Serious Case Review: Summary report – The G children

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1. Synopsis of the case and review

1.1. This Serious Case Review examines the circumstances of agency contact and involvement with six children in a family who range from the ages of 2½ years to 16½ years. The eldest child experienced neglect, abuse and maltreatment, whilst the other children experienced neglect and maltreatment to varying degrees; all children experienced considerable instability in their home and school life. Whilst some concerns about the welfare of the children were known about by agencies, the extent of the harm suffered did not really begin to emerge until statutory child protection intervention occurred in March 2018. The full extent of the harm was then acknowledged in June 2018 and which required legal intervention. The decision to conduct a Serious Case Review was based on the criteria outlined in statutory guidance[1] given the concerns about the way in which agencies worked together to safeguard six children from the same household, abuse and neglect being known or suspected, but also the seriousness of harm caused.

1.2. A full, thorough and systematic review was conducted and benefitted from the contributions of numerous agencies and services that had contact with the children and parents. The review also benefitted from the contributions of practitioners that had worked with the children and parents. The parents and eldest child were invited to contribute to the review. The views of the children's father were captured, albeit in a very limited way; however, he later declined to contribute any further. There was no contact from the children's mother or the eldest child.

1.3. The case review has captured and highlighted the challenges and dilemmas often faced by the professional network when dealing with family situations that fluctuate over a protracted period of time, and where there are concerns about neglectful parenting, dysfunctional family dynamics, and maltreatment. The case highlights, in part, two struggles; firstly, the challenges for the professional network to consistently evidence a threshold at which a more interventionist approach could have confidently been pursued at an earlier stage when concerned about children being neglected, and secondly; when working within the slippery threshold zone associated with neglect the impact for the children being stuck in a situation of experiencing a persisting yet cumulative level of harm over time. In such situations, as in this case, the professional network also became stuck and unwittingly, trapped, until an acute episode tipped the professional response.

1.4. By way of a summary, the following findings have emerged from this case review;

- The impact of the family moving 13 times between November 2004 and July 2017 meant that the children experienced numerous moves and a different set of professionals. This resulted in professionals starting afresh with their assessment of the children's welfare and the longer-term perspective being very limited.
- The eldest child, who for the purposes of this review will be known as Child A, effectively became invisible to the professional network due to being removed from formal education in 2015. Child A's significant educational and additional needs were not effectively assessed or managed and professional attention was distracted away from him by the child's father.
- Parental resistance and non-engagement were major contributory factors to the professional network becoming distracted away from focusing on the children's welfare, particularly Child A. Some professionals held their focus on the children's needs however their contact with the children did not highlight sufficient concerns to warrant statutory intervention; the changing nature of concerns especially when viewed in isolation rarely reached a threshold requiring more robust action by professionals involved.

[1] Working together to safeguard children, 2015, HM Government.

- The approach and response by some professionals to the parents was mixed, with some feeling intimidated and others feeling sympathy. This resulted in difficulties assessing, intervening and making decisions.
- Evidence points to Child A being singled out and scapegoated in the family, with him experiencing persistent neglect and emotional harm. It is only towards the end of the timeframe under review that the cumulative impact of this was robustly assessed and recognised.

Summary of local learning identified as a result of the review

A number of learning points were captured as a result of analysis of information and discussions with practitioners.

- When you have concerns about a child's welfare never assume that someone else is dealing with it. The information you have may contribute to a larger picture and inform decision making and assessment opportunities.

- When conducting enquires into actual, or likely, child neglect and maltreatment there may be value in checking with the local Regulatory/Environmental Health Services to see if they have been, or are, involved with the household. Noise and nuisance complaints may be symptomatic of a chaotic and dysfunctional household and referring information from neighbours should be treated with equal importance as those from other professionals.

- Consistency of worker, especially during pregnancy, can be of benefit to all concerned. Consistency can aid a more trusting relationship to develop and in cases where there may be concerns about vulnerability a trusted connection with a professional may support better outcomes for the mother and baby.

- It is important to remain actively curious about the quality of parental relationships when working with expectant women. When women have known vulnerabilities and are experiencing a high-risk pregnancy there will be value in seeking timely and reflective supervision to critically evaluate case history and case management.

- The importance attached to professionals conducting home visits cannot be under-estimated. It allows practitioners the opportunity to observe children in their home environment, observe family interactions, and assess the standards of the living environment.

- Parental non-engagement, or failure to enter into a dialogue about the welfare of children, should be viewed as a risk factor which may have an impact on a child's welfare and safety. Seeking assurance that the originating concerns or support needs have been resolved should be the baseline for taking a decision to close the case – not simply a failure by the parents to engage. The decision to close a case due to non-engagement, having made repeated attempts to engage parents, should be risk assessed against case history and current circumstances. Using the lack of parental consent as a reason to not pursue concerns about a child's safety may be a diversion.

- When the professional network is faced with complex family dynamics and there is a need to identify multiple sources of risk it is important to ensure there is experienced and authoritative multi-agency professional practice which continually exercises curiosity and scrutiny about whether sources of information have been pursued.

- An assessment of the situation pre-birth is different to a formal pre-birth assessment. It is important to be clear, and explain, what is driving the rationale for needing any assessment, particularly one which concerns the safety and welfare of infants. The circumstances of this case would have justified a formal pre-birth assessment, as detailed in the West Midlands Safeguarding Procedures: Pre-birth assessment

- When working with parents who are not living in the same household, or who are separated, each parent should have the opportunity to fully express and voice their views, wishes and feelings.

- When there are multiple children in a household, and numerous agencies/professionals involved with the family good practice would be to create, and maintain, a multi-agency chronology. This should be reviewed on a regular basis in supervision, and as a multi-agency group, especially when concerns about children's welfare are difficult to evidence. One major benefit of this is that it allows oversight of missed appointments which can potentially be used to evidence neglect.

- When faced with a parent, or adult, who can be intimidating and controlling it is often helpful to have the support of a co-worker, whether this be from your own agency or another discipline but also a tightly coordinated group of professionals working together. This requires joined up working, preparation and management support. All workers need to be supported by their management structures to feel empowered to confidently discharge their statutory duties when working to safeguard and promote the welfare of children.

- When faced with one parent who appears to take control it is important to explore the impact of this behaviour on children. Research[2] notes that *'… it is important to understand the role that children play where there is coercive control …* [and that] *they are not viewed as having been 'exposed to' or 'witnesses' to domestic abuse; rather children should be seen as 'human beings who live with, experience and make sense of' domestic abuse …'.*

- Group think is a situation that occurs when a group reached an agreement without a critical analysis of all of the information from all of the participants. It can be based on a wish not to generate disharmony or upset and which results in the contribution of individuals being restricted thereby avoiding conflict. Ensuring good quality chairing is one way to reduce this happening, as is allowing free reign on critical analysis of information shared.

- When working with families where there are multiple children in the household it will be important to understand the lived experience of all the children. When one child, in a household of many children, appears to be treated or described differently to the other there will be value in being additionally curious about this and fully exploring the lived experience for this child.

- When multiple appointments are scheduled across different services or agencies, and where there are known vulnerabilities about neglect it is important for recording systems to capture attendance at appointments and then for this to be examined at key decision and review points. Failure by parents to bring children to appointments can be viewed as medical neglect – a form of neglect where parents do not seek or prioritise the health/medical needs of a child. Children with complex needs are particularly vulnerable to medical neglect[3].

- Creating a multi-agency chronology, triangulating information and working together as a tight network is imperative when working with complex situations and families. The greater the number of professionals involved with a family the greater the need to ensure effective working relationships and links. Having a central point of contact for all professionals to come to can greatly assist this.

[2] McLeod, D., Coercive control: Impact on children and young people in the family environment, 2018, p.25, Research in Practice

[3] Horwath, J., Child neglect: Identification & assessment, 2007, p.27, Palgrave MacMillan.

- In this case, the Schools were able to offer valuable information and make positive contributions to the decisions made by the professional network. Schools are ideally placed to hear, understand and explore children's daily experiences and their contributions should always be sought.

- Complex situations in which children are living, often require critical thinking skills – the careful examination of information, beliefs and actions in order to gain a deeper analysis of what might be happening. Critical thinking can be supported by good quality reflective supervision or seeking impartial expert consultation.

- When individual children have complex needs, and live in a family where there is a level of complexity it will be important for practitioners to explore the relationship between different professionals that are involved with each member of the family, how they intersect and where the risks lay. Risks should be explored from an individual safeguarding perspective but also from an organisational, system perspective so as to avoid fragmentation and silo working.

Recommendations

As a result of this review agencies that have contributed have been able to identify learning that can be taken forward internally, and as such have submitted single agency action plans reflecting their internal learning and recommendations for improvement. A significant number of the issues noted in this report have resulted in single agency actions being agreed as the mechanism for improvement. The following additional recommendations are made for the Safeguarding Partnership;

1. To ensure the learning from this review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.

2. To seek assurance that the actions identified by each partner agency, as a result of this review, have been managed, implemented and embedded in a timely manner.

3. To strengthen and ensure local arrangements support all relevant practitioners to have sufficient knowledge and understanding about identifying and assessing neglect, and how to share concerns about neglect via the appropriate route.

4. As of April 2020, Children's Social Care will share a recording database with Early Help. Post implementation, the Partnership should seek assurance that Children's Social Care are accessing information held by the Early Help service to inform assessments and decision making.

5. To request a multi-agency audit of the revised process introduced in Compass in January 2019 and seek assurances that when consent is not given by parents, but concerns remain, assessment and decision making is sufficiently robust, child centred and achieved in a timely manner.

6. To seek assurance that concerns and referrals are not dealt with based on a hierarchy of referrer and that when, for example, neighbours and workers who may be perceived to have less status than others make referrals these are treated with an equal weight of importance.

7. To ensure that expectations around formal pre-birth assessments are clearly communicated, and understood, by all relevant agencies and professionals.

8. The Partnership to consider the best mechanism and criteria for escalating concerns where parents either (responding to parents that) overtly, or covertly, fail to engage, disengage or demonstrate inconsistent engagement with professionals.