GLOUCESTERSHIRE SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

SUBJECTS

Abigail and her siblings Bobbie, Charlie and Daisy

1: SILP Overview Report

2: Additional Section following Criminal Proceedings

PUBLISHED: 20th August 2014

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OVERVIEW REPORT

2 March 2014

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1 Introduction to the Significant Incident Learning Process (SILP)

1.1 SILP is a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in the new Working Together to Safeguard Children published in March 2013.

1.2 The SILP model of review adheres to the principles of;

- proportionality
- learning from good practice
- the active engagement of practitioners
- engaging with families, and
- systems methodology.

1.3 It has been generally accepted that over recent years the Serious Case Review (SCR) agenda had become over-bureaucratic and driven by Ofsted ratings. The practitioners in the case have often been marginalised and their potentially valuable contribution to the learning has often been under-valued and under-utilised.

1.4 SILPs are characterised by a large number of practitioners, managers and Safeguarding Leads coming together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the Overview Report.

1.5 Gloucestershire Safeguarding Children Board have requested that the SILP model of review be used to consider the circumstances of child Abigail and a number of her siblings, in order to learn lessons about the way that agencies in Gloucestershire work together to safeguard children.

1.6 Working Together 2013 states that SCRs and other case reviews should be conducted 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 to inform the findings.

1.7 This review has been undertaken in a way that ensures these principles have been followed.

2 **Introduction to the Case**

2.1. Abigail was admitted to hospital in November 2012 due to serious concerns about her health and development. Despite being nearly 3 years old Abigail was unable to walk and was having a number of other problems caused by physical, emotional and developmental neglect. These included severe nappy rash, anaemia, malnutrition, head lice infestation and decreased bone mineralisation (i.e. weak bones).

2.2 Both parents have been charged by Gloucestershire Police for criminal neglect. All of the younger children in the family are now in foster care or are placed with family members who are able to meet their needs, with the appropriate long-term and permanent court orders in place.

3 **Family Structure**

3.1 The subject children*:*
Abigail - age 3
Bobbie – of primary school age
Charlie – of primary school age
Daisy – of primary school age

3.2 The youngest child was admitted to hospital due to the impact of experiencing serious neglect from the parents. The other children are included in this review due to them having similar issues and experiences.

3.3 There are a number of other older half siblings to Abigail.

3.4 The parents of the 4 subject children are referred to in this report as:
Mother (of all the children)
Father (to Abigail, Bobbie and Charlie, step–father to Daisy)
The parents have been together since approximately 2007, and are married.

4 Terms of Reference

4.1 The detailed Terms of Reference and Project Plan appear at Appendix 1. The purpose, framework, agency reports to be commissioned and the particular areas for consideration are all described there. What the agency authors were asked to analyse and the format of the agency report appears at Appendix 2.

4.2 It was agreed that the scope of this review would be from 5 August 2010 when a strategy meeting was held due to concerns about the children, until 23 November 2012 when Abigail was admitted to hospital.

5 Process

5.1 A number of family members were contacted in order to ensure their views were considered and heard as part of the review. Neither Mother nor Father agreed to meet with the Independent Reviewers. Three telephone conversations were held with them, and although a number of appointments were made they were subsequently cancelled by the parents.

5.2 The Reviewers met with the oldest sibling, who is now living independently of the family, on 4 July 2013. The Overview Author and the Named Nurse Safeguarding Children, Gloucestershire Care Services NHS Trust, visited the children's Grandmother on 2 October 2013. This visit was arranged later as the Learning Event had determined how significant she had been during the period being considered by this review. The sibling and the Grandmothers views and information have been considered and will be referred to in this report.

5.3 A meeting for authors of individual agency reports was held on 17 May 2013, where the SILP process and expectations of the agency reports was discussed. A full day Learning Event took place on 9 September 2013. Most of the agencies involved were represented by both the report author and staff, including managers, who had been involved during the scope period. All the agency reports had been circulated in advance.

5.4 The GP surgery used the completion of their agency report as a learning tool for all staff, holding a meeting to look at the TOR and the report format, and considering as a team what happened and why. While not requested this was a positive way to learn lessons from the process.

5.5 At a recall session on 10 October 2013 participants who had attended the Learning Event considered the first draft of this report. They were able to feedback on the contents and clarify their role and perspective. All those involved contributed to the conclusions about the learning from this review. The final version of this Overview Report was presented to the GSCB Serious Case Review sub-group on 22 October 2013, the Executive Committee on 4 February 2014 and the GSCB on 20 February 2014.

5.6 The review has been chaired by Donna Ohdedar, an independent safeguarding consultant with no links to Gloucestershire Safeguarding Children Board (GSCB) or any of its partner agencies. This report has been written by Nicki Pettitt an independent child protection social work manager and consultant, who is also independent of GSCB and its partner agencies.

5.7 The process has been efficiently administered by Tahidul Alam of the GSCB.

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

6.1 The family has been known to a number of different agencies for over 16 years. Both of the parents had physical and mental health issues requiring a high level of contact with health practitioners. Over the 27 month period specified as in scope for this review there were 127 recorded contacts noted with Primary Health Care alone.

6.2 It is clear that poor home conditions have been an issue throughout the years of involvement with services. When Mother had her first child, it was noted on the primary visit from the Health Visitor that there was ‘a dead mouse under the cot, with fleas visible on the furniture’. The Agency Report for community health states that ‘regularly the house was noted to be dirty, untidy and smelling of faeces’. There were concerns about all of the children not reaching their developmental milestones at times, and that outstanding immunisations and other health issues were not always addressed by the parents.

6.3 On occasion other concerns also emerged. In 1999 the Police were involved when Mother alleged that her then husband had physically assaulted and injured their 3 year old child. This resulted in him receiving a Police caution. The Police Officers involved also commented on the children and home being unkempt and smelly.

6.4 In 2006 Mother’s next husband was convicted of sexually abusing two of the children. At this time neglect was again raised as an issue with the children and the home being described as ‘filthy’ and overcrowded by the Police Officers involved.

6.5 In 2007 an Initial Child Protection Conference was held due to concerns about the state of the home and the physical neglect of the children. The decision about whether the children should be made subject to a Child Protection Plan (or placed onto the Child Protection Register as it was then) was ‘deferred’ as there had been improvements. As this improvement was assessed to have been maintained by the time of the Child Protection Conference Review, it was cancelled.

6.6 This improvement was not maintained in the longer term however, and there continued to be concerns about the children. These were exacerbated by Mother marrying the younger children’s Father in around 2007 and then going on to have more children. Father is known to have potentially significant issues of his own. There were a number of contacts and communications made to Children’s Social Care (CSC) but the children were mostly the subject of short term assessment and interventions, including under a CAF (Common Assessment Framework - an early help model.) This approach

relied on the parents to work in partnership with professionals and them recognising they needed to improve.

6.7 In 2009 Education Welfare became involved due to the poor attendance at school of some of the children.

6.8 Abigail was born in 2009. The midwife recorded that mother had previous psychological problems, post-natal depression, prior contact with psychiatry services and a chronic pain problem. When attending after the birth of the child the midwife describes chaos, with rubbish and clutter everywhere, dog faeces seen on the bath mat, and a smoky atmosphere. She referred to CSC citing her concerns about parental capacity, including information that the older children were young carers. The midwife also identified that parents were co-sleeping with Abigail and were not taking professional advice on the risks involved with this.

6.9 An initial assessment was undertaken by CSC in response to the midwife's referral, and a multi-agency meeting was held attended by the Health Visitor, nursery nurse and school nurse, along with the parents. The parents agreed to improve the state of the home and the meeting concluded that the nursery nurse and Health Visitor would monitor the situation. The parents agreed to a CAF and this was completed and managed by Homestart, a voluntary agency that undertakes community based family support work with under 5's.

6.10 It is clear from the history available to the review through the Agency Reports, and from discussion at the Learning Event, 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 very poor home conditions, severe head lice and nappy rash, missed appointments, poor attendance, 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 Mother prioritised her own needs. Early in 2010 a Safeguarding Nurse wrote to the CSC Referral and Assessment team to state that the on-going neglect was having a wider impact, with the children 'showing signs of distress as a result of the neglect they were experiencing'.

6.10 Doctors at the family's GP practice know the family well and have been involved with the family since 1997. The information shared with this review provides valuable background information. This includes concerns during 2010 that the family would often refuse entry to and turn away health professionals. The GP also provided helpful information about the mental and physical health needs of both parent. The most significant being;

- Father's mental health issues, including a history of suicide gestures,
- Mother's history of depression,
- Father's tendencies to miss his own health appointments, leading to physical health problems,
- Mother's mobility and health issues, some of which have not been investigated due to lack of engagement, and are therefore unexplained.

6.11 The GP also provided a history of poor home conditions, and a view that the eldest sibling and their partner provided a lot of care to the younger children and helped to look after the home.

6.12 The older children's schools had a number of concerns during this period. There is evidence of letters being sent to CSC, not all of which were recorded or available on the social care records. The secondary school attended by one of the siblings (not a subject of this review) had written a number of letters explaining their concerns for the child. They included a strongly worded letter on 8 June 2010, copied to a senior manager, expressing clearly the level of concern the school had for the children and their frustration that Parents were not engaging in the CAF process. The report author for Children's Social Care could not find any response to this letter, or any others sent by the school.

6.13 The information shared with CSC about this sibling is relevant to this review, as the school Agency Report for this review states that the sibling was very small for their age, had very poor hygiene, head lice, a huge appetite in school and was ridiculed by their peers and increasingly isolated. This description does lead us to question why something wasn't done at the time.

6.14 During 2010 Bobbie and Charlie were referred to the hospital doctor due to concerns about poor physical and developmental progression. They had also

missed all but one of their immunisations, despite the parents signing a consent form for them all. Charlie was seen by the paediatrician at 22 months old in June 2010. Charlie was not walking and had friction burns and pressure marks from crawling. A heavy scalp infestation of head lice was also noticed. Despite this, there was reportedly some improvement seen, and the children were discharged from the hospital doctor's care after the family did not attend follow-up appointments during 2011.

6.15 The safeguarding nurse wrote to a team manager in CSC on the 19 March 2010 outlining some of the concerns about the children. It ended with 'I have grave concerns about the immediate risks to the children and the long term implications for this family and I would welcome a response from you as to whether a strategy meeting could be called or a meeting take place between ourselves which would initiate the resolution policy.' The review was informed that no response was received to this letter, and that CSC does not have the letter in their records. However on 29 October 2013 the CSC agency report author informed the overview author that this letter has in fact been found and that CSC undertook an initial assessment and decided that no further action was required. What is not clear is the author's view of the content, the quality or the conclusions of this assessment. As it was not within the scope of this review, it has been agreed that further details will not be pursued. It does however raise issues about both record keeping and the ability to source historical information on children.

6.16 It is also not clear whether the safeguarding nurse took any action to follow-up her intention to initiate the resolution policy, there does not appear to have been any further contact until a further letter was sent on 21 May 2010 stating that the safeguarding nurse had been asked to chair a meeting between health and education regarding the family, and requested that CSC send a member of their team to update on an incident involving one of the older siblings. The meeting went ahead, but CSC did not attend. This was because the children were seen as a CAF (early help) matter, and they did not wish to attend a meeting without the parents being invited.

7 Key Practice Episodes

7.1 This review will now focus on the key practice issues during the period that this review will concentrate on. There were 4 key practice episodes before 23 November 2012.

They were:

- August 2010 to January 2011 - strategy meeting leading to a core assessment
- January 2011 to May 2011 – emerging concerns about Abigail
- June to July 2011 – continuing concerns
- From February 2012 – escalation of concerns leading to a professionals meeting

August 2010 – January 2011

Strategy meeting leading to a Core Assessment

7.2 A strategy meeting was held in August 2010, after a local Children's Centre had informed the Children's Social Care Referral and Assessment team that a young man was living with the family who may pose a risk to children. There were also a number of concerns reported to CSC from Daisy and an older sibling's schools about their appearance and presentation, including persistent poor hygiene.

7.3 It has been discussed during this review whether the meeting was held because of the concerns about the man's presence in the house, or because of the on-going neglect concerns. It appears that the other agencies attending and the CSC manager responding to the contact in May from the Nurse Consultant were under the impression that it was held because of neglect.

7.4 The meeting acknowledged that there was a CAF in place and that it did not meet the needs of the children. The content and subsequent outcome of the meeting appeared to focus predominantly on whether the young man posed a risk, rather than the neglect issues. It was agreed that the threshold for a child protection conference was not met, but that a social worker should complete a core assessment, to be undertaken under section 17 of the Children Act 1989 (child in need). This required both the permission and cooperation of the parents.

7.5 A delay followed, with the assessment starting in October 2010, and completed in January 2011. The assessment was undertaken by an experienced Family Support Worker (FSW) rather than a qualified social worker, as was acceptable practice at the time. (See below for improvements in practice since 2011.) The issues identified were poor hygiene, limited diet, lack of interaction with and stimulation of the children by the parents, some developmental delay, anaemia, delays in immunising the children, and chronic head lice. Both parents had alleged chronic physical health issues which limited their mobility and ability to keep the house clean, with the older siblings appearing to assist with the cleaning up that did take place. The assessment concluded however that the risk was reduced due to the warmth and love the Mother showed to her children. This is questioned by the CSC Agency Author who is concerned about how this conclusion was drawn, considering Abigail was rarely seen at home visits or was left in her seat for the duration of the visit.

7.6 The parents were not willing for the assessment to be shared with key agencies, including the schools. As the assessment was undertaken on a child in need basis, this request had to be respected. There were three schools and a Children's Centre involved at the time, and staff there were not updated on the outcome of the assessment or involved in plans for future work with the family. The Agency Report submitted by CSC reflects that because the level of risk was judged to be at S17 (child in need) this gave the parents 'a lot of say about who was involved'. This meant that information which would provide detail on the impact that long-term neglect was having on the older children was not adequately considered in the core assessment. As the CSC Agency Author points out, the assessment did not assess the parent's capacity or motivation to change.

7.7 The Health Visitor received a copy of the assessment and wrote to the FSW to clarify her concerns about poor nutrition, lack of immunisations and the parents' refusal to allow Abigail to be seen by a Paediatrician due to concerns about growth. The Health Visitor had professional supervision at this time, which concluded that the parents were unwilling to acknowledge the long-term impact on the children of their parenting deficiencies. However this

supervision did not result in any progression of the concerns or any formal request for the issues to be considered a child protection matter.

7.8 In January 2011 a dentist was concerned about the level of decay seen in an older sibling. The dentist stated it was due to neglect and he said that it was one of the worst cases he had seen, with the child also smelling strongly of urine.

7.9 In January 2011 Abigail was in hospital for 2 days with a chest infection. It was recognised that Abigail had not had all of her immunisations. No other concerns are recorded. There is no evidence in the hospital notes that CSC were informed of the child being admitted, although it was open to the FSW at the time.

7.10 This key practice episode was significant as the numerous concerns about the care of the children had been shared, albeit not always as forcefully as would have been hoped, and the opportunity to undertake a core assessment was taken. There was an unacceptable delay in the commencement of the core assessment, which was undertaken by an experienced but unqualified member of CSC staff.

7.11 The assessment did identify and acknowledge the key physical neglect issues but did not appear to reflect on the impact these would have on the children in the long term, instead appearing to focus on the parents' needs and the view of the FSW that the impact was minimised by the belief that the children were loved and experienced warmth from their mother. Significantly the Core Assessment did not include any evidence that the children had been seen or spoken to.

7.12 Key professionals, including those who had concerns about the children, were not involved in undertaking the assessment as the parents refused to allow them to be contacted or for the result of the assessment to be shared with them. This included the children's schools, which held a substantial amount of both current and historical information about the family. This was not challenged as the decision had been made to work with the family under Section 17 (Children Act 1989) as a child in need issue. This effectively empowered the family to pick and choose who they would and would not work

with. There does not appear to have been any consideration of the appropriateness of this at the time, or any revisit of the decision not to undertake a child protection investigation or hold a child protection conference in light of this insistence by the family to avoid the involvement of key professionals. This was a missed opportunity.

7.13 The information from the dentist about the older sibling was shared with CSC, and should have been considered in its own right as a child protection concern. For a dentist to make a referral and for them to state it is one of the worst cases they had ever seen should have been taken very seriously. Research into child neglect suggests poor dental health is a clear indicator of neglect. The dentist's referral follows the NICE Guidance 2009 written for health professionals who do not work primarily in child protection fields to help them identify the early signs of neglect. The dentist was right to make the referral, and the lack of follow-up was a missed opportunity. The GSCB have explained that training of dentists in recognising and referring child protection concerns was a recommendation of a previous review, which appears to have had a positive impact.

7.14 From the children's perspective nothing had changed, as there is no evidence that the children were seen or spoken to in this key practice episode. It is unlikely they would have been aware of the core assessments being completed. At the time the older children would have been old enough to have contributed in a meaningful way in the assessment and any plan that would follow.

<u>February 2011 – May 2011</u>

<u>Emerging concerns about Abigail</u>

7.15 In February 2011 the Health Visitor asked the hospital doctor to see Abigail as there were concerns about Abigail's weight, which was moving down the centiles on the growth chart. Three appointments were offered but all were declined or not attended. The hospital doctor communicated to the Health Visitor and GP that there might need to be a meeting about these 'compliance issues.' This shows good interagency communication and use of the DNA policy. After a conversation with the GP, the Hospital Doctor agreed that another appointment would be offered and a strategy meeting would not be requested. The GP explained at the Learning Event that the pattern that had

evolved at the surgery, when responding to the family missing appointments, was to offer as many appointments as was required to ensure they were seen.

7.16 The Health Visitor shared her concern with CSC that Abigail's weight was 'falling through the centiles'. On a visit undertaken by the FSW jointly with the Health Visitor Mother was described as defensive and dismissive of concerns, openly disagreeing with the Health Visitor. A child in need (CIN) plan (S17) was completed and shared with the family on 25 February 2011. It was to be reviewed in 6 weeks. The plan included the home being cleaned and maintained, Abigail to see the paediatrician, children to attend the dentist, daily baths/washes, head lice to be treated and for the pre-school age older siblings of Abigail to attend the Children's Centre. It is of note that this plan did not include measures to improve the children's weight, diet or developmental delay.

7.17 The infant school Daisy and an older sibling attended reportedly had had serious concerns about the children for some time. They had contact with the allocated FSW, including copying in her manager when writing to her, on six occasions during February and March 2011, including requesting a multi-agency meeting on 28 March 2011. Their concerns focused on on-going physical neglect and Mother's hostility to the school.

7.18 Meetings were held to review the CIN plan on 24 March and on 13 May 2011. The meetings were attended by the Health Visitor and the parents, and were chaired by the Assistant Team Manager, who supervised the FSW. There was thought to be an improvement in the hygiene of the children and the home. The medical and dental appointments had not been kept however, and there was no record of an update on the children's development or growth. There was no record of the older children being spoken to and their wishes and feelings considered. There does not appear to be any consideration of involving extended family in the CIN plan.

7.19 At the Learning Event as part of this process, the Health Visitor was clear that she had been assertive about the fact that Abigail's weight continued to be an issue. The Chair of the meetings clarified that the meeting was aware that a

paediatrician was involved, and that this was thought to be sufficient to address the concerns. However, in light of the history and on-going concerns about the older children who regularly missed health and hospital appointments, this was optimistic.

7.20 A further joint home visit was undertaken by the FSW and HV in May 2011. Mother was observed to be playing with the children, the professionals noted with hindsight, that the conversation would always return to the parents own health needs. The parents stated they no longer wanted Children's Social Care involved, so it was agreed that the Health Visitor would continue to monitor the children and the case would be closed to the FSW. This was despite the ongoing concerns about the children's health and developmental needs not being met.

7.21 In summary, this key practice episode was a missed opportunity to ensure the needs of the children were thoroughly assessed and that the deficiencies were consistently addressed. When the family did not cooperate in regards to the key issues, such as attending the paediatrician, ensuring the children's dietary needs were met, and engaging with all of the relevant professionals including the schools, the need for a child protection conference should have been considered. The improvements were at best partial and significant gaps in the children's care and the wider assessment were evident.

7.22 From the children's perspective they are unlikely to have been aware of the child in need plan, as there is no evidence of them being involved. It is unclear if they were aware of the efforts that key professionals, particularly their schools and Health Visitor were making to secure suitable services for them.

<u>June 2011 – July 2011</u>

<u>Continuing concerns</u>

7.23 On 8 June 2011 the Children's Centre informed CSC that the older pre-school children had not been attending day care as expected. They were told the case was closed to CSC. The infant school continued to be concerned about the children who attended their school. They believe they had made a further referral, but this does not appear to have been made through the Helpdesk, as is the procedure. They also reflected at the Learning Event that they did

not always refer all of their concerns as they recognised that nothing had changed and the parents continued to show animosity to them. They believed that as the situation was chronic, and CSC had assessed before and the threshold was not met, they did not believe anything would change if they continued to refer the same on-going concerns.

7.24 On 13 June 2011 the FSW received an email, copied to them, from the paediatrician about concerns that Abigail had not been brought to appointments. They stated they were following the DNA policy and outlining their concerns about safeguarding issues in the family. On 22 June 2011 the school of an older sibling informed the FSW that the sibling's hygiene had deteriorated significantly. Neither contact resulted in the case being reopened to CSC. It is not clear if the FSW forwarded the information to the duty team to be seen as a new referral, or if the paediatrician and the school thought they were in fact making a referral. The school shared that they are now aware that they should always complete a MARF (Multi-Agency Service Request Form) rather than email a particular worker. However it is evident that they had not been informed that the case was now closed. Both the Paediatrician and the school were justified, however, in expecting that some action would be considered by CSC in light of the concerns being expressed.

7.25 As well as contacting CSC the Paediatrician also spoke to the GP, who appears to have reassured the hospital doctor that the concerns were not at a severe level. It was agreed between them to give the family another chance of attending, and a further appointment was therefore offered to the family at the hospital.

7.26 The same month the Health Visitor made a home visit after becoming aware that Abigail had missed three scheduled appointments with the Paediatrician. At the visit she noted that Abigail was not yet crawling or walking, and that no significant amount of weight had been gained. Advice was again given about nutrition and stimulation. A further visit was undertaken shortly afterwards and Abigail was said to be asleep. The parents reported that Abigail was now crawling and weight bearing. It is significant to note here that the interview undertaken recently with the older sibling provided information that the parents would put the children to bed when they were expecting a visit from the Health Visitor. This is likely to have been one of the occasions when this

happened. It certainly allowed mother to provide information about her child's progress that was later found to be untrue. At the Learning Event the Health Visitor clarified that she would attempt to time her visits at different times of the day in the hope of seeing Abigail awake, and to try and see the children at meal time, which did not happen.

7.27 On 29 July 2011, six weeks after the decision to offer another appointment, Abigail was assessed by the hospital doctor, but was not physically examined as Abigail was reluctant to leave mother's lap. The information noted by the hospital doctor is mostly as reported by the parents. There is no evidence that the specific issues raised by the Health Visitor were considered. The child was discharged to the care of primary health services. (GP and Health Visitor.)

7.28 No significant issues emerged during the next 6 months.

7.29 This key practice episode is significant because further concerning information was being noted and raised about the children, none of which led to a referral formally requesting the intervention of CSC. There are also signs that the professionals working with the children were becoming increasingly demoralised about both the family and the likelihood of the matter being seen as a safeguarding issue by CSC. This was not identified at the time however.

7.30 Again, there is little or no evidence of the children being spoken to or directly observed during this key practice episode.

<u>From February 2012</u>

<u>Escalation of concerns leading to a professional's meeting</u>

7.31 During 2012 Bobbie missed 4 out of 5 appointments with the hospital ophthalmology team. This is despite the parents being sent information that explained that the child's sight could be affected long-term without appropriate interventions.

7.32 In February 2012 there was a change of Health Visitor. The new worker took the opportunity of discussing the family with the GP. The GP said they were not concerned that Abigail was walking late, as they were following the pattern of an older sibling who also walked late. The Health Visitor did

establish that both parents suffered with depression and that father was addicted to a prescription pain killer and to Diazepam. After a number of attempts the Health Visitor was able to undertake a developmental review of Abigail. The locomotor skills were that of a 15 month old (Abigail was 28 months old at the time). The weight remained on the 2nd centile. The Health Visitor wrote to the GP and the Paediatrician with her concerns. The Agency Report from the hospital points out that a request for an appointment was not made, and that the Health Visitor may have been under the impression that Abigail was still under consultant appointment follow-up, which she was not. A further appointment was not offered by the Paediatrician.

7.33 The Health Visitor took her concern to her safeguarding supervision and the plan was to 'liaise' with other professionals and to monitor Abigail's development. On reflection, this could raise concerns about the effectiveness of this supervision. Information obtained at the learning event highlighted that paper records were kept with plans from supervision, however they were not available at this time. This meant that previous interventions were unknown, and the resulting lack of consistency was exacerbated by a new professional becoming involved.

7.34 Bobbie and Charlie were both supposed to be attending the Children's Centre nursery at this time, but their attendance was just 12 – 15%. In September 2012 the Children's Centre worker visited the family and was concerned about Abigail. She appeared unwell and they were told she had bad nappy rash. Father later told them that cream had been prescribed and that she was getting better. The Children's Centre expressed their concerns to the Health Visitor.

7.35 Health professionals were increasingly concerned about Abigail from around July 2012 when the nappy rash was identified as problematic. There had also been concerns about failure to thrive identified in a letter from a Paediatrician to the family, copied to the GP, who had stated that there was a potential safeguarding issue. The GPs also spoke to the parents about their concerns, and had weekly contact with the family over the next few months, as well as liaison with the Health Visitor. There was no contact with CSC until 17 October 2012.

7.36 The GPs had requested that a hospital admission be considered by parents in respect of the nappy rash, but the parents refused, insisting that there was an improvement in the matter. The GP involved at the time accepted the parents' report of improvement, and made the decision not to force hospital admittance. This decision was made without seeing the child. In hindsight this was a missed opportunity to intervene in the children's lives a little earlier.

7.37 The reviewers spoke to the eldest sibling of Abigail as part of this review. The sibling was living at home when Abigail had severe nappy rash. The reviewers were told that the parents did not use the prescribed medication to treat the nappy rash. The sibling reported that Mother had ensured that the cream be thrown away, so that when the Health Visitor visited and checked the medication it looked like it was being used. No one appears to have spoken to the teenager to gain their view of the situation at home. While they may not have made this disclosure, there is a possibility this information may have been shared at the time.

7.38 In this key practice episode the Health Visitor made many attempts to see the family and particularly Abigail. Most of the visits were missed by the family, and on the rare occasions access was granted, the Health Visitor continued to have concerns about the child's weight, unsteady walking, and persistent head lice. The Health Visitor was also informed by the GP of the concerns of a receptionist at the surgery, who had seen Abigail and father in the waiting area, and that Abigail kept saying 'sorry' to father. The receptionist had been very concerned. During this phone call the GP also stated that both parents were addicted to analgesics, and that father had issues with the use of both cannabis and alcohol.

7.39 No new referral was made to Children's Social Care until 17 October 2012 when a referral was made by the Health Visitor using the Multi-Agency Service Request Form. This was after a further safeguarding supervision session where the Health Visitor reflected on a further number of visits to review the nappy rash which were refused or missed by the family. The referral included information about the severe and chronically infected nappy rash being suffered by Abigail, a severe infestation of head lice in the children, and the parents' lack of ability to prioritise the children's care over

their own needs. In light of this referral and a joint visit between the Health Visitor and a duty Social Worker on 31 October 2012, it was agreed that a strategy meeting should be arranged.

7.40 It was clarified in December 2013 that the referral to Children's Social Care made by the Health Visitor on 17 October was initially closed in error, but the mistake was discovered and rectified on 22 October, when the child's case was opened for assessment. A letter arranging a visit was sent to the family on 26 October, they were spoken to on the 29 October, and visited on 31 October. When questioned why the referral was not treated more urgently, it was explained by the agency that as a number of professionals were actively involved, and the nappy rash had been an issue since June, it was not thought to be urgent at the time.

7.41 CSC and Police had a strategy discussion on 6 November 2012, and it was agreed to undertake S47 enquiries that included completing a core assessment. This happened in agreed timescales, with some of the older children being observed by the Social Worker on 19 and 20 November. The core assessment included information from key professionals. For the children there was no action taken to change their situation however until after 21 November when a further meeting was held. During these additional weeks Abigail would have experienced further damaging neglect.

7.42 On 30 October 2012 the GP spoke with the newly allocated duty Social Worker. The GP voiced his frustration by stating he just wanted the family to be made to attend all the appointments that had been offered. When reviewing Abigail and the nappy rash over the next few weeks the GP noted that the situation was much the same.

7.43 During October and November 2012 a professional who was not a child or adult services worker spent a significant amount of time in the family home, on an entirely unrelated remit. They contacted Children Social Care on 19 November 2012, stating they were 'shocked and upset' about the state of the home and the children. They provided particular details about Abigail who they described as still in nappies with nappy rash, that Abigail looked neglected and dehydrated, was grubby and seemed to be underweight. They

were told that the family were to be the subject of a child protection meeting due to a referral received previously.

7.44 A 'professional's meeting' was held on 21 November 2012. It was described as a professional's meeting rather than a strategy meeting as the Police were unable to attend. All of the other key agencies were present however and there was a high level of concern about the children, particularly the parent's failure to respond to Abigail's health needs. It was decided to progress to Initial Child Protection Conference.

7.45 Abigail was admitted to hospital on 23 November 2012, not to return home.

7.46 A later further strategy meeting was held on 27 November 2012 which was attended by the Police. This meeting appears to have been called to consider the severe neglect of Abigail and plan the investigation that was required.

7.47 This key practice episode was dominated by drift and the lack of action to address the needs of the children. One of the contributory factors for this was the fact that the parents were successfully avoiding professionals and the children were subjected to further neglect and harm. While the Health Visitor was most persistent in her attempts to access the family, and the GP made efforts to ensure the nappy rash was treated, the acceptance of the seriousness of the situation by all agencies was delayed and the parents reluctance to engage and blatant avoidance of professionals was allowed to go on for too long.

7.48 The older children watched as their youngest sibling became ill and, in the words of the Grandmother 'was fading away'. Again there is no evidence that any of the older children were spoken to, and the parental lack of cooperation led to limited opportunities for the younger children to be seen and assessed. Until the final decisive action was taken to remove the children from the care of their parents after the hospital admission on 23 November 2012, the children could not have had any faith that professionals were going to respond to their continuingly poor care.

7.49 In addition to the significant incidents listed above, it is of interest to note that during the review period Police attended the family home on 6 occasions in

regards to non child protections matters, mostly complaints of criminal damage or theft and neighbourhood disputes. On no occasion were concerns about the state of the home identified or reported by the Police Officers attending. When interviewed for the review, two of the Officers remembered that the house was untidy, unclean and smelly. However they did not have any concerns for the children at the time.

7.50 It needs to be pointed out that the practice outlined above is, at the time of reviewing this case, at least 12 months old. Those involved in the review have been given information about the improvements made across all relevant areas since the time of the incidents being considered. The improvements made are outlined in detail below, and are significant and positive. It has been accepted that there may be further lessons to be learned or certainly that the learning is reinforced, and this report will now outline these lessons as part of the analysis of what happened in this case and why these children suffered significant harm despite the involvement of a number of professionals.

8 Themed Analysis

8.1 The analysis section of the review will consider the information above, which was gained from the Agency Reports and the Learning Event, thematically. All of them lead to lessons that need to be learned from this review. The themes to be addressed here are:

A. Listening to children and seeing the child's world
B. Levels of need and the limitations of an incident led approach to child neglect
C. The impact of professionals feeling overwhelmed or desensitised, and the challenge of working with parents who are manipulative or show disguised compliance
D. Professionals not feeling valued and listened to, and the lack of a culture of resolving professional disagreements
E. Understanding neglect

At the end of each section of analysis the lesson learned will be stated, along with a recommendation as required. These will be reiterated in the specific sections towards the end of the report.

A. Listening to children and seeing the child's world

8.2 In April 2011 Ofsted published their fifth report evaluating Serious Case Reviews. Titled 'the voice of the child: learning lessons from serious case reviews' it has a single theme, the importance of hearing the voice of the child. The report has identified five key issues which ran through many of the cases considered:

I. the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings
II. agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute
III. professionals were prevented from seeing and listening to children by parents and carers
IV. practitioners focused too much on the needs of parents, especially vulnerable parents, and overlooked the implications for the child
V. agencies did not interpret their findings well enough to protect the child.

8.3 Working Together 2013 has legislated to ensure that this issue is addressed more fully by professionals working with children and their families. It states 'Children should be seen and listened to and included throughout the assessment process. Their ways of communicating should be understood in the context of their family and community as well as their behaviour and developmental stage. Children should be actively involved in all parts of the process based upon their age, developmental stage and identity. Direct work with the child and family should include observations of the interactions between the child and the parents/care givers'.

8.4 There is very little evidence that the 'voice of the child' was heard by a number of the professionals involved in this case, particularly those undertaking assessments. The school were clear about the needs of the older children and showed a good understanding of the children's difficult circumstances and knew the older children well. They should be applauded for this. Letters were sent from the secondary school to CSC, cataloguing concerns. Few received a response. It is easy to see why the school was frustrated. It was clear at the Learning Event that they had been very distressed over a number of years about their inability to effect positive change for these children.

8.5 The core assessment did not evidence that the children had been seen or spoken to, and other professionals recorded positive updates on the children that were reports from Mother, rather than observed themselves. Having to witness the neglect of their younger brothers and sisters must have been very distressing for the older siblings. The eldest child told the review that Mother would lie to professionals constantly. It has been a regular finding from Serious Case Reviews that professionals should be checking what they are told by observing children directly, and speaking to children if that is age-appropriate. Hearing the voice of the child and considering what their life is like needs to be a key part of any assessment and work with a family, with the information gained influencing plans and actions.

8.6 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

All of these were obstacles in this case. Consideration of the need to work with the parents in order to help the children, Mother's fierce stating of her rights, and the principle of needing parental permission to see the children and work with other agencies under S17/Child in need, lead to a failure to see the children in this case, both literally and metaphorically.

8.7 The review acknowledged that the older children in this family may have been young carers, and asked if this issue was considered by the agencies involved. The core assessment in 2010 – 11 commented on the fact that both parents had chronic physical health issues which limited their mobility and ability to keep the house clean, with the older siblings appearing to undertake some household chores. The schools reported that the older sibling was responsible for taking the children to school and collecting them.

8.8 The Core Assessment did not highlight that the older children were taking on a significant amount of the household or child care responsibility. However it

is not clear if it was explored with the children or the family. There does not appear to be any evidence that the older children's potential role as young carers was considered by any agency.

8.9 Learning Lessons from Serious Case Reviews 2008 - 2009 stated that 'young carers who may be caring for a disabled parent are not always receiving the assessments of needs to which they are entitled and as a consequence do not receive services which meet their needs.' Assessing the older children as potential young carers in this case may have made a difference to those children, and enabled them to receive the support they needed. Grandmother informed us that the eldest sibling 'did not have a childhood'. It is acknowledged however that in large families where the parents have significant needs of their own, the older children will often play a part in the running of the household.

8.10 <u>Lesson 1:</u>

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.'

<u>Lesson 2:</u>

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.

<u>Recommendation 1:</u>

GSCB to undertake an audit of assessments 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.

B. Levels of need and the limitations of an incident approach to child neglect

8.11 At times during the history of this matter, both before and during the scope period of this review, the decision was made for the children to be seen as in need of early help or universal services, or as children in need, rather than as children in need of protection. At no stage since the deferred conference in 2007 was the care of the children considered a child protection matter. This was despite communications with CSC regarding the condition of the home, concerns about the hygiene and development of the children, and issues with the parents not cooperating with services offered, including important medical appointments.

8.12 Despite brief periods where some improvement was noted in the state of the home and in the presentation of the children, there were numerous concerns about these children, which intensified during the period being considered by this review. The assessments undertaken in relation to the younger children did not take into consideration either the experiences of the older children, which were well documented in a number of agencies, or the extensive information held across agencies about both the parents and the children. When considering the information known to professionals at the time, if a more thorough assessment had been undertaken, including an analysis of all agency information and a thorough chronology compiled including all the information available since the birth of the oldest sibling, it should have been quite clear that the children were at risk of significant harm.

8.13 The failure of the agencies to pull together historical information, covering all of the children, appears to have led to an incident led approach and 'start-again syndrome', a term described in the Biennial Analysis of Serious Case Reviews 2003-2005. In these situations the parents' histories are not considered sufficiently and the focus was on the current circumstances. This led to a lack of systematic analysis of parenting capacity, including their motivation to change, and no acknowledgement of the lack of sustained progress. The children's experience of harm over a long period was being ignored.

8.14 As stated in the Police Agency Report ‘‘there is evidence from the records that each strategy meeting has perhaps concentrated on specific issues and has not looked at wider themes or taken a more holistic view which may have resulted in issues like neglect having been identified earlier”. Individual concerns and incidents did not appear to meet the threshold being used at the time for a child protection response in their own right, including the decision to call a conference. A child protection conference would have allowed all the professionals involved to share the history of the family and the current concerns in a setting chaired by an independent person, where the parents could not have decided who was involved and who was not.

8.15 Even without a child protection response to the children, the child in need plan and S17 response to the neglect was inadequate. The review saw no evidence of a clear, time-limited and outcome focused plan for these children, which involved the extended family as well as the parents. Grandmother states that despite her having regular contact with the family, she was never contacted by professionals either for information or to request her help and involvement in any support plan. She acknowledged that despite her own concerns she did not contact any agency. This was due to her fear that Mother would refuse to let her have on-going contact with the children.

8.16 The timeliness of responses by professionals to issues raised was part of the terms of reference for this review. The Agency Reports and the professionals around the table at the learning event acknowledged that decisive action was not taken in relation to the on-going chronic issues they were aware of. Delays were evident in the provision of appointments at the hospital; the start and completion of the Core Assessment; and in the holding of key meetings, including the meeting that resulted in Abigail being taken into hospital and removed from the parents care. For Abigail these delays probably led to prolonged suffering.

8.17 <u>Lesson 3</u>

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.

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.

C. The impact of professionals feeling overwhelmed or desensitised, and the challenge of working with parents who are manipulative and show disguised compliance.

8.18 It was clear at the Learning Event that the majority of professionals who had known the family over the years felt both confused and overwhelmed by the complexity of the needs of the parents and children in this family. The GP also stated that the primary health team became desensitised to the family's way of living. They provided GP appointments on demand, and this led to a degree of collusion with the parents. In the Agency Report the GP states 'Primary Care took the view that keeping the family on-side and making the system easily accessible was the most practical way of handling the situation'.

8.19 The Health Visitor said that it was hard to be child focussed when the parent's needs were so overwhelming. Mother's health always appeared to dominate the conversation. The school agreed that this was also their experience when trying to engage with the parents. The professionals at the Learning Event agreed that this family 'exhausted people'. 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 and sometimes fearful of families, this leads to avoidance and drift.

8.20 Grandmother told us that she would only criticise the parents so much, because Mother would tell her to stay away. Instead Grandmother would try and compensate for the poor parenting she recognised the children were getting by regularly having one or two of the children to stay, or going over on her day off and attempting to do some cleaning or laundry. This threat also stopped Grandmother contacting CSC.

8.21 The challenge of working with parents who are manipulative and/or show disguised compliance was a key theme when reviewing this case. The majority of staff who were involved in this case felt that professionals require more support, supervision and training when it comes to working with families who are dishonest, avoidant or won't engage. In this case the parent's dominance of the attention of professionals, to the detriment of their children, was an effective way of avoiding scrutiny of their parenting. Mother was particularly difficult to work with.

8.22 Without a robust multiagency plan that is clearly communicated to the parents, with clear contingency planning, that does not drift or get hijacked by the parents needs, the children's needs were not assessed or met.

8.23 Grandmother stated that Mother is manipulative and aggressive. She felt intimidated by Mother herself and believes that professionals would have felt the same way. She described Mother as very controlling of her husbands, the children and wider family. She believes Mother would also have wanted the power and control in any relationship with a professional. She said Mother had the potential to 'eat them alive'.

8.24 The GP Agency Report states that Mother 'was well known to all agencies to be manipulative and at times hostile. She was skilled at playing off one agency against the other'. The school Agency Report stated that Mother knew how systems worked and was described as 'calling the shots'.

8.25 Schools reported at the Learning Event that Mother could be aggressive, and that on occasion she swore at teachers if she felt challenged. Indeed her refusal to work with the schools in the first key episode of this review did not lead to a reconsideration of the need for a child protection response, but to a collusive agreement that these key professionals could be avoided if Mother agreed to work with the Health Visitor. While this might have been agreed in the spirit of partnership, the needs of the children were not prioritised over their Mother's unsubstantiated concerns.

8.26 '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 co-operating with agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention. There was no doubt at the Learning Event that both parents had adopted this stance as a way of avoiding the agencies who had voiced concerns about the children. They were successful for many years.

8.27 On occasion it is clear that there was over-optimism both about the relationship between Mother and her children (her being described by the FSW as loving the children) and regarding improvements in the children's development, hygiene and attendance at appointments.

8.28 Both Mother and Father had health and psychological problems of their own, which demanded a lot of professional attention. Grandmother described Mother as attention seeking. Grandmother also informed us that Mother loved being pregnant and having new babies, as she got attention. Grandmother said that after each baby was a few months old, Mother lost interest and started to plan her next child.

8.29 The health professionals in particular had the dilemma of how to build a relationship with the parents, in order to see the children and progress their work with the family, without angering Mother and isolating themselves as a help to the children. Mother would often talk about her 'rights', and 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. Again, without a robust plan to support their role, they did not feel they could push too much.

8.30 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.

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.

D. Professionals need to feel valued and listened to, and the lack of a culture of resolving professional disagreements.

8.31 It was clear at the Learning Event that at the time a number of professionals struggled to make themselves heard, particularly by Children's Social Care, who it was felt had to make the decision about what to do to help the children. The Health Visitor involved at the earlier stages expressed her frustration that she was unhappy with the progress the children were making, but felt 'impotent' as she was told it did not meet the threshold for child protection. She felt that it did, but that she was the lone voice.

8.32 On the 17 October 2012 the second Health Visitor made the important referral about the nappy rash, the head lice and the parent's failure to meet the children's needs, which resulted in an initial assessment being undertaken. However staff present at the Learning Event fed back that it appeared that it was not until the referral was made to a senior manager in CSC, by the

person spending time in the family home in an unrelated professional capacity a month later, that the strategy meeting was finally held. This was clearly a coincidence, as this was not the case. The Learning Event acknowledged that it is understandable that the professionals involved felt demoralized and not listened to in regards to their concerns about this family. It must be made clear however that the case had been allocated and CSC were responding to the health visitors referral, not the telephone call to a senior manager that was received later.

8.33 The secondary school records show that they did not feel that front line staff in CSC took their concerns seriously, feeling that they had to copy in senior managers to get any response. Even this had a limited impact. The infant school felt that relations with CSC were good in this case once the case was allocated. The issues were when the referral was made and it wasn't thought to meet the threshold, then relations were often strained.

8.34 At the Learning Event schools stated that they do not feel valued as professionals by CSC. The head of one of the schools stated that she felt undervalued and that in her previous local authority she had a better relationship with CSC and felt more on an equal footing with them. This viewpoint requires exploration by both CSC and the GSCB.

8.35 Good relationships were reported between the school and health professionals, particularly with the Health Visitors and Paediatrician. The review acknowledges 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 the child in need plan to be fully communicated and then continued.

8.36 There was positive communication from the Health Visitors to the GP, particularly during the 4th key episode. A study published by the Dept of Education in 2009 called the 'The Child, The Family and the GP" found that GPs preferred to consult with Health Visitors and other Health colleagues rather than with Children's Social Care where they had concerns that were not clear cut'. The study found that there was a general reluctance by GPs to approach Children's Social Care to make referrals unless there was a clear injury, disclosure or evidence of failure to thrive. 'The important role of the

Health Visitor in safeguarding children, and as a key fellow professional for the GP to refer to, was confirmed in this study."

8.37 There were a number of opportunities for concerns about what was perceived as a lack of decisive action in respect of these children by CSC, to be escalated via the Resolution of Professional Disagreements policy. On one occasion they were, with the Safeguarding Nurse formally escalating the Health Visitors concerns at the beginning of the period being considered by this SCR. On other occasions, while information and concerns were being sent to CSC, the resolution policy was not used. The Head of the Secondary School could have made use of the policy, and Children's Social Care could have directed him in the direction of the policy in response to the letters being copied to senior managers.

8.38 It was acknowledged during the Learning Event that different agencies have different cultures when it comes to the sending and receiving of letters. The use of formal letters in health and education as a way of keeping other professionals informed and updated is common, this is not the culture in Children's Social Care.

8.39 In 2010 GSCB undertook a major communication drive and road show in respect of a serious case review. This included the publication of an information poster for professionals. The poster shares the lessons learned, and was designed for a wide audience. The first four lessons are as pertinent to this case as they clearly were in relation to that SCR:

- **Advocate on behalf of your children - don't drop the ball.** Stay responsible for the child even after referring to a different agency - always push for the response you know is needed to fully meet the child's needs. Ensure referrals are of the highest quality. Use the professional disagreements policy if you are not satisfied with the response you receive**.**
- **Sharing Information.** Include all relevant information held by your agency when making a referral, including information on all adults and children, especially previous concerns – missing information could make all the difference.
- **Be Child Focused.** Always view your work through the eyes and experience of the children and young people in the family (and always consider the experiences of any children when working with adults).

- **Quality of Assessments.** Be challenging and rigorous in your assessment of risk – be aware of being too parent focussed, taking things at face value. Determine what is happening to the child and ensure change is taking place.

8.40 The poster is available on the GSCB website, but this case shows that there are still barriers to implementing and reinforcing learning, as the lack of use of the professional disagreements policy in this case proves. The school Agency Report states that the schools believed that no resolution policy was available at the time, which was not the case.

8.41 The majority of agencies reflected on a problem they had all experienced when sending referrals to CSC at the time. They stated that they couldn't tell if a referral had been accepted or not, often having to send repeat referrals in order to try and get a response. It must be noted that agencies around the table at the Learning Event reported that things have improved since the introduction of the 'request for service' system. School also stated that are now aware of the Resolution of Professional Disagreements Policy, and feel this is useful.

8.42 While very hard working during 2012 and trying all she can to get help for Abigail, the Health Visitor was not specific in her letters to the hospital Paediatrician that she wanted the child seen again. The letters seemed to be for information, rather than requesting a service. Neither the hospital doctor nor the Health Visitor clarified what was required or was being requested. As well as being clear with CSC about what is required for a child or family, all staff should be clear in all communications of the purpose of the information being shared and their expectations about what needs to happen next.

8.43 <u>Lesson 7</u>

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.

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.

E. Understanding neglect

8.44 One of the most concerning issues in this case is the apparent lack of understanding, at the time, of neglect and its impact by a number of the key professionals working with this family. This suggests a need to test whether this demonstrates a wider lack of understanding of the impact of neglect across the county.

8.45 Neglect is defined as 'the persistent failure to meet a child's basic physical and or psychological needs, likely to result in the serious impairment of the child's health or development'. In this case Abigail and a number of the siblings have experienced severe neglect that will have long-term implications for them. As stated by Daniel et al (2011) 'Apart from being potentially fatal, neglect causes great distress to children and is believed to lead to poor outcomes in the short and long-term. Possible consequences include an array of health and mental health problems, difficulties in maintaining relationships, lower educational achievements, an increased risk of substance misuse, greater vulnerability to other abuse as well as difficulties in assuming parenting responsibilities later on in life'. Grandmother informed us of her deep sadness that all of the children would have to live with the effects of what they experienced for the rest of their lives.

8.46 A recent SCIE systems review into another matter, and the OFSTED inspection of 2011, both found that neglect was seen as less serious than other types of abuse in Gloucestershire. Managers around the table at the learning event were open with the reviewers that at the time professional practice in regards to neglect was not good enough.

8.47 In their report 'The state of child neglect in the UK' (2013) Action for Children remind us that 'neglect is the most common reason that children are made

subject to a child protection plan, with neglect featuring in 60 per cent of all Serious Case Reviews'. In August 2013 547 children in Gloucestershire were subject of a CP Plan, of which 195 have neglect as the main category of abuse.

8.48 All of the signs were there, and had been for many years, that these children were suffering or likely to suffer significant harm due to neglect. At the time there were clear difficulties in ensuring that all of the information on all of the children was available to be considered and drawn together in order to ensure a complete picture. If this had been done, the list of concerns would have looked like this:

- **Tooth decay**. Empirical evidence suggests that there is a high level of agreement among different professional groups that poor dental health is an early indicator of neglect. A number of the children had tooth decay and lack of attendance at dental appointments.
- **Severe and persistent head lice**. Both the children and the parents had head lice most of the time. The GP Agency report states that 'No members of the Primary Care team assessed this as a neglect issue on its own'. The 2009 NICE quick reference guide to neglect highlights severe, persistent and untreated infestations of head lice as an indicator of child neglect. The Paediatrician who saw Bobbie in 2012 stated that the child had open sores on the scalp due to untreated head lice.
- **Poor growth and weight gain.** Most of the children were small and this was felt to be linked, as they grew, to inadequate diet with an over-reliance on cow's milk. The parents did not follow professional advice, despite the fact that the children were clearly failing to thrive on the diet they were receiving at home. At least one of the children had rickets.
- **Delayed development.** Walking and talking were both areas where professionals were concerned about the delay in the development of the younger 4 children, who are the subject of this review. No information was available to the review on the older children but the schools have noted concerns.
- **Anaemia.** It was the view of the paediatrician that both Bobbie and Charlie were suffering from severe non organic anaemia due to malnutrition in 2010-11. The review heard that is a very serious condition for young children, which could lead to cardiac arrest.

- **Missed health appointments.** It was reported that the Parents always gave plausible excuses for the failure to bring the children to appointments, but there was no assessment of the impact on the children's health and well-being of the parents not taking them to appointments.
- **Failure to immunise.** It is not a statutory obligation to immunise children, with many parents opting out. In this case the parents had agreed to the immunisations and attended some appointments, but the course was rarely completed. This potentially left the children vulnerable.
- **Failure to use prescribed medication.** The GP has stated that there were issues of compliance with prescribed medication in regards to a number of the children.
- **Severe nappy rash.** Most of the children, but specifically Abigail, suffered with chronic and painful nappy rash, which was not appropriately or consistently treated by parents. Professional advice was not sought or responded to with regards to this issue. 6 weeks before the admission, there was an opportunity for Abigail to be taken into hospital with the severe nappy rash. Father told the GP he would agree to Abigail going into hospital for the nappy rash to be treated, however Mother blocked this. The GP, with the support of the Health Visitor, pursued this, but believed the parents report that things had improved and did not push for hospital admittance. This decision was made without seeing the child. This was a missed opportunity to intervene a little earlier in the children's lives.
- **Poor hygiene and dirty clothes.** Was an on-going issue for all the children. This led to them being socially isolated and stigmatised.
- **Poor attendance at nursery and school.** Again, this was an issue for a number of the children, and most recently for Bobbie, Charlie and Daisy in relation to the nursery provided at the Children's Centre. The older children had the involvement of Education Welfare on a number of occasions due to poor attendance.
- **Non-compliance with advice from health professionals**. This was the case in relation to the children's diet, dealing with health issues, and co-sleeping with babies. It is recorded that the parents refused to listen to advice about the dangers of co-sleeping when parents are smokers. This was a risk, particularly as Father was alleged to drink and use cannabis.

  There was a concern raised in 2012 that Mother may be using her own medication to drug the children. This has never been proven.

8.49 The strategy meeting held in August 2010 did not fully acknowledge the neglect issues which had been identified over many years, appearing to focus on the more tangible risk the person staying in the home may bring. This raises the concern that the CSC professionals, including the chair of the strategy meeting, did not at that time have the knowledge and experience to recognise all aspects of the risks for these children. A contributory factor was that the staff were working within a system that, at the time, did not recognise the serious risk that physical and emotional neglect poses to children. The schools were not at the meeting as it was held in the summer holidays.

8.50 The GP Agency Report states that there was a pattern of delaying responses in this case, for example the delay in pulling together meetings, even as late as the meeting held just days before Abigail was admitted to hospital. 'This appears to be because of the feeling, with this family, that the concerns at the time were just *more of the same*.'

8.51 The Hospital Agency Report author points out that the Health Visitor was signalling indicators of severe failure to thrive, but that Abigail did not get the hospital assessment required due to the GP giving the hospital doctor reassurance about Abigail's well-being.

8.52 All schools felt there needed to be more clarity about the thresholds for neglect. They acknowledged however that recently there has been a Levels of Intervention document shared which helps, and neglect workshops run throughout the county. (See below.)

8.53 CSC reports that at the time of the first two key practice episodes, the culture that existed about neglect in the organisation was unhelpful for these children. Understanding about the serious long-term effects of neglect were not clear, and it was very difficult to get neglect cases into legal proceedings. As recently as November 2012 it took the critical incident, of Abigail's nappy rash and severe malnourishment, to ensure her removal from the family.

8.54 <u>Lesson 8</u>

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.

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.

9 Conclusions and lessons learned

9.1 As stated by the author of the Hospital Agency Report 'the child subjects of this report experienced chronic neglect of basic nutrition, of developmental/learning opportunity, and of emotional development whilst living within the family home in the responsible care of their parents'.

9.2 The study 'Working with Neglected Children and their Families: Linking Interventions With Long-term Outcomes' (Farmer and Lutman 2012) considers the processes that are likely to affect the longer-term management of families where there are neglect issues.

They are:

- Becoming de-sensitised to children's difficulties through habituation when undertaking medium- to long-term work
- Normalising and minimising abuse and neglect
- Downgrading the importance of referrals about abuse or neglect from neighbours or relatives
- Over-identification with parents
- Developing a fixed view of cases which discounts contrary information.
- Viewing each incident of neglect or abuse in isolation and not recognising their cumulative impact

The majority of these factors influenced the on-going work with the family. It is in many ways a classic neglect case. However the family were provided with

preventative interventions and early help strategies for a number of years, rather than working with them under a clear, robust and time bound plan that recognised and met the children's needs, and used a child protection remit as required.

9.3 Children's services in Gloucestershire have had to improve their safeguarding services after concerns were identified during an Ofsted inspection in 2011, which was when the serious concerns about Abigail were emerging. A follow up inspection in March 2012 found improvements had been made. The review was provided with information to show the relevant improvements. They include:

- GSCB provided a Neglect Workshop for partner agencies in March-April 2013. It was attended by staff from schools and colleges, early years, children centres, all health providers, Police, Probation, children's social care, as well as a number of voluntary sector providers.
- CSC devised and published their 'Standards with Timeline for children in need from the point of transfer to the Child and Families Teams' in 2013. The aim is to ensure more robust work with and oversight of child in need plans.
- CSC appointed an independent child protection consultant to provide a neglect presentation and a neglect findings report in 2013. Each team also received a neglect research papers file to supplement the presentation.
- GSCB has overseen the rolling out of multi-agency professional reflective meetings from April 2013, which take place when a child has been subject to a CP Plan for over 12 months. Although it would not have assisted in this case, it should assist in the development of good practice across agencies. The awareness of and benefit of this model will be explored with partner agencies in the Section 11 audit that Gloucestershire are undertaking in the autumn of 2013.

9.4 Two recent 'Learning Together' reviews have been undertaken in Gloucestershire using the SCIE systems model, firstly in 2012 and then in March 2013. This review has heard that a number of the issues identified in that review have also been noted here. The findings from the 2012 review included:

- Managers to use Safeguarding Practice Reflection. This should be used for all staff working with families across all setting.
- Keep Chronologies for children and young people. Record the significant events for your families and include any actions taken and outcomes. Multi-agency chronologies can easily be collated, they also assist with identifying needs, patterns and clear working strategies. Chronologies should be brought to multi-agency meetings to help inform interventions and assessments.

The findings in the second review included:

- A pattern of significant professional activity but little collaboration or challenge across agencies raises questions about what working together actually means in Gloucestershire.
- In Gloucestershire there is a pattern of focussing on the tool (e.g. the Plan for the child) rather than the impact that the content has had on the child's journey.

9.5 The CSC Agency Report provided helpful information in respect of progress in their systems and auditing in response this child's case, and others identified during the OFSTED inspections and other reviews undertaken. These include improving children's assessments and plans by implementing a Framework for Thinking. There remains work to do, but they are committed to embed the system across all teams. There are also improved auditing schedules, both single and multi-agency.

9.6 In January 2014, Ofsted undertook a thematic inspection of Early Help in Gloucestershire. It found that within the early help cases, children's voices were heard and the professionals know the children well. As a result of well coordinated early help work by professionals, the children and families were well engaged. There was positive feedback to Referral & Assessment teams for the advice they give to partners. Inspectors cited some specific good practice in coordinated services for children needing early help, including the Journey into Positive Parenting (JIPP) programme, Targeted Support Teams and Integrated Youth Services. This shows there have been positive improvements since the children in this case were referred into the system.

9.7 The reason for undertaking this review is to learn lessons. The Reviewers have been impressed by the commitment to this process shown by the staff of the partner agencies of the GSCB. In the Agency reports the terms of reference have been addressed, and the lessons for the agency have been identified, and recommendations made.

9.8 The lessons learned for the GSCB and inter-agency practice have been identified in the analysis above, they are :

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.

Good Practice and systems that worked well

9.9 It was clear that a number of professionals provided the children and family with a high level of support and assistance. This should not be lost in the analysis of why things went wrong. The family had good consistency of care from health and education professionals, who provided extra support and services to the family for many years, this included the Children's Centre, the Health Visitors, the GP and the schools. All undertook regular home visits. Both Health Visitors showed persistence in getting access to the house when appointments were regularly missed.

9.10 There were examples of CSC visiting with other professionals, particularly the Health Visitors, in both the first and last key practice episodes.

9.11 When meetings were held, they were very well attended. Whatever the status of the meeting, those that were invited attended. This reflects the amount of concern in the professional network, but also the strong commitment to the children.

9.12 Professional challenge was evident from the schools and the Health Visitors in particular, but also from doctors in primary and secondary care.

9.13 The three schools talked to each other regularly. Information on the children was transferred appropriately at transition and there was a good understanding of the challenges the children faced from their peers due to their problems.

9.14 Since the children were removed from their parents care the Local Authority has been proactive in placing them and getting appropriate orders to ensure their future. The children are reported to be settling well in their current placements, and are receiving help to recover both physically and emotionally from the significant harm they have endured.

10 Recommendations

10.1 Each agency report submitted to this review has included reflection on its individual learning, and made recommendations that are agency specific. The lead reviewers welcome this and recommend they are followed through and that progress is reported to the GSCB.

10.2 Listed below are the recommendations from this overview report.

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.

……..

Bibliography

Ofsted
Learning lessons from serious case reviews, year 2
October 2009

Ofsted
The voice of the child: learning lessons from serious case reviews
April 2011

Ward, H, Brown, R, Westlake, D
Safeguarding Babies and Very Young Children from Abuse and Neglect
2012

Action for Children
State of child neglect in the UK
2013

Farmer, E, and Lutman, E
Working with Neglected Children and their Families: Linking Interventions With Long-term Outcomes
2012

Brandon M et al
The Biennial Analysis of Serious Case Reviews 2003-2005
DCFS 2008

Appendix 1 – Terms of Reference and Project Plan

SCOPE

The subject child and where appropriate her three other siblings, during the period between August 2010 (strategy discussion) to 23rd November 2012 (admission to hospital).

FRAMEWORK

Serious Case Reviews and other case reviews should be conducted in a way in 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 to inform the findings

(Working Together para 10, March 2013)

AGENCY REPORTS TO BE COMMISSIONED

1. GP
2. School Nurse and Health Visiting
3. Education/Early Years/Children's Centre
4. Children's Social Care
5. Police
6. Hospitals Trust Gloucestershire (Midwifery and Paediatrics)

TERMS OF REFERENCE

Individual agency reports need to consider

1. The quality of risk assessment and how the levels of need / harm were assessed by individual agencies.

2. The individual agency reports need to encompass a view as to how an analysis of historical information was used to inform assessment and decision making and evidence of use of a chronology of key events.

3. The culture and approach of each agency (collective if more than one team / school involved) and individual within the agencies towards neglect.

4. Whether professional differences occurred and if so how they were responded to.

5. The level and quality of partnership working when the lead professional role was held in the community.

6. The level and quality of partnership working when social care were the lead agency.

7. The timeliness of responses by professionals (internal and external to the agency report) to issues raised.

8. To identify and include areas of good practice within each agency

A TEMPLATE FOR AGENCY REPORTS

Attached

TIMETABLE

Scoping / terms of reference	23 April
Commissioning letters	3 May
Authors Briefing	17 May
Distribution of material to all attendees	9 August
Learning Event	9 September
Drafting 1st report and distribution	3 October
Recall Day	10 October
Revising Report	17 October
Presentation to LSCB/SCR Sub group	23 October

Meetings with Family/Significant Others

Explanation of Process	10 May
Feedback re: experience of services	10 June
Discussion of final report	23 October

Appendix 2 – Template for Agency Report

AGENCY REPORT

(name of agency)

SIGNIFICANT INCIDENT LEARNING PROCESS

SUBJECT :

BORN :

Name of author

Job title

Date

INTRODUCTION

PURPOSE

Previous statutory guidance suggests the purpose of a serious case review is :

- To establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children

- To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

- Improve intra- and inter-agency working and better safeguard and promote the welfare of children

(Working Together para 8.5, March 2010)

FRAMEWORK

Serious Case Reviews and other case reviews should be conducted in a way in 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 organisation 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

(Working Together para 10, March 2013)

SCOPE

The subject child and where appropriate her three other siblings, during the period between **August 2010 (strategy discussion) to 23rd November 2012** (admission to hospital).

Section 1 – Summary of Facts

a. Summarise in narrative form the key information relating to W from your agency/service.
b. Summarise the services offered and / or provided to her and/or the decisions reached.

Section 2 – Other Relevant Information

a. Report any significant information prior to December 2010 which you consider to be relevant to the learning.

Section 3 – Analysis

a. Critically analyse and evaluate the events that occurred, the decisions made and the actions taken or not.
b. Where judgements were made or actions taken which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.
c. Demonstrate whether your agency/service heard and responded to X's views, wishes and feelings.
d. Identify and explain if your agency/service believes that other agencies/services should have been sought and /or provided.

You may find the 12 trigger questions from previous statutory guidance (para 8.39 of Working Together 2010) helpful in framing your response. However, it is not expected that you methodically answer every question. Use it as a guide.

These questions are attached as appendix 1.

Section 4 – Terms of Reference

Individual agency reports need to consider

1. The quality of risk assessment and how the levels of need / harm were assessed by individual agencies.

2. The individual agency reports need to encompass a view as to how an analysis of historical information was used to inform assessment and decision making and evidence of use of a chronology of key events.

3. The culture and approach of each agency (collective if more than one team / school involved) and individual within the agencies towards neglect.

4. Whether professional differences occurred and if so how they were responded to.

5. The level and quality of partnership working when the lead professional role was held in the community.

6. The level and quality of partnership working when social care were the lead agency.

7. The timeliness of responses by professionals (internal and external to the agency report) to issues raised.

8. To identify and include areas of good practice within each agency

Section 5 – Conclusions and Recommendations

In your conclusion please consider learning for your agency and multi agency learning as separate issues. Highlight strengths as well as weaknesses. Consider how you will recommend improvements may be made to services, ie

- What action should be taken by whom and when?
- What outcomes should these actions bring, and in what timescales, and
- How will the organisation evaluate whether they have been achieved?
- Single agency recommendations should be brought into the overview report and Questions here should be more positive to promote good practice e.g. where was good practice identified?

APPENDIX 1

a. Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

b. When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?

c. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

d. What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

e. Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?

f. Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

g. Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?

h. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

i. Were senior managers or other organisations and professionals involved at points in the case where they should have been?

j. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

k. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations?

l. Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

m. Was there sufficient management accountability for decision making?

GLOUCESTERSHIRE SAFEGUARDING CHILDREN BOARD

SUBJECTS

Abigail and her siblings Bobbie, Charlie and Daisy

Overview Report – Additional Section

Author: Janice Waters MSc Registered Nurse

Specialist Nurse Safeguarding

12th August 2014

CONTENTS

1. Introduction

Working Together 2013 (Department for Education 2013) states that serious case reviews (SCR) of incidents involving children 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.
- Uses relevant research and case evidence to inform the findings.

With this in mind, a serious case review was undertaken through a SILP review process. Following the court proceedings, further work has been undertaken in a way that ensures these principles have been followed, including a multi agency Practitioners Learning Event. This additional section records the findings of this further work.

Rationale for the report

As was anticipated, other significant information about the family came to light during the court process in respect of the parents of Abigail and her siblings Bobbie, Charlie and Daisy.

The additional information has emerged from 3 sources

- The sentencing remarks during the criminal proceedings (16th June 2014)
- The report of the Psychotherapist (30th June 2014)
- Additional views sought from Stroud District Housing (2nd July 2014)

In keeping with the SILP report, and the methodology of this additional section, a follow up Practitioner Learning Event was held on the 4th July 2014 to uncover any new learning from the new information. Abigail's parents declined the offer to take part in any discussion at this time. The PLE was found to be especially powerful in supporting practitioners to effectively collaborate in the process of learning and analysis and to this end Gloucestershire Safeguarding Children Board (GSCB) would like to thank those taking part for their timely and effective contribution to the process.

This additional review does make further recommendations; the additional Practitioner Learning Event (PLE) has confirmed support for the recommendations made. Professionals felt the value of their additional discussions would be best reflected by identifying the key issues that the safeguarding board should consider. It is for this reason that this additional section will pose a series of challenges to the Gloucestershire Safeguarding Children Board (GSCB) rather than the setting out of specific recommendations. This is in line with serious case reviews produced nationally using the systems methodology that has also informed this case review.

This section will therefore

- Focus on practitioner reflections at the learning event of the new information that emerged as a result of the court process.
- Take the opportunity for further reflection on practice in the 6 months leading up to the parents' arrest on 24th Jan 2013.
- Reflect on what has changed since that time.

2. Methodology

The methodology for this additional work is taken from 'Systems analysis of clinical incidents: The London protocol' (Taylor-Adams et al. 2004). This system is based upon James Reason's 'Swiss Cheese model' of accident causation used in risk analysis and management in systems such as aviation, engineering and healthcare (Reason 2000). The model likens human systems to multiple slices of Swiss cheese stacked side by side and is sometimes called the cumulative act effect. The Swiss cheese model of accident causation illustrates that although many layers of defence lie between hazards and accidents, there are flaws in each layer that, if aligned, can allow the accident or incident to occur

Taylor-Adams' and Vincent's protocol provides a structured, systems approach to the process of learning from incidents in health care settings, providing a "window on the system". Examples of their work have been adapted in various ways to support investigations outside healthcare, for example by the Social Care Institute for Excellence (SCIE). The purpose of the protocol is to ensure both a comprehensive and a thoughtful investigation of an incident and to move practitioners beyond the identification of fault and blame. Thus, a structured approach to the use of practitioner reflection has been found to be successful in utilising clinical experience and expertise to its fullest extent.

This approach is reported by Taylor-Adams and Vincent to assist the reflective investigation process, because:

- *'While it is sometimes straightforward to identify a particular action or omission as the immediate cause of an incident, closer analysis usually reveals a series of events leading up to adverse outcome. The identification of an obvious departure from good practice is usually only the first step of an investigation'.*

- *'A structured and systematic approach means that the ground to be covered in any investigation is, to a significant extent, already mapped out. This guide can help to ensure a comprehensive investigation and facilitate the production of formal reports when needed'.*

- *'If a consistent approach to investigation is used, members of staff who are interviewed will find the process less threatening than traditional unstructured approaches.'*

- *'The methods used are designed to promote a greater climate of openness and to move away from finger pointing and the routine assignation of blame.'* (The London Protocol)

This methodology supports the inclusion of 'contributory factors' adapted from the London Protocol, using the notion of holes or weaknesses identified in James Reason's 'Swiss cheese' model. Contributory factors are deemed to be features that reveal examples of either good practice or practice that could be improved.

Contributory Factors

Child or family factors; examples of which may include;

- Complexity of the problem(s)
- Personality and social factors
- Manner of presentation, language and communication – relationship with professional(s) - seeking help, hostility, disguised compliance, impact on professionals and how they worked together

Task and technology factors; examples of which may include;

- Understanding nature of task – e.g. waiting for serious incident, or gathering a cumulative picture?
- Decision making aids utilised (or not)
- Availability and use of protocols

Frontline Professional factors; examples of which may include;

- Knowledge, skills, competence
- Human reasoning
- Communication/Information sharing
- Managerial support/Supervision
- Clarity of roles between professionals
- Attention (what were the professionals focussing on, the same, or different things?)
- Culture of dealing with disagreement – was it explicit or covert?

Organisational and management factors; examples of which may include;

- Organisational priorities, structures, cultures – either single, or multi-agency
- Thresholds, application of local policy & procedures
- Availability of or gaps in services e.g. expert assessment on personality/capacity to change?

National level factors; examples of which may include;

- Statutory policy e.g. on information sharing, is this a help or hindrance?
- Tools: assessment, risk management
- Links with external organisations

An interaction matrix is available in the appendix and offers a visual interpretation of the contributory factors drawn out at the Practitioner Learning Event (Appendix 1).

3. The new information

This section will consider in turn, the summaries of

- The sentencing remarks

- The Psychotherapist's feedback
- The housing information

Within each summary, consideration will be given to the influencing contributory factors, the response of the practitioners at the learning event to the new information and any learning and challenges which were highlighted.

4. Summary of the sentencing remarks

The main points that professionals reflected on in relation to sentencing remarks relate to

- 'Peaks and Troughs' in episodes of neglect throughout the years
- Reference to this not being a case of 'deliberate behaviour'
- The presence of physical disabilities for both parents.

4a: Peaks and Troughs (Child and family factor)

Peaks and troughs in episodes of neglect were highlighted in the sentencing remarks.

Whilst there were undoubtedly times when care of the children appeared to improve, the phrase 'peaks and troughs' used by the Judge was reflected on by professionals who worked with the family in the context of 'Disguised Compliance'. This means a situation which poses difficulties for professionals working with families and involves the parent or carer giving the impression of co-operating with services in order to diffuse professional intervention.

The term, disguised compliance is attributed to Reder, Duncan and Gray in 'Beyond blame: child abuse tragedies revisited' (Reder P et al. 1993). The effect of disguised compliance is to neutralise the authority of the professional, examples of which occur in this case in the sporadic attempts at increased school attendance, attending medical appointments, engagement with professionals for a limited time or the cleaning of the home prior to visits by professionals.

4b: Not a case of deliberate behaviour (Child and family factor)

Sentencing highlighted that this was not a case of deliberate behaviour but stated that the parents were 'inadequate, stupid, stubborn, incompetent but not wicked'.

Practitioners at the learning event reflected on the parents' stubbornness in not responding to professional advice and felt that, on occasions, they exhibited disguised compliance. Examples of this were cited as when the prescribed cream for Abigail's nappy rash had been squeezed out so as to appear that it had been used and another occasion when it was hidden from view during a professional visit. On other occasions, the cream was used to reinforce a sense of compliance with professionals in an aim to reassure them that the nappy rash was being treated. Professionals at the learning event were clear that Abigail's mother was resistant to following advice given by them.

4c: Physical disabilities (child and family factor)

The physical disabilities of both parents were referred to in the sentencing remarks. The children's parents both had health and psychological problems of their own, which demanded a lot of professional attention. Practitioners at the learning event confirmed that there was no clear evidence of physical disabilities being the reason for neglect of the children, but rather a case of the parents placing of their own needs above those of the children. This led the PLE to reflect further on incidents where parents appeared to prioritise their own needs;

One example includes the number of GP appointments that the parents attended; a total of 100 appointments are recorded during the period for the parents whereas there are just 40 for children despite the number of children involved, the nappy rash, a diagnosis of anaemia and the hospital admissions.

Further examples of parental need above that of the children includes the parents taking a holiday which was longer than had originally been planned and stating that they had taken the nappy rash cream with them, but in fact did not. Practitioners at the learning event reported that Abigail's mother had told them they had never had a honeymoon and that it was their right to do so.

5. Summary of the Psychotherapist's feedback

The main points to be discussed within the Psychotherapist feedback relate to

- Powerful personality disorder
- Professional splitting
- Systemic Paralysis

5a: Powerful personality disorder (Child or family factor)

The Psychotherapist and her colleagues, working in a separate capacity with a member of the family, made contact with the review team as a result of the family court case.

The Psychotherapist recognised within Abigail's mother a 'diagnosable and powerful personality disturbance'. She reports a very clear view about the power of Abigail's mother as a personality who continually interrupted the interview process with her daughter and who could not prioritise her children's needs above her own. An example given was an incident where the older daughter understood that her baby's nappy needed changing but appeared to wait for her mother to give her permission to do so.

Abigail's mother was reported to be open and confident in revealing to the Psychotherapist and others that she had been advised to admit Abigail to hospital but had gone against this advice. She described herself as a busy mother who loved her children very much. This confidence was further evidenced by not hiding the nappy rash from the visitors in the house, professionals at the learning event queried whether this was an opportunistic or purposeful act.

Abigail's Grandmother was reported to have been wary of upsetting her daughter for fear of being excluded from the care of the children.

5b: Professional Splitting (Frontline professional factor)

The powerful personality displayed by Abigail's mother appeared to give her the opportunity to divide professional opinion between the Psychotherapist and her colleagues. This was described as a case of 'professional splitting' (Melia et al. 1999). Melia et al described professional splitting as the ability to divide loyalties amongst professionals by comparing and complaining about one with another.

Abigail's mother was reported to have the ability to 'literally fill the room' and that by doing so was able to divide opinions amongst the Psychotherapist and colleagues, thereby 'splitting the group'. This resulted in one half of the group reporting that the state of the home and the presentation of the child was 'none of the their business' and the other half reporting that 'serious risk issues were being identified'.

Practitioners at the learning event reflected on this additional information from the Psychotherapist and discussed the comments about 'professional splitting' in the context of their own experience of the parent's complaints about one organisation to another. Abigail's mother was described as being able to influence others, for example the children's

hairdresser who was persuaded to write a letter to health services to say that the children didn't have head lice when evidence pointed otherwise.

Child protection thresholds were viewed as having been reached by some professional groups but not all. This allowed the parents to split professional opinion and resulted on one occasion in Abigail not being admitted to hospital for treatment of her nappy rash.

Recognition of 'professional splitting' is an example of good practice and could be improved through the sharing of information that recognises the difficulties faced by professionals when dealing with families who criticise professionals and organisations.

5c: Systemic Paralysis (Frontline professional and organisational contributory factor)

The Psychotherapist revealed discussions held with colleagues about the filthy state of Abigail's home and describes the smell emanating from the family and the malnourished appearance of Abigail, who at 3 years old was still in nappies. These were described as serious safeguarding concerns by some, but not all of her colleagues.

In light of her concerns, the Psychotherapist reports that she made numerous attempts to contact Children's Social Care (CSC) but was not able to speak with a social worker for a couple of weeks due to a number of missed attempts at contact by both parties. She questions that in her opinion, whether a 'systemic paralysis' was in evidence. By this time CSC were conducting their own investigations and did not view this information as warranting immediate, additional action.

Systemic paralysis is described as the act of professionals unconsciously colluding with a parent's denial of a given situation and themselves becoming at risk of using the same defensive processes as the parents. Practitioners at the learning event reflected upon this statement but did not agree with the Psychotherapists findings. Practitioners at the learning event questioned why the Psychotherapist did not follow up their concerns with a letter or escalate to the manager of the team is there was no response from the social worker.

The Team Manager of the team was not aware that this professional had been unable to speak with the social worker so had not been in a position to intervene. The social worker in question was not part of the review as they no longer work for the local authority.

5d: Challenges

The following reflections and challenges for local services are provided in relation to the information above and placed 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?

6. Summary of further information from Housing

The main points from the Housing related to

- Record keeping
- Access to the home

The feedback from the Housing Department at Stroud District Council (SDC) informed the further PLE that they 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 staff members undertake training in safeguarding and are aware of the need to report concerns with 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.

6a: Record keeping (Frontline professional factor and organisational factor)

The family was noted to be difficult to contact and records suggest that, therefore correspondence tended to be by letter.

The housing officer involved at the time of the issues raised by the SCR is reported to be no longer employed at SDC and therefore clarity is being sought by them as to whether or not contact was made with the family but not entered into the case notes. If so, an individual management review will be recommended.

6b: Accessing the home (Task and frontline professional factor)

Factors relating to the child and family are apparent in the difficulty experienced by the housing officer in accessing the house.

The difficulties experienced by other professionals, for example hostility and a lack of cooperation may have also been experienced by the officer working with this family. Opportunities to engage with other professionals were unfortunately not identified and may therefore have been missed.

Right of entry could have aided this case, for example during gas and heating boiler checks. This may have assisted housing officers in accessing the home perhaps in conjunction with other professionals and therefore represents a missed opportunity to intervene in the welfare of the children.

The photographs picturing ivy in one of the children's bedroom were used by the police during the court case to convey the state of the house and were reflected upon during the practitioner 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 while the children were actually living in it.

6c: Challenges

- 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?

7. Practitioner Learning Event: What we are doing differently

As the majority of the responses to the new information are contained within each of the preceding sections, this section highlights the remaining areas of conversation during the practice learning event and highlights what Gloucestershire are already doing differently.

A: Healthy challenge involves checking, clarification, being inquisitive and asking the question why. The safeguarding system does not exist without healthy challenge. Healthy challenge has taught us to be aware that just because parents say something it doesn't mean that it is happening.

Some professionals and individual agencies felt that they don't always have the information to be able to challenge because parents or carers don't always wish to share information and as a result do not give consent to do so. School practitioners reported that they were not always able to exercise healthy challenge at the level of 'child in need' section 17 Children Act 1989 enquiries (s.17) as experienced in this case where Abigail's mother did not consent for the school to receive the report.

A better understanding across agencies now exists of when the threshold of child protection is met and a strategy discussion needed as opposed to when a multi-agency meeting is required.

B: At the time of the case, agencies felt although they might **share information** they would not always get something back. Working with neglect requires proper information sharing across agencies which is less straightforward than it might appear. When working with a Child in Need under section 17 of the Children Act, parental consent to share information is vital. This meant professionals working with Abigail were not necessarily free to gather information from all professionals to identify whether this revealed persistent neglect, as the parents withheld consent for information to be shared between all agencies. Social Workers in the case were particularly mindful of the judicial risks of escalating enquiries to child protection level and the full sharing of information without enough supporting evidence to do so. This is an area under scrutiny by the GSCB as part of the MASH (Multi-agency Safeguarding Hub). Social care reflected that it is rare that a parent refuses consent to share information and when they do their parental rights are respected, but the reasons why they might be withholding consent need to be robustly considered.

C: Professionals agreed that the assessment under the Common Assessment Framework (CAF) was not robust in that it wasn't child focussed, was inadequately monitored and wasn't multi-agency. Professionals discussed the **robustness of the plan** and recognised that this is what is important. The level of the plan, whether it is a CAF (Common Assessment Framework), CiN (Child in Need) or CPP (Child Protection Plan) isn't what makes the plan 'right'. It is about the plan being able to meet the needs and hearing the voice of the child.

This 'culture of practice' has moved on and professionals now consider more closely the impact of the plan for the child with a clear contingency plan in place. Plans are tighter and time limited. Police will be involved in the process sooner.

D: There was recognition of the fear of **family disengagement** within the group and a discussion of how organisations made attempts to keep children safe. For example, schools report achieving this by placing importance on being able to see children at school on a daily basis.

E: Frustration amongst practitioners was evident in the response to Children's Social Care who they felt had not always responded adequately to the situation of children in this family historically. CSC confirmed that they had made unannounced visits to the family which did not raise concerns for them and at times what was observed in the family home appeared to invalidate the concerns about neglect that were being reported by professionals.

F: In this case the **parents were difficult to work with**. Professionals were trying to work with them and not allow a breakdown of the professional relationship due to the fear of family disengagement and not being able to keep the children safe is very powerful. Abigail's mother was discussed as being extremely manipulative with the ability to isolate professionals. Practitioners at the learning event discussed how practice has improved and they would now have a better understanding of the history of the families they are working with.

G: Practitioners at the learning event reported that sometimes their experience is that the **rights of the parent** seem paramount to the rights of the child and at the time of this case, this was thought to be so.

Of course this will always be an area where a balance needs to be maintained. There is now an emphasis on seeing children as individuals in their own right who are encouraged to express their opinions, wishes and desires.

H: Agency drop off was discussed and described as the experience of Children's Social Care (CSC). This means that once a referral has been accepted by CSC then other agencies expect them to take the lead whilst the continued involvement and engagement from key professionals is vital to protect children. Agencies were encouraged to maintain their involvement.

Challenges

- 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 the 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?

Conclusion

The new information that has now become available in this case suggests that the contributory factors are predominantly associated with the child and family (Appendix 1). It is likely that these factors caused problems for frontline professionals who felt the full force of the difficulties associated with working with this family. Systemic paralysis, if indeed it exists, in combination with a lack of robust planning, feature as organisational contributory factors.

Professionals at the learning event were able to confidently identify areas of improvement and 'moving on' in order to give reassurance for future practice. Training on the importance of neglect has been rolled out across the partnership. Relationships are reported to have improved and there is increased evidence of 'joined up' working. Children are seen individually and their voices are heard and recorded. Practitioners reported that it is good to be challenged, it is welcomed and that we are working in an environment where we need to keep the children at the forefront.

The GSCB will receive the systems learning points, recommendations and challenge issues set out in the SILP report and the additional section in order to produce a robust Response Plan which will be monitored until completion of all agreed actions.

Janice Waters

References

Department for Education. 2013. *Working together to safeguard children* [Online]. Available at: http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children [Accessed: 12.07.2014].

Melia, P. et al. 1999. Triumvirate nursing for personality disordered patients: crossing the boundaries safely. *Journal of psychiatric and mental health nursing* 6, pp. 15-20.

Reason, J. 2000. Human error: models and management. *Bmj* 320(7237), pp. 768-770.

Reder P et al. 1993. In: Routledge ed. *Beyong blame: Child abuse tragedies revisited*. pp. 106-107.

Taylor-Adams, S. et al. 2004. Systems analysis of clinical incidents: the London protocol. *Clinical Risk* 10(6), pp. 211-220.

Appendix 1

Interaction matrix to reveal where contributory factors impacted on the case

	Child or family factors	Task Factors	Frontline professional factors	Organisational factors	National factors
Judge's sentencing comments	Peaks and Troughs Not a case of deliberate behaviour Physical disabilities				
Psychotherapist's feedback	Powerful personality disorder		Professional Splitting Systemic paralysis	Systemic Paralysis	
Housing feedback		Failure to access the home	Lack of record keeping Failure to access the home	Lack of record keeping	
Practitioner Learning Event	Lack of healthy challenge Fear of family disengagement Parents difficult to work with Rights of the parents over the children	Lack of response by CSC	Lack of information sharing Agency drop off	Lack of robust plans	