Gloucestershire Safeguarding Children Board

SERIOUS CASE REVIEW

Executive Summary

SUBJECTS

Abigail and her siblings Bobbie, Charlie and Daisy

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12th August 2014

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1 Introduction

1.1 This Executive Summary sets out the findings of a Serious Case Review about "Abigail" (not her real name), a 3 year old girl who lived in Gloucestershire with her parents, brothers and sisters. Abigail was neglected by her parents. When professionals tried to help her parents, or challenged them, they were unable to prioritise the children's needs over their own or were obstructive. Abigail and her younger brothers and sisters are now thriving, being cared for in foster care or living with family members who are able to meet their needs. In 2014 the full extent of the neglect was laid before a judge and jury after an extensive criminal investigation. Abigail's parents were convicted and sentenced to a term of imprisonment in June 2014.

1.2 As was anticipated, other significant information about the family came to light during the court process. For this reason, further work was planned into the Serious Case Review process, focussing on practitioners' reflections after the court process on practice in the 6 months leading up to the parents' arrest, reflecting on what has changed since that time and on new information which has emerged.

1.3 It became clear from the history available to the review through the Agency Reports, the court process and discussion at the Learning Events, that a number of the older siblings also had similar issues to those now identified in respect of the younger children. These historic issues included poor home conditions, severe head lice and nappy rash, missed appointments, poor attendance at school or nursery and professional concerns about inappropriate diet and the over reliance on cow's milk. There was ongoing evidence that the parents often avoided professionals and that the children's mother prioritised her own needs.

1.4 The Serious Case Review has helped inform how the local safeguarding system functions and has provided a focus for improvement to practice. The findings highlight how working with neglect is complex and has to take account the inter play between many different and often contradictory factors. The learning process has led to recommendations and "Challenge Questions" that support learning and improvement.

2 Why the Serious Case Review was done

2.1 The Government provides guidance in *"Working Together to Safeguard Children" on* when to hold a Serious Case Review (SCR). It is an important learning tool when a child has died, or been seriously harmed because of abuse, and there may be lessons to learn about the way local professionals worked together to safeguard and promote the welfare of a child.

The purpose of a SCR is to *"identify improvements which are needed and to consolidate good practice*[1]*".* The aim is to learn how services could be improved in the future to reduce the risk of other children suffering in the same way.

2.2 In Abigail's case, there was no statutory requirement for a Serious Case Review to be carried out, however since the GSCB had already identified the category of neglect as a priority for exploration, the Board decided to hold a SCR to learn from the case and what it tells us about the wider safeguarding system. This decision is in line with the GSCB's commitment to continuous improvement in strengthening multi-agency working, to better safeguard and promote the welfare of children in Gloucestershire.

3 Scope of the review

3.1 The GSCB set the timeframe for this Serious Case Review to be about involvement with Abigail and her siblings from August 2010 when a multi agency Strategy Meeting[2] was held because of professionals' concerns about the children, to November 2012 when Abigail was admitted to hospital. Terms of reference were agreed for the review and upon request of the GSCB, an additional learning event was held after the conclusion of the criminal proceedings. The purpose was to reflect on a) the sentencing remarks of the judge, b) additional information from a Psychotherapist working with another member of the family, and c) additional views from Housing to contribute to wider learning.

4 Method Used for the Serious Case Review

4.1 *Working Together* says Serious Case Reviews should be done in a way which;

- 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 inform the findings[3].

4.2 In keeping with the guidance in *Working Together*, the GSCB decided to use a method called "systems learning". This means learning from an individual case as a 'window' on the

[1] Paragraph 7, Chapter 4, Working Together to Safeguard Children – HM Government - March 2013

[2] A Strategy Meeting is a formal multi agency meeting, convened when it has been assessed that a child may be suffering from significant harm. The Strategy Meeting decides whether a Section 47 child protection enquiry is appropriate and the most effective way to carry out the enquiry.

[3] Paragraph 10, Chapter 4, Working Together to Safeguard Children – HM Government - March 2013

wider safeguarding system, looking at contributory factors in terms of what helps good practice and what gets in the way. It moves beyond specific incidents and actions to what it tells us about how well the system is working. This "systems" way of reviewing a case is supported by *Working Together* and helps the GSCB to learn implications for safeguarding practice and service more generally.

4.3 There are several methods for "systems" reviews and the GSCB chose what is called the *Significant Incident Learning Process* (SILP). This was followed by a Practitioner Learning Event after the court case. Both involved a large number of practitioners, managers and Safeguarding Leads coming together for a series of learning events.

4.4 The Chair of the Gloucestershire Safeguarding Children Board appointed two independent people to lead the SCR: Donna Ohdedar, an independent safeguarding consultant and Nicki Pettitt, an independent child protection social work manager and consultant. They had no previous links with the local agencies that were, or potentially could have been involved in the case, GSCB, or any of its partner agencies.

4.5 The first step for the SILP was each agency involved with the family completing a "chronology" of their contact with the family as well as analysis of the professional practice by their agency. This was provided by the Police; the Hospitals Trust; School Nursing and Health Visiting; the GP; Children's Social Care; the Education setting and the Children's Centre. The Independent Authors then led a Learning Event for practitioners involved in the case; then a recall session for professionals to consider the Overview Report, to feedback on the contents of the report and make sure it reflected their experience, views and learning points.

4.6 The method for follow up learning after the trial was adapted from *'Systems analysis of clinical incidents: The London Protocol'* (Taylor-Adams et al, 2004) and James Reason's 'Swiss Cheese model'. These are used to learn from incidents in systems such as aviation, engineering and healthcare. The model uses the analogy of human systems of working being like multiple slices of Swiss cheese stacked side by side, illustrating that although many layers of defence lie between hazards and accidents, there can be 'holes' in each layer that, if they line up, can allow the accident or incident to happen. This was a helpful way of thinking for practitioners to review "contributory factors" to good practice and to issues that got in the way.

5 Family Contribution to the Serious Case Review

5.1 Abigail's parents were made aware of the SCR from the start and were contacted in order to make sure their views were heard and considered as part of the review. They were assured

the learning process was not about their court case but about what the agencies themselves needed to learn about their own practice, but neither parent agreed to meet with the SILP Independent Reviewers. The review did however learn from one of Abigail's older siblings and one of her Grandparents, which was enormously helpful to learning from the voices of children and of wider family. Following the trial, Abigail's parents were again asked if they wanted to contribute to the learning. They have declined to take part in any discussion at this time.

6 Case Background

6.1 This family had been known to a number of different agencies for over 16 years. Both parents had physical and mental health issues and a high level of contact with health practitioners. At times there were also serious concerns about all the children, for example when developmental milestones were not reached, health issues not always addressed by the parents, and the house being dirty, untidy and smelling of faeces.

6.2 A key feature in the background to the case was peaks and troughs in concerns about neglect; In 2007 an Initial Child Protection Conference[4] was held but the children were not made subject to a Child Protection Plan[5], because by then there had been improvements. A Review Conference was arranged, but was cancelled as this improvement was thought to have been maintained. However the mother went on to have more children against a backdrop of previous psychological problems, a history of post-natal depression and chronic pain, with a partner who had mental health issues of his own including suicidal gestures. Some of the mother's mobility issues were never able to be investigated and are unexplained, due to lack of engagement.

6.3 There were a number of contacts and communications made to Children's Social Care (CSC) and the children were as a result subject of assessment and interventions, including an assessment under the Common Assessment Framework[6] (CAF). Things improved somewhat but the impact was minimal because of the parents' limited engagement.

6.4 Abigail herself was born in 2009, and in the same year there were concerns about poor

[4] A formal meeting of professionals from key agencies such as Health, Police, Children and Young People's Services and those professionals who have worked with and know the family. The purpose is to decide the level of concerns for any child in the family and whether they are at risk of significant harm or will likely be in the future.

[5] Child Protection Plans are put in place as a result of a Child Protection Conference, if the threshold for significant harm is met, to set out who will take what action and in what timescale. Core Group meetings are held between Conferences and involve the key professionals and the parents in order monitor the progress of the Plan.

[6] A CAF is a four-step process whereby practitioners identify a child's needs early; assess those needs; deliver coordinated services; and review progress. The CAF is for children who have additional needs to those being met by universal services. The process is voluntary; consent by the family is mandatory and they can choose what information they want to share.

school attendance for some of the older children. Professionals on home visits described chaos, clutter, dog faeces in the home and a smoky atmosphere. There were concerns that her parents were not taking on board or acting on professional advice.

6.5 During 2010 two of Abigail's siblings were referred to the hospital due to concerns about poor physical and developmental progression. The children were discharged from the hospital doctor's care after some improvement was reported and following an initial assessment of need, no further action was taken by Children's Social Care.

7 Summary of Events examined by the Review

7.1 In terms of professional interventions with the family during the scope of the review, this can be divided into four distinct phases of professional interventions;

The first phase scrutinised in the SCR was between August 2010 and January 2011, looking at what happened after a multi agency Strategy Meeting was held[7]. The meeting acknowledged that there was a CAF in place and that it did not meet the needs of the children. However it was agreed that the threshold for a Child Protection Conference was not met[8], but that a social worker should complete a Core Assessment of Need under section 17 of the Children Act 1989[9]. However, the assessment was actually completed by an experienced family support worker, a practice that is no longer acceptable in Gloucestershire and has not been since 2012. This by law required the permission and cooperation of the parents. The opportunity to complete a core assessment was taken and lots of concerns were shared between professionals, but not always as forcefully as would have been hoped. The Serious Case Review revealed that Abigail's mother could be aggressive, and on occasion swore at professionals if she felt challenged. Indeed her refusal to work with the schools in this first key episode of this review did not lead to a reconsideration of the need for a child protection response, but to an unconsciously collusive agreement that this could be avoided if mother agreed to work with the Health Visitor. While this was agreed in the spirit of partnership, the needs of the children were not prioritised over their mother's.

[7] A Strategy Meeting is a formal statutory, multi agency meeting, convened when it has been assessed that a child may be suffering from significant harm. The Strategy Meeting decides whether a Section 47 child protection enquiry is appropriate and the most effective way to carry out the enquiry.

[8] The threshold for a Child Protection Conference is met where child protection enquiries are indicating that a child may be suffering, or be at risk of suffering, significant harm as a result of abuse.

[9] A Core Assessment is done either under Section 47 of the Children Act for a child protection enquiry, or it is done under Section 17 if working with a Child in Need where it is clear that a greater depth of assessment is needed in some complex areas to clarify exactly what the needs are and what types of service will meet the child's needs.

7.2 **The second key phase** of involvement was from February 2011 to May 2011, when emerging concerns about Abigail were becoming clearer. The SCR found significance in the way the family did not cooperate with key issues such as attending appointments with the paediatrician, following dietary advice for the children, engaging with all of the relevant professionals including the schools. At this point with hindsight the need for a child protection conference should have been considered, but at the time professionals were seeing partial improvements and not some of the significant gaps in the children's care.

7.3 **The third phase** of professional interventions was between June to July 2011, when there were concerns about the older pre-school children. There were signs that the professionals working with the children were becoming increasingly demoralised about both the family and the likelihood of the matter being seen or responded to as a safeguarding issue by the statutory agencies. This episode was significant because further concerning information was being noted, but none led to a referral formally requesting the intervention of CSC. During this time Abigail was assessed by a hospital doctor, but the information noted was mostly as reported by her parents and Abigail was discharged.

7.4 No significant issues emerged during the next 6 months, but the **fourth key phase** from February 2012 onwards examined in the SCR shows an escalation of concerns after missed appointments for one of the children and ongoing concerns about neglect, leading to a multi agency professionals meeting. The SCR found this episode was dominated by lack of effective action, with one of the key contributory factors being that the parents were successfully avoiding professionals. Despite persistent efforts from the Health Visitor to see Abigail, and the GP's efforts to make sure her serious nappy rash was treated, the parents' reluctance to engage and blatant avoidance of professionals continued, meaning that the understanding of all agencies about the seriousness of the situation was delayed.

In October 2012 the Health Visitor made a referral to CSC and Abigail's case was appropriately opened for assessment. This did not begin till the end of October, because CSC mistakenly thought that as a number of professionals were actively involved, and the nappy rash had been an issue since June, urgent action was not necessary. In November however a Strategy Discussion was held and it was agreed to complete a Core Assessment under Section 47 of the Children Act.[10] During this time a psychotherapist working with

[10] The Core Assessment provides a structured framework for social workers to gather evidence during a child protection enquiry, which under Section 47 of the Children Act is when there is reasonable cause to believe that a child has suffered or is likely to suffer significant harm, for example a child is suffering or likely to suffer significant harm in the form of physical, sexual, emotional abuse or neglect. The social worker contacts the other agencies involved with the child to inform them that a child protection enquiry has been initiated and to seek their views. Parental permission to undertake these inter-agency checks is not mandatory and can be overridden if this would be prejudicial to the child's welfare, or there is concern that the child would be at risk of further significant harm.

another member of the family, independently of the local agencies, was shocked to see the state of the home and the children, and contacted CSC. They were told that the family were to be the subject of a child protection meeting due to a referral received previously. A professionals' meeting was held in November and it was decided to progress to Initial Child Protection Conference. However, Abigail was admitted to hospital on 23 November 2012 with severe nappy rash, found to have anaemia, malnutrition, head lice infestation and decreased bone mineralisation, and was not returned home.

7.5 Throughout the period under review, the Housing department overseeing the family's tenancy were not aware of any concerns from a housing perspective, apart from the use of a wood burning fire in the property, which is not an issue related to the neglect of children. Reassurance has been given that all Housing staff members undertake training in safeguarding and are aware of the need to report concerns to the lead safeguarding officer. It is good practice that staff are all trained in safeguarding, but another perspective on the family might have been gained if they had been more involved at the time.

8 Key Themes

8.1 Contributory Factors to Good Practice

8.1.1 Joint Working

The SCR highlighted a commitment to early intervention which led to professionals trying to help the family through a Common Assessment (CAF), and professionals' understanding of the principles of partnership led to them working hard to secure the trust of the parents and work alongside them. A culture of joint working was evident in some clear examples of a number of professionals providing the children and family with a high level of support and assistance. The family were given good consistency of care from health and education professionals, who provided extra support and services to the family for many years. All undertook regular home visits. There were good examples of CSC doing joint visits with other professionals, in both the first and last key phases of professional intervention. When meetings were held, whatever the status of the meeting, they were very well attended. This reflects the amount of concern in the professional network, but also the strong commitment to the children. The schools talked to each other regularly. Information on the children was transferred appropriately and there was a good understanding of the challenges the children faced from their peers due to their problems. There was positive communication from the Health Visitors to the GP, particularly during the fourth key phase.

8.1.2 Professional persistence

Health Visitors showed persistence in getting access to the house when appointments were regularly missed. Professional challenge was evident from the schools and the Health Visitors in particular, but also from doctors in primary and secondary care. The police demonstrated very considerable persistence in bringing criminal charges and Abigail's parents have been successfully prosecuted.

8.1.3 Child Focussed Remedial Action

Since the children were removed from their parents' care the Local Authority has been proactive in placing them and securing appropriate orders to ensure their future. Since the children have moved into a caring and loving environment they have shown encouraging signs of improvement, receiving help to recover both physically and emotionally from the significant harm they have endured.

9 Contributory Factors that made working with this case difficult

9.1 Despite these examples of good practice, with hindsight there were a number of complex contributory factors that hampered the process of protecting the children from neglect, within a culture at the time where neglect was seen as less serious than other types of abuse. Key contributory factors drawn out through the SCR are highlighted below.

9.2 Understanding the Nature of the Neglect

A key feature of this case was the complexity of recognising and responding to neglect. Exploration of why this is the case pointed to the fact that incidents in this case were often observed in isolation. With hindsight, the list of neglect factors present in this case would seem to clearly indicate neglect – tooth decay, head lice, poor growth and weight gain, delayed development, anaemia, missed appointments, failure to use medication, severe nappy rash, poor hygiene, poor attendance at school, non-compliance with advice from health professionals - but at the time, establishing the cumulative picture was hindered. There were clear difficulties at the time in ensuring that all the information on all the children was available to be drawn together. This meant that overall the professional concerns about neglect were never sufficiently supported by evidence collected and collated on a multi-agency basis which resulted in appropriate decisions not always being made. A contributory factor was that staff were working within a system that, at the time, did not recognise the risk that physical and emotional neglect poses to children, compared to other cases they were dealing with such as physical or sexual abuse. There was a pattern of delayed responses, for example delay in pulling together meetings and an understanding

about the serious long-term effects of neglect was not clear across all the organisations. As a result it took the critical incident of Abigail's severe nappy rash and malnourishment to ensure her removal from the family.

9.3 Peaks and troughs

Peaks and troughs in episodes of neglect highlighted in the Judge's sentencing remarks were reflected on by professionals who worked with the family, in the context of the 'Disguised Compliance' they had experienced. This involves the parent giving the impression of co-operating with services, in order to diffuse professional intervention. The effect was to neutralise the authority of the professionals to take further action, for example in this case in the sporadic increased school attendance, attendance at medical appointments, engagement with health professionals or the cleaning of the home before visits by health professionals. In addition the SCR found it noteworthy that during the review period, Police attended the family home on 6 occasions for non child protections matters and none of those occasions gave rise to concerns about the children at the time. CSC also made unannounced visits to the family which did not raise concerns. Photographs picturing the level of chaos and decay in the house used during the court case were reflected upon during the learning event, it was confirmed that these were taken 2 months after the children had left the home and did not represent how workers saw the home during home visits.

9.4 Disguised Compliance

An Ofsted 2014 report about neglect noted that in those cases where children were not making positive progress, a common feature was lack of parental engagement with the process; however, many social work professionals failed to challenge these parents and only a few multi-agency groups showed clear strategies for tackling non-compliance. The SCR found that in this case, a predominant feature was how the mother avoided professional interactions. Despite some committed interventions by a number of practitioners, there was little success in effectively engaging the family and so implementation of the support to Abigail was significantly compromised. A key contributory factor was disguised compliance. This involves a parent or carer giving the *appearance* of co-operating with agencies, to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention. The challenge of working with parents who are manipulative and/or show disguised compliance was a key theme when reviewing this case. There was no doubt throughout the SILP and the additional work after court, that both parents had adopted this stance as a way of avoiding the agencies who had voiced concerns about the children. This view was strengthened by the experience shared by Abigail's grandparent and older sibling, who gave examples of manipulative, hostile behaviour by Abigail's mother and disguised compliance such as squeezing out the

prescribed cream for Abigail's nappy rash so as to make it appear that it had been used. The Psychotherapist involved with another member of the family felt the mother had a diagnosable and powerful personality disturbance, not able to prioritise her children's needs above her own.

9.5 Focussing on the child

Obstacles to focussing on the child identified during the SILP included elements that are usually good practice; preservation of the family, the partnership principle, empowerment, respect for parents' rights. However the SCR emphasises how the mother's fierce stating of her rights, and the lack of parental permission for all agencies to work fully with each other led to a failure to see the children in this case, both literally and metaphorically.

The children's parents both had health and psychological problems of their own, which demanded a lot of professional attention. Practitioners involved in the SCR however confirmed that there had been no clear evidence of physical disabilities being the reason for neglect of the children, but rather a case of the parents placing their own needs above those of the children. A number of the professionals felt they had to carefully negotiate their position to avoid losing any opportunity they had to engage with the family. They had the dilemma of how to build a relationship with the parents, without angering the children's mother and isolating themselves as a help to the children.

A powerful way to combat this is to speak directly to the children. It is true that the children may well have faced emotional and psychological barriers in talking to professionals, out of loyalty to their family. Nevertheless, the SCR found insufficient evidence of efforts to speak with the children. During the SCR Abigail's sibling felt safe enough to tell the review that the mother would lie to professionals constantly and many of the positive updates that other professionals recorded about the children were based on information from their mother.

9.6 Sharing Information

Sharing full information was complicated in this case. Abigail and her siblings were being worked with as Children in Need under Section 17 of the Children Act, which meant parental consent to share information was vital. Abigail's mother did not give consent for all professionals to share information with each other. This meant they were not free to gather information from all sources to identify whether this revealed persistent neglect; to do so would have been to illegally escalate an inquiry during which information was shared, without enough supporting evidence to do so.

9.7 Start again syndrome

Despite brief periods where some improvement was noted, concerns intensified during the

period being considered by the SCR. However there appeared to have been an incident led approach and 'start-again syndrome' - in these situations the case history is not considered sufficiently. The SCR found that this led to a lack of analysis of parenting capacity, including their motivation to change. The Agency Reports and the professionals at the learning events acknowledged that decisive action was not taken in relation to the on-going issues, with delays in the provision of appointments at the hospital; the start and completion of the Core Assessment; and in the holding of key meetings. On occasion there was over-optimism about the relationship between the mother and her children and improvements in the children's development, hygiene and attendance at appointments.

9.8 Systemic Paralysis

Serious case reviews have often commented on the difficulty, in child neglect cases, for professionals to decide when 'enough is enough' and that when staff feel helpless, this leads to avoidance and drift. The Psychotherapist working with another member of the family at the time felt systemic paralysis was happening, with professionals unconsciously colluding with a parent's denial of the situation. Although not all professionals reflecting back agreed with this, it was clear within the SCR that professionals who had known the family over years felt confused and overwhelmed by the complexity of the needs of the parents and children in this family. Some became desensitised to the family's way of living. Some took the view that keeping the family on-side and making the system easily accessible was the most practical way of handling the situation.

9.9 Professional Splitting

The powerful personality displayed by Abigail's mother appeared to give her the opportunity to divide professional opinion between the psychotherapist and her colleagues, described as a case of 'professional splitting'. Abigail's mother was reported to have the ability to 'literally fill the room' and by doing so was able to divide opinions amongst the team, thereby 'splitting the group'. This experience was recognised by local professionals in the context of their own experience of the parent's complaints about one organisation to another. This directly linked to the contributory factor of child protection thresholds reported to have been reached by some professionals but not all. This had allowed the parents to split professional opinion about thresholds for intervention and what actions were needed which resulted in the child's needs being hidden.

9.10 Resolving Professional Disagreements/Healthy Challenge

The review acknowledged the hard work that school staff and Health Visitors put into this family, and the attempts they made to communicate concerns, even when parents had refused permission for full communication. It was clear within the SCR that at the time, a

number of professionals struggled to make themselves heard, unhappy with the progress the children were making but feeling 'powerless' when told it did not meet the threshold for child protection. The SCR acknowledged it is understandable that professionals felt demoralized and not listened to about their concerns. It also noted a number of opportunities for concerns to be escalated via the Escalation Protocol; on occasion, letters from one professional to another were taken to be for information rather than requesting a service, and the escalation protocol was not sufficiently recognised or used at the time.

10 Priorities for learning and change as a result of the review

10.1 The SILP overview report emphasises that the practice examined was, at the time of reviewing this case, at least 12 months old, and much had changed since then. The Independent Reviewers recognised improvements made across all relevant areas since the time of the incidents being considered and outline those in detail, as significant and positive contextual information However recommendations were made to consider further learning or where lessons already learnt need to be reinforced;

10.2 **Lesson 1:**

Professionals in the agencies involved in this case had difficulties in keeping a clear focus on the needs of the children, due to the need to negotiate the many demands and difficulties of the parents. Supervision needs to play a clear role in ensuring that **assessments, plans and interventions listen to the child's voice and consider this information when taking actions.** To quote Working Together 2013 *'Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.'*

Lesson 2:

The child's experiences should be at the heart of all plans. Robust, time bound and outcome focused plans need to be in place for all children where there are concerns about the capacity or motivation of the parents to improve the children's circumstances. These plans should include extended family members.

Lesson 3

The following issues remain of concern and require a clear message to all agencies:

- The need for clarity regarding **sharing information** on children and their siblings and parents, when they are not identified as a 'child protection case'.
- The need for clarity about the option of **holding professionals meetings** without

the parents attending, which may have been useful in this case.

- The need for clarity regarding the **ability of all agencies to request a strategy meeting.**

Lesson 4

It is the **robustness of the plan**, which must include a contingency plan and the involvement of all agencies and the family, which will ensure the needs of the children are assessed and met. Not the status of that plan. In this case it is clear that the plan should have made it clear that if the parents did not cooperate fully with what was required to ensure the children's needs were met, that legal advice would be sought.

Lesson 5

All assessments of risk should **consider and analyse the historical information** held across agencies.

Lesson 6

All professionals working with children and families need to be trained and supported, to include the provision of reflective supervision, in the **identification and challenge of parents who use manipulation and disguised compliance,** to ensure the needs of the child remain the priority.

Lesson 7

All agencies need to have the **confidence to challenge or question** decisions taken by other professionals in partner agencies. Clear guidelines and training, supported by supervision, needs to give professionals the confidence to challenge each other and to escalate any concerns they have via the resolution policy. The review has heard that agencies defer to Social Care when it comes to decisions about the need for services to be provided to children in need and in need of protection. GSCB need to ensure that they advertise the message, including in training, that professional disagreement is a positive sign of a healthy safeguarding system.

Lesson 8

Staff across all agencies must have a **shared understanding of neglect** and its impact on the safety, wellbeing and development of children. All professionals working with children should be trained and supported in regards to recognising child neglect, and be provided with the tools to work effectively with children and families where there are concerns about neglect. This includes a focus on building a shared understanding of the children's history by incorporating all of the information held on the family across the agencies involved.

11 What is being done differently

11.1 The SCR noted that children's services in Gloucestershire improved their safeguarding services after concerns were identified in the 2011 Ofsted inspection, which was when the serious concerns about Abigail were emerging, and that the inspection in 2012 found improvements had been made. The Independent Reviewers noted relevant improvements such as provision of neglect training, a clearer 'request for service' process when contacting CSC, the roll out of professional reflective meetings, improved auditing schedules, increased evidence of children's voices seen in internal audit and an Ofsted thematic inspection of Early Help in Gloucestershire. The Independent Reviewers concluded that there have been positive improvements since Abigail and her siblings were referred into the system.

11.2 In addition, professionals reflected that whilst there still needs to be more clarity about the thresholds for neglect, the Levels of Intervention document published since the time of the case, has helped,. Professionals are more aware of the Escalation Protocol; feel that there is a better understanding of when a strategy discussion is needed, that plans for children are tighter and where necessary police are involved in the process sooner.

12 Recommendations and Critical Challenges for Future Development

12.1 **Recommendation 1:**

GSCB to undertake an audit of assessments and of child in need and child protection plans to ensure that the child's voice has been heard and is taken into account in the conclusion of the assessment and throughout the plan.

Recommendation 2:

The GSCB should support a framework of meetings which allow professionals involved in particular cases to meet and reflect on professional dynamics and disagreements without the presence of children and families.

Recommendation 3:

That the GSCB review its model of reflective supervision, to ensure that it is fit for purpose in assisting professionals to gain confidence in working with parents who are manipulative and show disguised compliance. Consideration is to be given to using this model with more complex Child in Need cases, as well as those subject to a Child Protection plan.

Recommendation 4:

That the GSCB's new Levels of Intervention model includes a clear link to the professional

challenge policy, and is clear that requests for explanations of why decision have been made should be sought as applicable.

Recommendation 5:

That GSCB review their neglect training to ensure that it has improved the shared understanding of neglect across agencies. This review should include a request that all agencies review professional training and qualification courses locally to ensure they include training on child development and the impact of neglect.

12.2 Having considered the SILP overview report, Gloucestershire Safeguarding Children Board have agreed to consider the following "challenge questions" to inform the formal GSCB Response Plan. This is in addition to the recommendations being implemented as a result of the SILP. The following challenges for local services are provided in relation to the learning from the case, within the context of systems learning:

- *Should further training be developed for professionals to enable them to remain focused on the purpose of a home visit and take the lead in the conversation rather than following the lead of the parents or carers?*
- *Is there sufficient understanding of the concept of 'professional splitting' across partners?*
- *Are professionals across the child protection system able to recognise when systemic paralysis may be occurring?*
- *Should training be made available to assist professionals to recognise the symptoms of professional splitting and systemic paralysis?*
- *Is the importance of the role of housing recognised in child protection work locally?*
- *How do we ensure there is a better understanding of 'right of access' in respect of the condition of homes owned by LAs or social landlords?*
- *How do we enhance the understanding of housing professionals of the impact of housing conditions on families e.g. on a child's education?*
- *How can we progress collaborative working with Housing professionals and should the model of basing family support staff within Housing agencies operating within Families First be replicated?*
- *Should the GSCB provide more information and training on how to deal with families who employ disguised compliance?*
- *Peaks and troughs were observed in this case, a better understanding of the long term impact of neglect demands a long term perspective in understanding whether families are able to make sustained improvements. How can GSCB promote good planning and clear milestones?*
- *Are professionals now better able to balance conflicting needs within families so that parents needs do not take priority over the needs of the children?*
- *Are we confident that practitioners respect each other's views regarding thresholds and avoid unintentionally colluding with challenging families?*

13 Conclusion

13.1 The Department of Health definition of neglect is the *persistent failure to meet a child's basic physical and psychological needs* likely to result in the serious impairment of the child's health or development. This definition is clear – yet it is also clear that for social workers and other professionals working with this family, there were complex contributory factors to not collating a complete picture sooner, including establishing the evidence, thresholds for intervention, and parents' rights under law about information sharing.

13.2 The family were provided with preventative interventions and early help strategies for a number of years, but a shift to child protection processes was made more difficult by several contributory factors including the limits to information sharing where parents have the right to withhold consent in non child protection cases; disguised compliance; and an inadequate culture at the time of healthy mutual challenge. These complex factors caused task problems which in turn led to frontline professionals feeling the full force of the difficulties associated with working with this family.

13.3 Professionals at the learning event were able to confidently identify areas of improvement and 'moving on' in terms of current practice, with increased experience of 'joined up' working, more priority given to the child's voice and practitioners welcome a stronger culture of mutual, healthy challenge. However, given the complexity of the safeguarding system and how this case revealed what can happen when several contributory factors line up to cause weaknesses within it, there is a need to check and to reinforce all the lessons learnt and recommendations made within this SCR.

14 Next Steps

Recommendations from this Review will form the basis of a formal GSCB Response Plan. This will be overseen by the GSCB Executive Group and regularly monitored by the GSCB Serious Case Review Sub Group. The SCR and Response Plan will not be the subject of a formal evaluation by Ofsted; that arrangement was ended in July 2012. However the SCR and the associated responses will be examined as part of the unannounced inspection of arrangements to protect children that takes place in all Local Authorities.