\) Brandon et al New Learning from Serious Case Reviews 2009 – 2011. (2012)
9.18 Communication between professionals and information sharing is also key to working with families who use anger and aggression to intimidate professionals, and who do not engage. When the professionals got together in the meetings held in KE4 they identified the difficulties with engagement and the way they felt the parents had professionals ‘tied up in knots.’ It was then that the case moved into the child protection arena and a child protection conference was agreed. What was not identified sufficiently, however, was the parents’ cognitive limitation and the impact this may have had on their understanding and their ability to engage in a meaningful way. There was also limited consideration of the impact that the family’s culture may have had on their engagement or of providing them with effective cultural support.

9.19 The lack of a coordinated approach by professionals was evident in this case, and was an issue across the wider system at this time. This was in part due to staffing difficulties in key positions in social care and legal services.

9.19 The identified learning:

- It is difficult for professionals who are involved with a family to differentiate between those parents who are overwhelmed with the amount of appointments and demands of caring for children with special needs, and those who are unwilling to engage and show disguised compliance. Professionals need to be encouraged to state ‘I am struggling to engage.’ The use of supervision and peer challenge to identify these issues is crucial.

- The notion of ‘high support, high challenge’ should be the aim of engagement with families. It is a complex and difficult balance when working with all families, but particularly so when engaging with Minority Groups or Groups that are hard to reach. To do this well requires skilled practitioners, relevant cultural support, reflective practice, and effective supervision.

- Families require specific support and approaches when facing a safeguarding intervention. Contact should be characterised by sincerity, politeness, and respectful assertiveness, acknowledging the anxiety that professional involvement can cause.

**Drift and changes of professionals:**

9.20 It was identified in agency reports and at the learning events that a large number of professionals had been involved with the family over the course of the review period. There were issues across the whole system about changes of professionals, these include social workers and managers in the children with disabilities team at the time. This had an impact on the case management, particularly regarding the identification of safeguarding concerns and the need to have a robust plan in place for the children in this family. In the first 6 months that the younger children were on a child protection plan, there were 4 changes of social worker.

9.21 Other places in the system had difficulties at this time. There were 5 health visitors allocated to the case in the space of a year, most of whom were newly qualified. They described the difficult physical environment the health visiting team were working in at the time, with basic needs not being met; there were not enough chairs in their office,
for example. The Local Authority Legal Department had employed locum solicitors, with limited management oversight, leading to additional drift in the case in Key Episodes 4 and 5. Four different solicitors were involved in the initial stages of the case. The commissioning of provision for child sex abuse medicals was also inadequate. There were a large number of paediatricians involved with the family (around 8 across the time-frame of this review) and it has been identified that they had differing views about the impact on the children of the care they were or were not receiving. The children were also registered with a number of different GPs.

9.22 The difficulties in sustaining a consistent staff group around the children in this family probably had an impact on the drift evident in the case and the lack of identification of consistent and damaging neglect. It would also have made meaningful engagement with the family, and open and honest communication, very difficult. Threats made by the family may have been better dealt with had they received a more consistent and culturally sensitive service.

9.23 The wish to keep working in cooperation with the family also had an impact, with professionals stating a desire to work in partnership with the family for as long as possible. In 2012 Brown, Ward and Westlake of Loughborough University considered the obstacles to focussing on the child when undertaking child in need and safeguarding work. They listed them as follows:
- Preservation of the family
- The partnership principle
- Empowerment, fairness and their limitations
- Parents’ rights

These obstacles were evident in this case.

9.24 In most cases a child protection plan (CPP) is not required to ensure the children’s needs are being met. In this case it appears that the parents were not willing and / or able to ensure the level of cooperation required to ensure their children’s needs were met, either under a CAF, a CiN plan or a CPP. This was not identified in a timely way.

9.25 The 2014 Miller and Brown report notes that OFSTED has found that children in need work was not always well coordinated, with many plans lacking detail and focus on outcomes, and that this lack of rigour increased the likelihood of child protection concerns not being identified early enough. They also found delays in identifying thresholds for child protection when concerns were less clear-cut, especially neglect. This appears to have been the case here.

9.26 The CAF plan was focused just on one child, and was predominantly maintained to ensure the involvement of Mother, rather than to meet the needs of the specific child and their siblings. The parenting issues listed were limited to an expectation that Mother and MGM provide a safe home for the children. It was closed at a time when a new baby was due, as the schools did not have concerns about siblings. It would have been good practice to have remained involved until after the birth in order to ensure that there was adequate support, and to monitor the impact on the other siblings of a new baby in the home. The issues that had been shared about siblings’ hygiene were not thought to be at the level to warrant an intervention, however there is no evidence that the concerns were discussed with the family and the wider professional group in any of the
CAF meetings. This meant that little change was effected by the CAF, and those at the learning events agreed there had been little professional curiosity, limited focus on the child’s lived experience, and no attempt to seek and consider the voice of the child.

9.27 There were issues with the quality of the child in need work in this case during KE 3 and 4. There was a lack of focus, limited insight into the children’s individual needs, and no rigour in the assessment of the impact of the parent’s lack of consistent engagement and their own limitations, on the children. The case recording by the allocated social workers and the evidence of management oversight was reported as being of very poor quality. Those involved at the time have left the employment of the local authority, so what work was undertaken is largely unknown.

9.28 When the children became subjects of a CP Plan, there was drift and delay, and evidence that the expected visits and meetings were not undertaken. Even when an agreement was made to start care proceedings they did not begin in a timely way. It is acknowledged that the paper work required to begin care proceedings on so many children is extensive, and those involved at the time spoke at the Learning Event about their lack of experience and the limitations of management support at that time. There was little support available from the legal department and no appropriately applied pressure to ensure the proceedings progressed in an acceptable way.

9.29 The parents told the Lead Reviewer that even when they were aware that professionals had concerns about the children, there was very little contact with them, particularly from social workers, and that communication both with them and between professionals was generally poor. They described feeling very uncertain about what the plan was and not feeling able to ask anyone what they were doing well and what needed to change. This is a significant message in this case, and one that professionals in the area need to consider in their work with all families, but particularly those from a minority group.

9.30 There was delay evident in investigating the blood identified in the child’s underwear in KE4 which was upsetting and frustrating for the child, the parents, and the professionals involved. Those involved at the time explained during the review that there were a large number of tasks to be undertaken on the day in question, some of which are cumbersome and frustrating to arrange. There also appeared to be a lack of understanding of the forensic 72-hour deadline for obtaining medical evidence when an urgent child sexual assault medical is required, particularly out of office hours.

9.31 The identified learning:

- The lack of a consistent and co-ordinated group of professionals and managers working in key positions with the family led to drift and delay in the identification and acknowledgement of significant harm and in the plan to safeguard the children.
- In order to respond effectively to allegations or concerns about sexual abuse, a review of the provision for medicals needs to be undertaken.
- When a family is told there are concerns about their children/parenting, there must be a maintained level of contact with that family to ensure they are aware of what needs to change and what support they will receive to achieve this, as part of a clear child in need or child protection plan.
• When it is necessary to commission a child sex abuse medical, staff require clarity about the process including the importance of timeliness for the preservation of forensic evidence.

**Multi-agency meetings:**

9.32 A number of issues have been identified with both the use of meetings or lack of meetings. At the Learning Event it was not possible to be clear exactly how many meetings had been held in this case, what meetings were held (particularly strategy meetings) and what the purpose of each of the meetings was. It was also clear that the decisions made were not always reported back to those not at the meetings. This was particularly an issue with strategy meetings or discussions that did not involve schools, who did not receive any feedback from the meeting/discussion, even if they had made the referral. It is accepted, however, that professionals should chase the outcomes of a meeting if they do not hear anything.

9.33 Staff from all partner agencies need to be clear what any meeting they are attending is for, how it fits with LSCB procedures, and who is responsible for the chairing and recording, and for monitoring the outcomes of any decisions made. The ‘professionals meeting’ held in December 2014 did not meet the above standard. The meeting had no formal status, the parents were not aware of the meeting, a number of the professionals involved with the family had not been invited, and those who had were not clear about the focus or remit of meeting and felt it was held to ‘shut them up’ (school.) At the time the CSC team (a specialist team for children with disabilities) appeared to be in crisis. They were not managing expectations from the professionals involved in this case, and did not appear to be clear about the expected processes within either the LSCB or their agency’s procedures. The team had a succession of team managers who had little team leader experience and a limited child protection skill base.

9.34 The record of the ‘professionals meeting’ had detail of what the children were saying and what was being observed as interaction between the parents and children, much of which was concerning. However, the reported impression of the professionals at the meeting was that the meeting was used to suppress concerns and dissatisfaction with the management of the case by CSC. There is no evidence that the concerns about this meeting were formally escalated to senior managers within the local authority. There is also no evidence that the family was informed that this meeting was being held.

9.35 Even when the children became the subject of Child in Need (CiN) then Child Protection plans the expected meetings were not held. The lack of evidence of core groups was formally raised by the CP Conference chair after the first RCPC. When meetings were held, they do not appear to have been adequately administered. Agencies regularly had to chase up minutes of strategy meetings, CiN and Core group meetings and written plans.

9.36 There was limited response to the escalation of professional disagreements, and the formal policy was not followed, which should have led to a meeting between the relevant professionals in order to clarify concerns and if the disagreement was upheld the meeting should agree a plan, with clear timescales, for improvements.
9.37 It is also important to recognise that good safeguarding practice does not always rely on meetings. The professionals involved in this review were keen to stress that improved information sharing and communication outside meetings is just as important, and that assessments, actions and regular conversations need to happen outside of meetings.

9.38 The learning identified:

- When arranging, chairing, attending and recording any multiagency meetings there must be clarity about who needs to attend, why they are there, and what the expected outcome of the meeting needs to be. Those involved should challenge the chair if the meeting is not addressing the concerns, should be clear about what is expected next, and should inform others if anything changes between meetings.

**Each child’s world:**

9.39 It was difficult for agencies to ensure they focused on each child in the family, that each child’s individual needs were considered, recorded and addressed, and that each child was seen when visits were undertaken. A number of issues have been identified with practice in this regard. The parents often limited the amount of contact professionals had with each child in the family home, however there were opportunities to see a number of the children in their school and nursery settings throughout the timeframe of the review.

9.40 The initial focus of the case was on one particular child in the family, and the CAF focused just on this child. Later concerns were identified with the other children, and it was then that each child should have had an individual assessment, should have been seen separately, and should have had their own needs considered, which included the impact of the special needs of the siblings on them. This was limited until the ICPC was held. Concerns were also raised by the CPC Chair regarding these issues after the children became the subject of plans.

9.41 A multi-agency chronology for each child is a good way of understanding the child’s journey through the system. It should consider ALL of the children, ALL of the agencies and ALL of the history. This assessment tool needs to be supplemented by work with the child to understand their world and to hear their voice. Professionals at the learning events stated they had contributed to chronologies, but that they had not seen the final product. It was confirmed that the chronologies in this case had not been merged, were not scrutinised and analysed and were mislaid.

9.42 With a large sibling group there is always the risk that professional time and efforts are spent on those most in need or those with problematic behaviour. In this case it was believed that the parents had a tendency to ‘hide’ their children from professional scrutiny on occasion. For example, one particular child was rarely seen by professionals, and Mother stated she wished to home school them so that they could remain a ‘baby’. When assessments or investigations were being undertaken there was a need to consider each child separately, to attempt to see and speak to each child and to consider the needs of that child, to include the impact of the siblings needs on each specific child. The social work recordings, for example, did not state clearly if any child had been seen or not, and the recording of the children’s voices was stated to be extremely poor.
9.43 Not only were the younger children’s voices not sought, there was also limited analysis of their behaviours as a way of considering their world. One child regularly showed what was considered to be distressed behaviour by hair pulling, and the children were often described as ‘attention seeking’. On occasion one child was noted to ‘flinch’ when near their mother. It was clear to those undertaking medical examinations on the children that their response was unusual. They were either very distressed or passive and watchful, none of which are expected responses in the experience of those undertaking the examinations. One child was described by one paediatrician as ‘always miserable’.

9.44 Good practice was identified with the eldest child, with their views being explicitly sought and shared at the ICPC, and after the support worker was allocated to provide advocacy and one to one support for them. There is also evidence that the younger children’s school provided helpful information in understanding and sharing the children’s wishes and feelings.

9.45 The identified learning:

- The use of a specialist worker to provide advocacy and support to families in specific circumstances, for example, for families from different cultures/families where the parents have learning disabilities, is helpful and should be available in specific cases as appropriate.

- In families with a number of children, each child must have an individual assessment, should be seen separately, and should have their needs considered, this should include a consideration of the impact the needs of their siblings have on them.

- In large families with complex needs, consideration should be given to compiling a multi-agency chronology. It should include ALL of the children, ALL of the agencies, and ALL of the history.

- When parents are oppositional it is sometimes difficult for professionals to see the children and to gain their views. There is also a risk that children will be silenced. This should be seen as an additional risk when undertaking assessments.

**Internal and external escalation of professional disagreements:**

9.46 Partner agencies must have access to a quick and straightforward means of resolving professional differences; it is then that they can effectively safeguard the welfare of children. Good working together depends on a belief that there is a genuine partnership and joint working across the system. Professional disagreement is only dysfunctional if it is not resolved in a constructive way and within appropriate timescales. It should be accepted and encouraged within a system that when a professional disagrees with a decision or response from any agency regarding determining the level of need for a child, they should ensure they debate the issue with those who made the decision. If that does not achieve the required response, a formal escalation should be made. It was acknowledged with those involved in this case that a positive culture of raising and receiving concerns, both informally and formally, would be helpful.
The LSCB has a clear policy within the regional interagency procedures for professionals who wish to escalate their concerns about the decisions made by another agency. The procedure states ‘all workers should feel able to challenge decision-making and to see this as their right and responsibility in order to promote the best multi-agency safeguarding practice. This procedure provides a means to raise concerns about decisions made by other professionals or agencies by:

‘a) avoiding professional disputes that put children at risk or obscure the focus on the child
‘b) resolving the difficulties within and between agencies quickly and openly’

While the policy exists, there are concerns about how helpful it is. The process is described as complicated, and the schools involved in this case state it is not ‘school friendly’ and that it does not fit with their structures, language and responsibilities. This was not felt to be a reason not to use it, however, despite an acknowledgement it could be improved.

It was agreed at the learning events that the policy was not widely used, and that in this case the concerns that were appropriately raised were not responded to as should be expected. While issues were pointed out, a formal response and a plan to resolve the disagreement was not evident. It appears that issues were raised by email and that a number of these were not available to be considered by the review, as they were not methodically copied onto the children’s case records. This is always a risk, especially when there is a high staff turnover which has been the case here over the time period of this review. It was stated at the learning event that ‘there is probably significant email information within the in-boxes of those involved, and their managers, about these children.’

The health visitor involved in KE4 evidenced that she had emailed and telephoned CSC asking for a S47 investigation into the children’s care. One of the schools also had evidence of their statements that they were not satisfied with the CSC response being passed to both the education and CSC representatives in the MASH team. This was good practice, but the lack of response was not. The education officer in the MASH, when asked for advice by the school due to the concerns they had about the lack of response in this case, sent an email to the school that stated ‘there seems little consistency on responding to cases from social care and lack of communication is frustrating’.

There is no evidence this serious issue was shared with senior managers in CSC or with the LSCB. It was also an indication at the time that the MASH was potentially functioning not as a combined unit but in single agency silos.

Issues were also identified with the lack of consistency of views across a number of medical professionals involved with this family. There was a clear need for a more joined up approach regarding the health needs and risks for these children. The professional differences needed to be formally addressed to ensure a consistent approach was being delivered to the family and a clear steer was given to non-medical staff.
9.52 The learning identified:

- Every formal escalation/professional disagreement should receive a response. The process for escalating and responding must be transparent, timely and clearly communicated.

- As well as escalations of concern about decision making or planning being promoted across the single and multi-agency workforce, the learning from escalations should be considered and embedded to ensure there are improvements beyond a single case.

**Specialist social work provision and legal processes**

9.53 Social work responsibility for the children in this case was transferred to a specialist team within the Council, the children with disabilities team (CDT), in key episode 3. While this brings together social workers and support staff that have experience, skills, and an interest in disability, there is not always a high level of experience and knowledge of safeguarding and child protection in such a team. This appears to be the case here, with a number of workers in the team, including the managers, lacking the required confidence and experience to identify abuse and neglect and to follow the correct procedures and processes. However, concerns have also been identified about the practice of CSC prior to this transfer.

9.54 The wider context at the time was that the local authority was facing significant difficulties due to high levels of both Looked After Children and those on a CP plan, resource issues within CWD, high staff turnover and high case-loads. This was thought to be a significant issue in the delay in determining that these children were suffering significant harm.

9.55 When the case was held as a child in need case within the CWD team, and then as a child protection case, there was a continued lack of focused planning, and procedures were not followed. When the decision was made to instigate a legal gateway (planning) meeting there was more delay. It has been acknowledged that the process is a difficult one. Social workers have to have a large amount of paperwork in place, including chronologies, assessments and care plans for all the individual children in a case. The work had not been evidenced as expected when this case was taken to the Legal Planning Meeting and the social worker was told to go and do what was required, seemingly despite the delay this would cause for the children.

9.56 Although the judgement of the allocated social worker was clear, at the Initial hearing there was not sufficient evidence provided by the local authority before the court to evidence significant harm posed to a number of the children, and therefore the Guardian could not support the proposed removal of the children from the parents' care at this stage. The decision to undertake a serious case review in this case was influenced by the identified concerns at the delay in seeking legal orders and the difficulty the court and CAFCASS had in being convinced, by the local authority, that the threshold had been met. This was in part due to the lack of coordinated evidence that should have been available from the professionals involved.
9.57 Cases of neglect can often struggle to meet the legal threshold for significant harm when placed in front of the courts. The complexities identified in this case, and difficulties in evidencing the effects of neglect where the children have disabilities and health needs, exacerbates the difficulties. Marion Brandon et al describe a number of these challenges in “Missed Opportunities: Indicators of Neglect – What is ignored, why and what can be done” (2014). It is clear that this authority is not alone in finding this area of safeguarding work a challenge.

9.58 The PLO\(^{16}\) was not well known or utilised in the CWD team at the time, and this case would have benefited from the structure, seeking of evidence, specialist assessments, and challenge, that the PLO provides pre-proceedings. It would also have allowed the parents to receive legal advice and clarity about the concerns at this stage. A need for better training and support both in pre-proceedings work and in court work has been identified within agencies in this authority. The review was told that a high number of cases that are taken to court by the local authority fail to receive the orders requested, and do not meet the expected timescales, so this is an urgent requirement. In this case the social work team required good quality legal advice and support from the Legal Department. They did not receive this.

9.59 The learning identified:

- Staff working in specialist roles with disabled children require appropriate experience, and support to ensure they are able to undertake the full range of child protection work.
- Legal advice and planning needs to enable the safety of children to be secured promptly and at the earliest opportunity.
- When children with complex health needs are the subject of a Legal Gateway Meeting, it is good practice to have a health professional involved in the meeting to provide information and advice.
- Effective child protection relies on sufficient qualified and experienced professionals across a range of disciplines, including legal, social care, and paediatrics. All organisations need to ensure that they are reporting to the Local Safeguarding Children Board where there are shortfalls in workforce capacity and capability.
- The Public Law Outline should always be utilised in neglect cases that meet the threshold for care proceedings to ensure that parents are completely aware of the concerns about their children, how serious those concerns are, and to ensure they receive early and appropriate legal advice. Consideration should be given at an early stage to the ability of the parents to meaningfully understand the concerns and the complex court processes.

\(^{16}\) Public Law Outline
10 Conclusions

10.1. This SCR has made judgements in regards to the individual case, and has identified learning which is relevant both to this specific case and to the wider system. It has clearly identified statements of learning which were developed from the themes considered above, and they have also been listed at the start of this report.

10.2. Individual agency learning is crucial in this case and the LSCB has ensured that a robust consideration of the concerns identified has been undertaken by each agency involved in this matter.

10.3. When considering the learning from this SCR the LSCB has agreed to give a clear message to the senior manager of all partner organisations stating that it is their expectation that appropriate resources and staff with the right skills to complete the work are in place, and that they are supported through adequate supervision.

10.4. The overall most significant finding from this review is that professionals need to understand and consider the combined complexities presented by culture, neglect and disability when working with families.

10.5. It is important to learn from the good practice identified during the course of this review. Good practice across a number of agencies has been acknowledged throughout the report, and can be listed as follows:

- Communication between the schools and health professionals during the key episodes.
- CP conference chair identified issues at the RCPC
- Appointment of a support worker to work alongside the family at the stage of the care proceedings, and the quality of the work undertaken by this professional.
- The eldest child being able to share their views in a meaningful way via the support worker.
- GP’s regularly liaised with and referred to paediatricians and health visitors over aspects of the children’s health, including immunisation, feeding problems and hospital appointments.
- Good practice from health visitors in terms of handover to new staff, with the support of their senior.
- Close working between the social worker who instigated the care proceedings and the health visitor at the time.
- The clear observations and concerns shared by the paediatricians in this case.
- The second Guardian involved in the case undertook a thorough piece of work and ensured she met with all of the children. A good relationship also developed with the social worker.
- Communication between schools, nurseries and health visitors.
- The way that a number of the schools, health visitors and paediatricians advocated on the children’s behalf and focused on their needs.
- CSC requested that the reports from the children’s child protection medicals be amended.
10.6. It is also acknowledged that there has been a high degree of cooperation and engagement from agencies with the SCR process.

10.7. There have been some changes within partner agencies of the LSCB since the work was undertaken with this family. The LSCB’s response to this SCR will outline the relevant changes.

10.8. As part of the Learning Events, professionals, their managers, and agency safeguarding leads were asked to reflect on what helps them to safeguard children in this locality and what gets in the way, having considered this case in detail. The following is a summary of what was identified:

- It was agreed that this case required a lot of work, across agencies, in order to consider each child and work with parents who were either not able or did not wish to engage. The capacity to undertake the work and to reflect was stated to be extremely difficult at the time. As stated by Daniel et al. in 2011, the bigger obstacles to acting on concerns may be ‘professional anxieties about what could and should be done by professionals when they are constrained by resources and by their perceptions of insurmountable thresholds for access to other services.’ It is acknowledged that safeguarding services ‘are under significant pressure and this is being felt by practitioners on the front line across the UK’ (Burgess et al, 2014). In this case the social worker undertaking the care proceedings had a very high caseload.

- There was a high turnover of staff in a number of agencies during the time considered by this review. There were also organisational changes. These challenges are on-going and have a negative impact on safeguarding practice.

- Communication continues to be an issue, particularly in basic areas such as the amount of time involved in having to establish the dates and venues for meetings or the contact details for a newly allocated worker.

- There are delays in gaining assessments of parents who have their own difficulties, particularly prior to legal intervention.

- It helps if all agencies are aware of a child’s and their parents’ history across agencies.

- For multiagency groups such as core groups which involve families, there may be times when some facilitation to help move a stuck case forward needs to be made with the agreement of the entire core group.

11 Recommendations

11.1. It is recognised that actions have already been taken in relation to some of the individual agencies’ identified learning. The agency reports included recommendations which have largely been completed by the conclusion of the SCR.

11.2. The purpose of providing additional recommendations is to ensure that the LSCB and all professionals in the partner agencies of the Board are confident that any areas identified as of concern in this review are addressed. The recommendations have been written by the Lead Reviewer along with the SCR sub-group of the LSCB and members of the LSCB, to ensure ownership and local relevance.
Recommendation 1:
The LSCB to seek assurance that all agencies affiliated to the Board participate in training their workforce in culturally competent practice, as exemplified by the Local Authority’s Children’s Directorate and the Police.

Recommendation 2:
The LSCB to seek assurance that operational services have an appropriate range of risk assessment tools to use when assessing children who may be at risk of significant harm and that these are being used effectively.

Recommendation 3:
The LSCB to ensure that there is an effective multi-agency childhood neglect strategy in place.

Recommendation 4:
The LSCB to request assurance from the local authority (Children’s Social Care and Legal Services) that the issues identified in this report in regards to the PLO process are being resolved and monitored.

Recommendation 5:
The LSCB to request that the Director of Children’s Services provides the LSCB with an addendum report that outlines the changes to the children with disabilities service since the time period of this review.

Recommendation 6:
The LSCB to request that NHS England undertakes a review of its commissioning arrangements for child sexual abuse medicals in the local area.

Recommendation 7:
The LSCB to provide guidance on when a full multi-agency chronology should be undertaken.

Recommendation 8:
The LSCB to promote and seek assurance that Early Help and other safeguarding processes consider and reinforce the whole family approach.

Recommendation 9:
The LSCB, through its Quality and Assurance Sub Group, to agree a mechanism to ensure that the LSCB is kept informed of the number of professional disagreements, understanding the themes and monitoring the outcomes.

22.9.16