Serious Case Review

The G children

Review report

Independent Reviewer: Kevin Ball

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1. Introduction to the case under 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 (at the time of the decision to initiate a case review). 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. 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. This is encapsulated by research[2] findings *'Chronic neglect … is more a process or way of life, than a single event. This can have a paralysing effect on the workers involved with the family. They may become desensitised to the effects of unremitting low-level care of children or come to share the pervading sense of hopelessness that is often associated with chronically neglecting families. This inability to act may be compounded by an ideology of partnership … unless something new happens social workers and other professionals may continue to have contact with the family on a regular basis, without the situation changing fundamentally – perhaps for years …'.*

1.4. By way of an overall 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 of school 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

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

[2] Turney, D., & Tanner, K., Working with neglected children and their families, p194, 2001, Journal of Social Work Practice, Vol. 15, No, 2.

statutory intervention; the changing nature of concerns especially when viewed in isolation rarely reached a threshold requiring more robust action by professionals involved.

- 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.

2. Process for conducting the review

2.1. The decision to initiate a Serious Case Review was taken in June 2018 by the Independent Chair of the Board. Due to not wanting to disrupt other parallel proceedings and a need to better understand the complexity of the case it was agreed to delay the start of the review process. As such, an Independent Reviewer was not appointed until January 2019 and the review did not begin in earnest until the end of February 2019. The Board commissioned Kevin Ball as the Independent Reviewer[3]. The approach taken has complied with the expectations as set out in statutory guidance[4] and used a Soft Systems Methodology[5] which has provided a way of looking at and analysing frontline practice as well as organisational structures and learning from a whole safeguarding system perspective.

2.2. From February 2019, the following steps were taken;

- Initial terms of reference for conducting the review were set by the Learning & Improvement Group[6] and then further refined by a Panel of agency representatives in collaboration with the Independent Reviewer,
- A briefing session of single agency authors for those organisations that had contact with the children was held in early April 2019,
- Single agency reports[7] and chronology were requested and submitted in May 2019, which in turn generated a combined chronology of agency involvement. This process provided each agency with the opportunity to reflect

[3] Kevin Ball is an independent & experienced safeguarding consultant with a background in children's services, an Independent Scrutineer and has specific experience of chairing and authoring case reviews.

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

[5] Soft Systems Methodology by Checkland, P., & Poulter, J., in Systems Approaches to Managing Change: A Practical Guide, Reynolds, M., & Holwell, S., Open University, 2010.

[6] The Learning & Improvement Group is a sub group of the Shropshire Safeguarding Children Board.

[7] Single agency reports were submitted from the following agencies;

- West Mercia Police
- Shropshire Council Children's Social Care
- Shropshire Council Learning & Skills Service
- Shropshire Council Housing Options
- Shropshire Council Regulatory Services
- Shropshire Council Early Help Services
- Shropshire Council Adult Safeguarding Team
- Shropshire Clinical Commissioning Group
- Shropshire Community Health NHS Trust
- Midlands Partnership Foundation Trust
- Royal Shrewsbury & Telford Hospital Trust
- Education provision 1
- West Midlands Ambulance Service University NHS Foundation Trust
- The Shrewsbury & Telford Hospital NHS Trust
- RSPCA
- Primary School A
- Primary School B
- School C
- School D
- School E
- School F
- Nursery A
- Education provision 3
- Education provision 2

on their involvement with the children. As a result, agencies have been able to consider actions required of themselves in order to make improvements to practice early on in the process,

- Two facilitated multi-agency workshops were convened involving practitioners who had come into contact with the children; one in July 2019 and another in September. These workshops examined what happened in this case by seeking the perspective of those practitioners most closely involved with the children and to capture learning and improvement actions,
- The report was finalised and presented to the Safeguarding Partnership Board in November 2019.

2.3. The timeframe under review was from August 2014, when the Mother became pregnant, to May 2018 when the family were considered to be at risk of leaving the country. Relevant historical information is also considered.

3. Family structure & contribution to the review

3.1. For the purpose of conducting this review the following individuals are relevant;

Individual	Identified as
Subject child:	Child A
Sibling 1:	Sibling 1
Sibling 2:	Sibling 2
Sibling 3:	Sibling 3
Sibling 4:	Sibling 4
Sibling 5:	Sibling 5
Father:	Father
Mother:	Mother
Paternal Grandmother:	Grandmother

3.2. Seeking the contribution of family members has been an important consideration. The Independent Reviewer spoke with the Father over the phone following an unsuccessful attempt to meet face to face. Attempts to speak with the Mother were made however due to them being out of the country this was problematic and did not happen.

3.3. The Father spoke about his contact with professionals during the timeframe under review, and particularly during recent months given the ongoing proceedings. He expressed a very clear view that the majority of professionals involved with his children had been unhelpful, had not offered any support whatsoever and were in denial about the extent of Child A's needs. He conveyed a negative view of Children's Social Care and the local authority Learning & Skills Service and that they were particularly in denial about Child A's additional needs and what was needed to support him. The Father expressed a view that none of his children were ever neglected or malnourished and that lies had been created by professionals in order to make a case. The Father was more positive about three practitioners recent contact and involvement; one being a Social Worker from adult services, a mental health worker and a Looked after Child worker. The more positive view was based on their capacity to understand Child A's needs.

3.4. Further attempts to engage the father and Child A with the review and its findings were unsuccessful.

4. Synopsis of relevant case history

4.1. In 2004 Child A had been assessed as having speech and language delay with him receiving support through to 2008. In 2010 a referral was made to assess Child A for being on the autistic spectrum however this was not followed through by the parents resulting in him being discharged from the local child mental health services in 2011. Child A was assessed as having special educational needs in 2008 due to social, emotional and behavioural difficulties. Concerns about his attendance levels at school persisted throughout until it was reported by his Father in July 2015

that he was going to be home educated. Whilst Child A was attending school there were numerous reports about the family struggling to manage his behaviours, concerns about him not eating, looking unkempt and him being left alone at home. Similar concerns persisted once out of school, with Child A very occasionally being seen by professionals such as Health Visitors and School Nurses during visits to the family home. One school expressed concern that they had a suspicion that Child A was being neglected and the parents were using a diagnosis of autism as a way of masking the other issues. The schools that Siblings 1, 2 & 3 were attending had almost contrasting views with them having few concerns about the siblings.

4.2. Concerns about the parents refusing treatment for ringworm for Sibling 3 were noted in early 2014. At this time the Mother was reported as suffering from a serious illness and accessing treatment, albeit inconsistently. Child A was referred back to the child mental health services in May 2014 and continued to have contact until May 2018.

4.3. In August 2014 it is recorded that the Mother's health treatment was suspended due to her being pregnant; she was expecting her fifth child and had been recently diagnosed with a learning difficulty. The possibility of the family being evicted from their own home became a real likelihood due to repossession. During a routine antenatal scan, which confirmed twins (Siblings 4 & 5), foetal abnormalities were apparent in one foetus however the Mother's engagement with follow up appointments was inconsistent. Concerns began to emerge about all the children experiencing some level of neglect, living in unkempt and dirty housing conditions which included many animals; however contrasting views, observations and interactions persisted highlighting a conflicting picture. Children's Social Care, the Police and the Housing Service were intermittently involved and home visits were often unsuccessful or access was refused by the Father. The response to these concerns by Children's Social Care was initially at the Early Help level, and then with a social work assessment being conducted in December 2014; this resulted in a Child in Need[8] Plan for all children. The situation failed to improve and the family were evicted from their own property in early 2015. During this episode the Mother threatened suicide and was assessed under the Mental Health Act but declined further services. The family were temporarily re-housed in hotel accommodation. From this point, the children's attendance at school became increasingly problematic and was inconsistent. The Mother, heavily pregnant in February 2015 gave birth in a hotel room refusing the opportunity to be taken to hospital until several hours after the birth. Sibling 4 was born with significant physical abnormalities. In March 2015 the family were re-housed in temporary accommodation however the children were not registered in local schools, the family had no social networks and continued to struggle.

4.4. Records indicate Child in Need meetings were held but with some being cancelled. In April 2015 a Strategy[9] discussion was held due to increasing concerns and information received from a GP, however the threshold for a section 47 investigation was not met and that the family continued to be supported via a Child in Need Plan.

4.5. Throughout this timeframe the children were inconsistently brought to medical and routine health appointments – some of which were important for the infant children. The Father was observed to be controlling of access to his

[8] Child in Need - Section 17 of the Children Act 1989 imposes a general duty on the Local Authority to safeguard and promote the welfare of children who are 'in need' and to promote the upbringing of children in need by their families by providing a range and level of services to meet those children's needs. A child in need is defined as a child: i) who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services; ii) or a child whose health or development is likely to be significantly impaired, or further impaired, without the provision of services; iii) or a child who is disabled.

[9] Strategy discussion is convened under Section 47, Children Act 1989; where a local authority has reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make such enquiries as they consider necessary to enable to them to decide whether they should take any action to safeguard or promote the child's welfare.

family by professionals on a number of occasions. He sought the involvement of Child & Adolescent Mental Health Services (CAMHS) for Sibling 2 concerned that she had autism.

4.6. In April 2016 Children's Social Care, in agreement with the Primary School A and the Health Visitor, confirmed that they would be stepping down their involvement, ending the Child in Need Plans. Despite additional information in the form of referrals from the NSPCC, the Police, neighbours and community safety officers, Children's Social Care maintained no further role having again reassessed the situation in November 2016. A network of professionals maintained contact with the family via the Early Help process. Concerns continued yet refusal of consent to share information by the Father did not result in any changes in the professional response.

4.7. In November 2017 Sibling 1, aged 12 years claimed whilst at school that she had been self-harming since being six years of age due to the pressures at home to contribute to the care of her brother and the noise in the house. Sibling 1 stated that she *'… had run out of love for him …'*, and gave consent for her father to be informed but not the mother. The Father did not follow through any actions having been informed of Sibling 1's self-harming.

4.8. The Police were often called out in response to Child A's behaviours; information was shared with Children's Social Care as a result of their attendances but not on every occasion. In total the Police received 27 contacts during the time frame under review due to screaming, fighting and disturbances from in the home. The Ambulance Service attended on two occasions in early 2018 and expressed concerns about the home conditions and Child A. The RSPCA were contacted and involved on 11 occasions due to concerns about the welfare of animals in the home environment. Regulatory Services – responsible for responding to complaints about noise and neighbourhood nuisance/behaviour - were contacted by neighbours due to disturbances on multiple occasions.

4.9. The involvement of the Ambulance Service seems to have prompted section 47 enquiries resulting in an Initial Child Protection Conference[10] in March 2018. By way of a summary, the following issues were noted;

- Sibling 1 self-harming.
- Dog faeces and the smell of urine in the house.
- A persisting history of lack of engagement with services
- Child A having virtually no secondary education.
- A persisting history of neglect.
- Child A wearing the same clothes for a month.
- Child A being confused about his gender.
- Missed health appointments for Sibling 4.
- A persisting history of poor school attendance for all the children of school age.
- A persisting history of neighbours reporting shouting, swearing and banging.
- The garden not suitable for children with dog faeces on the trampoline.
- Animals in the house, often taking priority over the children (12 dogs, 2 cats, guinea pigs, chickens & cockerels).
- Child A spending most of his time in a room needing assistance to leave, not being able to use a toilet and the room smelling of urine.

4.10. As a result of the Initial Child Protection Conference, all six children were made subjects of a Child Protection Plan[11] under the category of neglect[12]. Core Group[13] meetings were held however progress against agreed actions was

[10] Child Protection Conferences - West Midlands Procedures

[11] Child Protection Plan - West Midlands Procedures

[12] Definitions of abuse & neglect - West Midlands Procedures

[13] The Core Group - West Midlands Procedures

problematic. A Review Child Protection Conference was held in May 2018 which judged that the children should remain subject to a Child Protection Plan. Prior to the Review Conference Children's Social Care had sought legal advice as additional concerning reports about the children's welfare were received. Following the Review Conference, the Mother and Siblings 1 – 5 left the country, leaving the Father and Child A. Child A was taken into Police Protection having been left unsupervised by the Father, and was then admitted to hospital dehydrated, malnourished and with severe head lice. As a result of the Mother and siblings leaving the country the matter was placed in front of the Court; consequently, all six children were made subjects of Interim Care Orders[14] with Recovery Orders[15] also being granted for Siblings 1 – 5. These were later discharged and arrangements made by the relevant authorities in the country the Mother and Siblings had fled to, to monitor their care. At the direction of the Court Child A has now returned to live with his Father, despite a period of time living in alternative care.

5. Analysis of professional practice & the multi-agency safeguarding system

1. From the position of having mapped the professional and agency contact with Child A and his siblings over this timeframe, there are a number of features that stand out that help us understand what happened, and why events occurred as they did. These features are relevant from a multi-agency safeguarding system and practice perspective and, as such, provide us with the greatest insight into the quality and effectiveness of the response to Child A and his siblings at the time. Where possible, an explanation of why events occurred as they did, has been provided. Learning points for use by all professionals and trainers have been emphasised. The following area are explored;

- The recognition of abuse, maltreatment & neglect in the household.
- The quality & effectiveness of assessment, planning and intervention.
- Opportunities to hear, and understand, the daily lived experiences of the children in the household.
- The quality and effectiveness of multi-agency working.

2. By way of a summary the following findings are made;

- Between November 2004 and July 2017, the family had moved to 13 different homes in different areas of Shropshire; this resulted in a large number of school changes for some of the children and often a different set of professionals having contact with the family. The impact of this was that professionals were often having to start again with their assessment of the children's welfare which reduced the opportunity for the longer perspective to be gained.
- Child A was removed from formal education in 2015 resulting in him effectively becoming invisible to the wider professional network. Child A had significant educational and additional needs and these were not effectively addressed because of the family circumstances distracting attention away from Child A.
- Parental non-engagement and resistance to professional support and intervention was a major contributory factor to the professional network becoming unwittingly distracted away from focusing on the children's welfare, particularly Child A. Whilst a small number of professionals were not distracted their contact and involvement with the family did not reveal concerns to be at a sufficient level to warrant intervention, or when it did, concerns

[14] Interim Care Orders

[15] Where it appears to the court that there is reason to believe that a child to whom this section applies (a) has been unlawfully taken away or is being unlawfully kept away from the responsible person; (b) has run away or is staying away from the responsible person; or (c) is missing, the court may make a Recovery Order, section 50, Children Act 1989.

were addressed by the parents. This false positive response supported a view of fluctuating concerns which, when viewed in isolation, rarely appeared to reach a threshold requiring more robust intervention.

- Some professionals involved felt intimidated by their contact with the Father, whilst some professionals involved felt sympathetic towards the Mother. The combined effect of these human factors hampered effective assessment, intervention and decision making.
- Child A appears to have been singled out in the family and he experienced persistent neglect and emotional harm. The cumulative impact of this was only recognised and authoritatively assessed towards the end of the time period under review.

5.1. The recognition of abuse, maltreatment & neglect in the household

5.1.1. Statutory guidance[16] in place at the time provided definitions of abuse describing *'… somebody may abuse or neglect a child by inflicting harm, or failing to act to prevent harm …'*. The descriptors of emotional abuse and neglect are of particular interest. The crucial descriptor spanning both of these categories being about the persistence of any abuse; noting the *'…persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development … and the persistent failure to meet the child's basis physical and/or psychological needs, likely to result in the serious impairment of the child's health or development …'.* The review has highlighted that a number of agencies had insights into the standard of care given to the children, with contrasting perspectives about whether it ever signified actual, or likely abuse and neglect. The following analysis sets out these contrasting views.

Schools, educational provision & education-based services

5.1.2. School F, which Child A attended for two months from November 2013 to January 2014, noted that he was *'…often dirty, wore very muddy clothes and looked unkempt. He would occasionally be hungry and be without lunch or money to purchase lunch …'*[17].

5.1.3. Education provision 3, which Child A attended for four weeks in April 2014 noted that he was a very thin child who was very often dirty and obsessed about what food he ate. No other concerns were identified.

5.1.4. Education provision 2, which Child A attended from May to October 2014 noted insufficient evidence of concerns although there was a recognition about some degree of neglect due to Child A's behaviour, presentation and weight loss – possibly due to a perceived eating disorder. This information was appropriately shared.

5.1.5. Education provision 1, which Child A attended for four days in May 2015 had limited opportunity to notice any concerns; consequently, none were identified.

5.1.6. School E, which Siblings 1, 2 & 3 attended from September 2014 to March 2015, considered their attendance levels as reasonable (between 84 – 86%) given the eviction and transportation difficulties; *'… the children were sometimes poorly presented, wearing dirty and ill-fitting clothes … frequently not having appropriate clothing for school activities … One occasion they all arrived with greasy looking hair because they were covered in a treatment for head lice … parents provided packed lunches but they turned up late … meaning the children couldn't eat dinner with their friends. The lunch boxes were sometimes dirty inside and contained food that wasn't wrapped … homework*

[16] Working together to safeguard children, p. 92, HM Government, March 2015.

[17] School F, submission to the review.

wasn't done … parents didn't attend parents evening … the way the parents managed the children was very contrasting. Father was seen shouting and seemed very dominant; whereas the Mother was very quiet …'[18]. These issues were actively monitored however a threshold was not met to elevate concern, but do reflect persisting indicators of neglect and a disorganised family over a seven-month period.

5.1.7. School D, which Sibling 1 attended from September 2016 to July 2017, did not have concerns about abuse, maltreatment or neglect; *'… Sibling 1 was well presented, clean, tidy and completed her homework on time … she did not appear malnourished … had good hygiene and no marks or bruises that required investigation … had a good friendship group and did not appear to be distressed during her time at the school …'*[19] Sibling 1's attendance was lower than hoped (around 80%) however this improved once the Father had been spoken with. These reflections provide no evidence of neglect over an 11-month period.

5.1.8. Primary School A, which Siblings 1, 2 & 3 attended from April 2015 until September 2017, were aware of some welfare concerns and attendance issues having received information from the children's previous school. In practice, this meant that the children were more closely monitored. Although worries about attendance and late arrival persisted, concerns fluctuated and often reduced when the parents were spoken with and which then resulted in improvements being seen. A range of reasons were provided by the parents for the children's poorer attendance and frequent late arrivals at school which included traffic, car trouble, needing to prioritise other family members, sickness, over-sleeping and late leaving home. During one discussion this resulted in the Mother admitting she felt overwhelmed by having to care for all the children, not getting any support from the Father and the need for an Early Help assessment being seen as a helpful option. At the time of this discussion with the Mother, the parents were living in separate locations and the Mother was caring for all the children other than Child A, who was living with the Father. Individual assessment work completed by the school with Sibling 2 did not elicit any concerns about her welfare or that of any members of her family. As a result of the persisting concerns about attendance an Education Welfare Officer and Social Inclusion Manager visited the family home noting *'… it smelled strongly of animals, it did not look unclean. The floors were clear and there was no dirt of animal faeces. The kitchen was clean and tidy – the worktops were clean and there was washed dishes on the draining board. Siblings 1, 2, 3, 4 & 5 were seen and all seemed happy and clean and were completing work … the Mother was chatty [when alone] … but when sitting with the Father was silent and still … Child A was dressed appropriately … came downstairs and said 'hello' … and emotional warmth [was observed] towards the children from both parents, which the children reciprocated, although with the Mother more than the Father …'*[20]. These descriptions indicate, on one hand a level of chaotic and disorganised parenting, but on the other hand, adequate parenting which dispel concerns of persisting neglect.

5.1.9. Primary School B, which Siblings 2 & 3 attended from September 2017 until May 2018 had no concerns about Sibling 3 although she did express worry about the home conditions at one point. This information was appropriately shared. Concerns about Sibling 2 included social and communication difficulties, rigidity and periods of anxiety – but not necessarily neglect. The school were aware of the previous issues from other schools attended.

[18] School E, submission to the review.

[19] School D, submission to the review.

[20] Primary School A, submission to the review.

5.1.10. Nursery A, which Siblings 4 & 5 attended from February to March 2018 have not expressed any concern of significance in their interactions other than the parents sometimes being defensive when being asked to explain about any minor injuries noticed on the children.

5.1.11. From the perspective of the schools, nursery and other educational provision it is evident that there were often contrasting experiences. Home visits conducted by those professionals associated with educational provision highlight overall positive findings. Positively, there is evidence of information following the children from one school, or provision, to another enabling maintained monitoring. Evidence indicates that Siblings 1, 2, 3, 4 & 5 were observed to be clean, well presented and happy children for a considerable period of time and who were able to apply themselves to school work, manage the transition from home life to school day and form friendships. This is indicative of each of the children possessing a level of individual resilience, but also be in receipt of support and care from a competent parent. However, concerns emerge about Siblings 1, 2 & 3 at around the time of the build up to, and then the eviction of the family in January 2015. The immediate aftermath of the eviction and the birth of Siblings 4 & 5 (January - April 2015) resulted in a level of general demand on the parents in managing six children, each with differing needs. This is when the presence or absence of any persisting concerns are tracked more easily. Indicators of intentional harm or abuse are hard to pinpoint, where-as indicators of omissions in care and parenting are more apparent. Arguably, these omissions can be attributed to the circumstances at the time i.e., housing and instability.

5.1.12. Notwithstanding the differing levels of care provided to all the siblings the care and welfare of Child A stands out, in that concerns about actual or likely neglect persist up until he is removed from a formal education setting and starts being educated at home. Concerns about Child A's presentation and behaviour appear to be constant and reflect acts of commission and omission in terms of emotional abuse and neglect.

5.1.13. The Learning & Skills Service became involved due to the educational issues relating to Child A. In 2014 an Educational Psychologist conducted a home visit to conduct an assessment of Child A. No concerns were noted about Child A's presentation however the home conditions were considered sparse and unkempt and there being many animals kept in cages. The Educational Psychologist was *'… concerned with Child A's state of mind due to his obsessions and repercussions about wearing football kits, his self-image, his diet and lack of social interaction due to not being in school. Child A was working with CAMHs at this time and in receipt of medication ...*'[21]. This episode reveals that there was a recognition of potential, or actual, harm to Child A however the information was not shared with Children's Social Care because it was known that other professionals already had concerns and an additional referral was not considered necessary.

Learning point: 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.

5.1.14. In 2016 a second Educational Psychologist engaged with Child A as the Father had requested a new look at the situation. This Psychologist conducted a home visit and conditions were noted to be *'tidy enough'*. The concerns noted related to Child A's limited social development and isolation given he was being home educated. Again, these concerns were not shared with Children's Social Care because the Father was presumed to be engaged in working with Children's Services by attending core group meetings and an assumption was made that Children's Social Care would know about the issues.

[21] Learning & Skills, submission to the review.

5.1.15. In April 2016 an Engagement Officer from the Learning & Skills Service received information from a neighbour concerned about Child A's welfare as the Father was reportedly taking Child A *'… out late at night, wearing just shorts and thin coat, regardless of weather …. Child A was heard to say 'please don't leave me alone again, I don't like to be left alone' …'.* This information was shared with Children's Social Care but did not reach a threshold to justify taking further action.

Services not directly responsible for child health, care or welfare

5.1.16. West Midlands Ambulance Service attended the house in January 2018 due to Child A suffering mental health problems and noted *'… this was a hectic household with dogs running around the property, clutter stacked up everywhere but the other children were clean and appeared happy and well looked after …'*. During another call-out the ambulance crew noted that Child A was unkempt and that he had refused to change his clothes in the last month, there were animals in the kitchen and the property smelt of urine. This information was shared with Children's Social Care and prompted further action, as outlined above.

5.1.17. The RSPCA conducted 11 visits which included observing animals inside and outside of the property. Advice was given verbally and in writing, with one notice requiring improvement action to be taken within 72 hours. At no point were concerns about children's welfare identified however the persisting nature of the call-outs were a cause for concern. As no child welfare concerns were identified the RSPCA did not refer any information to the NSPCC, as per their nationally agreed policy guidelines.

5.1.18. Regulatory Services, responsible for responding to complaints about noise and neighbourhood nuisance/behaviour were passed information about the children's welfare on multiple occasions from local residents, clearly indicating persisting concerns. Sound recordings were shared by local residents which, when assessed by Regulatory Services, were judged as being inappropriate and passed to the First Point of Contact (FPOC) in Children's Social Care (now Compass). One member of staff noted following a visit that the shouting and screaming *'… wasn't bad enough to get police out but enough to raise concern of how children were being treated although there was not considered to be any imminent danger to the child …'*. The assessment of noise and nuisance was never judged to reach a threshold to judge it a statutory nuisance[22]. Reflections from their involvement in these episodes include *'… Officers acted to direct residents with concerns of abuse, maltreatment or neglect of children to contact the FPOC line directly to provide information when the concern arose … Statutory nuisance is based on subjective elements and officer judgment and experience. A statutory nuisance only exists if noise is found to be unreasonable and have a material impact on the enjoyment of a person's property. Analysis of the case suggests that the officer actions were reasoned and justified and that the screaming and shouting alone did not create a statutory nuisance ...'* [23].

5.1.19. An alternative view has been put forward by neighbours, who were experiencing noise and behaviour. They feel that they were significantly impacted by living near to the family. They describe noise issues both day and night which include shouting and screaming between the adults within the home as well as at the children, wailing and screaming from the eldest child, stomping up and down stairs, smashing furniture and hammering. Neighbours experienced bad smells coming from their neighbour's home and garden regularly. They also complained of verbal abuse and threatening behaviour from some of the family members, along with distressing comments on social media.

[22] Statutory nuisance as defined in the Environmental Protection Act 1990.

[23] Regulatory Services, submission to the review.

This was deeply distressing to neighbours and had an impact on their sleep, mental and physical health and enjoyment of their home and garden.

Learning point: 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.

5.1.20. The Housing Options Service recognised potential animal neglect and noise complaints from neighbours by making a referral to the Public Protection Team who were investigating possible neglect of animals and the noise complaints received from neighbours. This information was shared with Children's Social Care.

Health, Police & social care services

5.1.21. The Shrewsbury & Telford Hospital NHS Trust Maternity Service's opportunity to recognise abuse, maltreatment and neglect was whilst supporting the Mother during her pregnancy with Siblings 4 & 5. The pregnancy was assessed as high risk due to the Mother's own health needs, a history of low mood and the foetal abnormalities associated with Sibling 4. As a consequence of this complex history the Mother was advised to attend a large number of appointments. The Trust have reflected on this *'… under normal circumstances, the need to attend the number of appointments required would be demanding for any mother who already had a young family at home, this was evident in this case from the missed appointments recorded. Every woman is allocated a community midwife / team who also offer antenatal care in the community either in the clinic setting or occasionally in the home. The Community Midwife is often the professional that builds a relationship with the mother and family, … Building this relationship was a challenge due to the number of additional hospital appointments and complicated further following the family's eviction (the family had moved three times to different bed and breakfast accommodation around the County during this time) ...'.* The result of these complications was that the Mother never benefitted from one stable relationship with a Midwife during the pregnancy and their ability to spot patterns of behaviour or neglect would have been compromised due to inconsistent oversight.

Learning point: 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.

5.1.22. With the benefit of hindsight, the issue of control by the Father of the Mother has been raised by the Shrewsbury & Telford Hospital NHS Trust Maternity Service's as of possible concern. From a safeguarding perspective this may be relevant as it links to a similar controlling dynamic noted between Child A and the Father during some interactions with schools and education provision and may be seen as an indicator of abuse or maltreatment. Possible indicators of this include;

- During an early scan the Mother needed to be re-scanned and was advised to go for a short walk. The Mother never returned; the Father excused the need to return due to the high number of appointments needed.
- Later in the pregnancy the Mother failed to attend scheduled appointments on a number of occasions. When contact was made by the Midwifery Service the Father always answered the phone and cited reasons such as inconvenience, needing to respond to housing issues and the Mother being unavailable. Concerns about these missed appointments were escalated to the Supervisor who also made attempts to engage the Mother; a similar response was given by the Father resulting in no further contact by either the Mother or Father.

- The birth of the children in a hotel placed them at significant risk, heightened by the delays in them going into hospital. The delays were due to the parents not calling the appropriate services and then them considering their options. During the delays both new born children became cold, which increased risk.
- The Father seeming to take a lead and direct professionals in the majority of interactions.

5.1.23. An alternative perspective has been put forward by Children's Social Care which counters the view about the control being exercised by the Father. Instead, it has been argued that it was easy to assume that the Mother was viewed as a victim within the relationship with there being evidence that the Mother was competent, exercised a level of control over the Father and found it difficult to contain her emotion and views. The Father's dominance has been viewed as a strategy for managing the Mother and helping her avoid getting into volatile arguments with professionals – and not a relationship where coercion and control may be present in the sense of wishing to cause harm. It is possible that the Father used a similar strategy when with Child A. Without concrete evidence to confirm the style and nature of the relationship between the Father and Mother it is important to be cautious about drawing conclusions. However, there is sufficient information to warrant a level of curiosity about the quality of their relationship. This was not picked up as an issue due to the inconsistency of practitioners outlined above and events being viewed in isolation. Information about this has only emerged as part of the ongoing case management. Research[24] confirms the impact of such dynamics and behaviours on family life *'… Coercive control reduces a victim's power to make decisions, which limits the ability to exercise independence … '.* This remains relevant from a safeguarding perspective as it can be viewed as a contributory factor when assessing the quality of parenting alongside the emotional impact on children of living with such dynamics. This is examined further in section 5.2. The Trust have noted that there was no evidence to indicate routine enquiry about domestic abuse. It is now mandatory practice in the Shrewsbury & Telford Hospital NHS Trust Maternity Services to ask about domestic abuse. The lack of safeguarding supervision has also been cited as a potential contributory factor for midwives not critically reflecting on the contact and involvement with the Mother and Father.

Learning point: 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.

5.1.24. Shropshire Clinical Commissioning Group, on behalf of the three GP Practices that the family were registered with during the timeframe under review have found that two of the three GPs the family were registered with had no concerns, noting that *'… clinicians were actively looking (in response to the flagging notice on the GP record) … three of her children, all look happy and well cared for (December 2014) … thriving … smiling baby (April 2015) …'*[25]. One GP appropriately raised concerns with Children's Social Care in March 2015 following the birth of Siblings 4 & 5 about the delays by the parents in seeking medical treatment. This referral prompted the Strategy discussion which concluded, by all attending, that the threshold for further intervention had not been reached. From a GP perspective there was no evidence to indicate persisting harm, and the concerns referred by one GP in March 2015 resulted in a multi-agency decision not to take further action.

5.1.25. Shropshire Community Health NHS Trust, responsible for the provision of community paediatrics, community public health nurses such as Health visiting and School Nursing, and therapists, have noted they had minimal contact

[24] McLeod, D., Coercive control: Impact on children and young people in the family environment, 2018, p.21, Research in Practice.

[25] Shropshire Clinical Commissioning Group, submission to the review.

with Child A and Siblings 1, 2 & 3. Their main involvement came once there had been a Strategy discussion in January 2018 prompting a health needs assessment to be conducted by the Health Visitor and School Nursing Service.

5.1.26. At Sibling 1's health needs assessment prior to the Initial Child Protection Conference in March 2018 concerns were raised about how she negatively described her brother, Child A, how she appeared to take on a caring role for her younger siblings, and self-harming. Following on from this assessment, and at further home visits which were gathering information to inform an assessment of neglect, it was found that Sibling 1 had no bedding and the bedroom was occupied by animals which were using pads on the floor to defecate and urinate on.

5.1.27. Sibling 2 also had a health needs assessment however at the appointment displayed selective mutism; concerns were raised about her emotional wellbeing however despite further assessment work being undertaken outside of this health needs assessment appointment no further issues of concern were identified. A home visit revealed Sibling 2 also did not have any bedding but did have a sleeping bag.

5.1.28. Sibling 3 had a health need assessment and no specific health needs were identified. Sibling 2 is noted to have commented on not liking her brother's behaviour towards her siblings, and that Sibling 1 did most of the cooking. No other concerns were recorded about Sibling 2.

5.1.29. Sibling 4 had a severe disability yet despite this was observed to have a very positive bond with the Mother. Sibling 4 often attended Nursery A wearing grubby clothes and concerns were expressed when she was removed from the Nursery as it was considered to be a positive experience for her and meeting her needs. Sibling 4 was not brought to a number of appointments for therapy e.g., occupational and physiotherapy. Despite this she was assessed as meeting developmental milestones, with the Trust reflecting *'… Sibling 4 achieved milestones which would lead to the belief that her developmental needs were being met at home. Missed appointments were followed as per Trust policy with further appointments offered being attended. So, whilst appointments were missed it was not consistent enough to trigger a safeguarding risk due to subsequent appointments being attended ...'*[26].

5.1.30. Sibling 5 was also seen, often alongside Sibling 4. No health concerns were recorded and there was noted to be a positive, healthy relationship with the Mother. During the later timeframe under review Sibling 5 was assisting in the care of her older brother, Child A.

Learning point: 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.

5.1.31. The contact with Child A prior to this by Shropshire Community Health NHS Trust was minimal because he did not attend a mainstream education provision from July 2015. During one home visit to gather information for the Education, Health & Care Planning process Child A was observed to be wearing clean clothes, have long greasy hair but otherwise seemed clean, being slim but not obviously underweight. Child A did not want any further examination, not wanting to be diagnosed with anything. Child A was not brought to a pre-arranged health needs assessment appointment prior to the Initial Child Protection Conference in March 2018 prompting a home visit. Information submitted describes concerns *'… there was concern raised at safeguarding supervision … that previous practitioners had been in the home and yet Child A was still living in squalid conditions urinating in a shampoo bottle and defecating on the floor resulting in an overpowering smell, concerns about his dirty clothing and not having his basic hygiene needs*

[26] Shropshire Community Health NHS Trust, submission to the review.

met in addition to the issues around his meals. The household had numerous animals that also urinated and defecated on pads left around the house including the children's bedrooms …'[27]*.*

5.1.32. Midlands Partnership NHS Foundation Trust, responsible for the provision of mental health services to children and adults were involved with Child A in 2004, and then again in 2007 regarding speech and language development, sensory, social skills and behavioural issues. Autistic Spectrum Disorder (ASD) traits were recognised however were inconclusive and the opportunity for a second opinion were never followed up locally by the parents (notably the Father). The issues were re-referred in 2012 due to behaviour problems, anxiety, obsessive and compulsive behaviours, eating problems and possible autism. It is unclear what the outcome of the assessments completed at the time was, however in 2014 no concerns were raised about Child A's presentation or distress at home during an appointment with a Psychiatrist. This view shifted over time with Child A being observed to be unkempt and dishevelled, with cuts on his wrist, in November 2014. Other concerns about emotional harm were noticed, which included; *' … the Father's focus on changing Child A so that he does not upset the Mother … Child A being scared stiff of his Mother who had mental health issues … Child A having attachment difficulties, not Asperger's … the Father disclosing marital problems and … arguments in front of Child A which caused him distress … the Father pushing professionals to record an ASD diagnosis in writing against Child A's express wish for this not to happen …*[with the practitioner feeling] *… that this was emotional abuse and an attempt to exert control within the family … Child A had indicated his distress by stating he would kill himself if a diagnosis was given in writing …'*[28]*.* Adult Mental Health Services identified the Mother as possibly being emotionally abused and that the whole family were vulnerable due to their housing and life situation. These identified issues were responded to in relative isolation and there was no consideration of sharing the concerns more widely with other agencies.

5.1.33. The Police received 27 reports during the timeframe under review raising concerns about the welfare of the children. These were all logged as 'no crime' incidents which meant that they were not reviewed by the Police's specialist Protecting Vulnerable People Unit. The issues reported included possible domestic incidents, shouting and screaming, Child A being alone in the car, the children being left unsupervised, chaotic lifestyle and animal related concerns, a request by School A to conduct a 'safe and well' check, and distressed crying. During one visit in July 2015 the house was observed to be tidy, the children looked well and no welfare concerns were identified. In February 2016 the Police were called out due to the children being left alone, the front door locked and the fire alarm sounding. This resulted in the Fire & Rescue Service being called to find an unattended pan on fire. The Father returned and explained he had only been gone for a short period of time. Although no damage was caused and the matter was referred to Children's Social Care, there was no follow up or investigation. From a Police perspective the following reflections by one Officer offer an insight into the reasons why it may not have been pursued from a criminal angle *'… it is an unusual situation … with six children spread over two flats, three of the girls were left in the flat temporarily while the father went to the other flat to check on the other children …'*[29]*.* This is further highlighted during another call-out in July 2017 when the Officer noted that the children were well fed, reasonably clean and apparently health, with the house noted to be *'… below the standard level of cleanliness to the average person, but was described that the 'parents were trying*

[27] Shropshire Community Health NHS Trust, submission to the review.

[28] Midlands Partnership Foundation Trust, submission to the review.

[29] West Mercia Police, submission to the review.

their best' …'. Both of these incidents reflect a level of sympathy for the parents who were viewed as in crisis and trying to do their best, a bias in assessment and decision making and limited insight into potential abuse or neglect.

5.1.34. Shropshire Early Help Service attempted to work with the family from December 2016 to May 2017 although the parents failed to engage in support offered; on this basis the case was closed. Despite efforts, the Support Worker did not meet any of the children or enter any of the properties the family were living in. The Support Worker met with the Father on one occasion but outside of the property at a local library. No further engagement occurred and the case was closed in May 2017. There were no openings created for the Early Help Service to see any of the children; their ability to recognise abuse, maltreatment and neglect was therefore non-existent. A further opportunity to work with the family arose from July to November 2017 by the Early Help Service; this was more effective at engaging professionals and to a degree, the family but remained limited.

Learning point: 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.

5.1.35. Shropshire Children's Social Care have considered their involvement and reflected that *'… a number of concerns were raised regarding the neglect and mistreatment of Child A, by professionals and members of the public during the time period of this review … Child A's presentation and behaviours were incorrectly attributed to his reported health conditions, including autism, and social factors, instead of the mistreatment by his parents. The parent's chaotic lifestyle, lack of suitable housing and varied engagement with professionals acted to mask the abuse and risk later identified … A section 47 investigation at an earlier stage, followed by a multi-agency child protection conference and child protection plan may have prevented significant harm to Child A, Sibling 1, 2, 3, 4 and 5 …'*[30].

5.1.36. A number of referrals were received in relation to this family, and responded to by a number of workers in Children's Social Care. The following findings have been made;

- In August 2014 a referral from Education Provision 2 was made following Child A sharing concerns about the Mother's aggressive behaviour. Following the family's eviction in January 2015 the Mother's extreme behaviour (threats of suicide) was considered as an isolated incident and not alongside the August 2014 referral citing aggressive behaviours. From a safeguarding perspective this is relevant as Child A witnessed both incidents which, more than likely, will have had an emotionally harmful impact. The response to convene a Strategy discussion by Children's Social Care was delayed. At the point of the Strategy discussion previous chronological information was not fully explored, including information about the eldest children potentially being subject to a Child Protection Plan whilst living in London (which remains an unknown despite good efforts to confirm this). This limited the quality and effectiveness of assessment and decision making. It also failed to acknowledge that Child A had been out of formal schooling for some time and there was no school oversight of Child A's progress, health or welfare.
- Following the birth, there was a delay of eight hours by the parents in seeking medical attention. A Strategy discussion was held and attended by Children's Social Care, Police, Health Visitor, and Midwife, a representative from Adult Safeguarding, Schools and Housing Options. All those attending unanimously agreed that the

[30] Shropshire Children's Social Care, submission to the review.

threshold for further enquires was not met with *'… the family were felt to be in a complex crisis situation and there was no evidence of significant harm on the children. The family had also fully engaged with Children's Social Care and the Police …'*[31].

- The lack of confirmed diagnosis or communication with CAMHS about Child A resulted in professionals relying on the Father's accounts. This was not triangulated and potentially masked any neglectful parenting.
- In February 2016 a fire was started whilst the family were living in split accommodation. The Mother had left one property and the siblings alone. For a period of time Child A had also been left alone whilst the Father checked on the siblings; this was the second time the children had been known to be left alone in the circumstances. No Strategy discussion was convened as a result of these incidents.
- Consideration of Siblings 1, 2, 3 & 4 acting in a caring capacity to Child A are missed altogether.

5.1.37. Reflections from some of the workers involved have highlighted a number of potential contributory factors to the issues identified above being missed. These include;

- The family were viewed as an 'alternative family' in as much as they had two disabled children, one of whom was being educated at home. The mother had been diagnosed with a learning difficulty and was from another European country and therefore had a different cultural background. These factors may have resulted in an acceptance of their 'differences' causing workers to not challenge standards and appear discriminatory.
- The Father was described as articulate and plausible in his explanations of events, would often take a lead in conversations and appear to have an explanation to every question raised. This had the impact of creating a level of optimism and confidence in what was being said.
- The parent's views of being let down by services became a strong narrative when interacting with professionals, leading to an acceptance that this became a truth, and which went unchallenged. The parents' capacity to confidently challenge the professional network effectively diverted attention away from the children.
- Child A had been described as having autistic spectrum disorder traits, attachment difficulties and speech and communication difficulties by CAMHS, and described by the Father as also having pathological demand avoidance syndrome. The use of diagnoses and labelling – whether accurate and confirmed or not – may have become a distraction from noticing and assessing Child A's actual day to day experiences.
- The family was viewed as victims of their circumstances, rather than instigators of it, which resulted in a degree of sympathy for their situation.

5.1.38. In considering the recognition of abuse, maltreatment and neglect in the circumstances set out above research[32] supports the view that *'… parenting a child with complex needs is, by definition, likely to be more complicated, more time consuming, less familiar, more anxiety provoking, physically harder and emotionally more difficult … knowing what is involved in a child's day to day care can powerfully operate on our expectations about what is good enough parenting. One possible consequence of realising the demands is a downward shift in our assessment standards, for example lowering expectations of what constitutes reasonable parenting …'.* This is important in this case given Child A's significant learning and psychological needs and Sibling 4's disabilities.

[31] Children's Social Care, submission to the review.

[32] Marchant, R., Making assessment work for children with complex needs, p. 208, in The Child's World, The comprehensive guide to assessing children in need, Edited by Horwath, J., 2nd Edition, 2010, Jessica Kingsley.

5.1.39. During the timeframe under review Child A was known to have multiple needs and vulnerabilities, Sibling 4 had significant needs from birth, and the Mother was diagnosed with a complex set of health needs. This cocktail of dynamics, when placed alongside caring for four other children, maintaining a household which included a large number of animals, and dealing with serious housing issues created a level of complexity and demand any competent adult and parent would be challenged by. Assessing this, from a professional perspective would also have required a level of experience and competence necessitating skilful coordination and collaboration.

5.1.40. Research[33] also confirms that disentangling multiple forms of abuse, when coupled with concerns about neglect can be hugely challenging for busy practitioners. Untangling concerns about neglect can be an important task when faced with an overwhelming number of potential contributory factors. Jones[34] describes one model for unpicking neglect which is particularly pertinent to this case. He identifies three types of neglect;

5.1.41. Firstly, passive neglect where *'… parents, often single parent mothers, are ground down and exhausted by previous and current circumstances … often in poor physical and mental health, with unpaid bills and … with little or no support from extended families … and had contact with multiple agencies, all of whom were demanding of their time and attention and experienced as harassing …'.* Evidence confirms the Mother was, at one point living by herself with five of the children, feeling overwhelmed by her circumstances but that she also, when living with the Father, commented to professionals about not getting any help from him; appointments were not kept, money was clearly an issue given the eviction, and sources of support were limited. Passive neglect can result in omissions in care.

5.1.42. Secondly, chaotic neglect where *'… parents may have had poor parenting experiences themselves and have little understanding of the needs of their children or how to parent well … they may have little tolerance and no routine … their children maybe left unsupervised and … they are not necessarily intentionally uncaring, and might fight hard for their children in disputes … but they lack awareness of the impact they are having on their children …'.* Evidence confirms that the parents' lifestyle was somewhat chaotic, that routines were lacking resulting in variable school attendance, finances were not managed, home routines were weak (or weakened by continual house moves) and that the Father was heavily advocating for Child A to have the correct diagnosis without thought about the impact on his day-to-day experiences.

5.1.43. Thirdly, active neglect may have been a feature in this case if we support the view about a level of control being exercised by the Father towards Child A, but also the Mother – irrespective of the motives behind this control. This type of neglect is *'… about anger and control … it is where a parents or parents turn on and scapegoat a child or children. … It might also be associated with domestic abuse and controlling behaviour towards the other parent …with no social class bias with socially powerful and well-connected people needing to be challenged and confronted …'.*

5.1.44. Passive neglect and chaotic neglect can be described as *'slow-burning'* forms of neglect which can be challenging for the professional network to effectively identify, assess and intervene. Research[35] has considered the challenges for professionals which has been set out above. It highlights the following relevant factors which contribute to making it harder for professionals to recognise the need for action, '… *The chronic nature of [neglect] can become*

[33] Marchant, R., Making assessment work for children with complex needs, p. 208, in The Child's World, The comprehensive guide to assessing children in need, Edited by Horwath, J., 2nd Edition, 2010, Jessica Kingsley.

[34] Jones, R., The conundrum of neglect, April 2016, p. 22, Professional Social Work, British Association of Social Workers.

[35] Brandon, M., Glaser, D., Maguire, S., McCrory, E., Lushey, C., & Ward, H., Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? November 2014, p.7, Department for Education.

habituated to how a child is presenting and fail to question a lack of progress … Unlike physical abuse … the experience of neglect rarely produces a crisis that demands immediate proactive, authoritative action … Neglect can in some cases be challenging to identify because of the need to look beyond individual parenting episodes and consider the persistence, frequency, enormity and pervasiveness of parenting behaviour which may make them harmful and abusive … There is a reluctance to pass judgements on patterns of parental behaviour particularly when deemed to be culturally embedded or when associated with social disadvantages such as poverty … The child may not experience neglect in isolation, but alongside other forms of abuse as multi-type maltreatment …'.

Learning point: 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.

5.1.45. In considering all of the information set out above, evidence submitted and discussions held it is clear that professionals from a range of agencies were alert to abuse, maltreatment and neglect and that, at times, it could have been judged as a feature in the children's lives. However, and importantly, accounts indicate fluctuating and often contrasting standards in how the siblings presented and the conditions of the home environment; making the persistence of neglect harder to evidence. This is indicative of a family that functioned within a grey threshold zone making the task of assessment and decision making a slippery issue to authoritatively respond to. The only persisting feature is the level of concern about Child A's appearance, behaviour and condition – which was recognised.

5.2. The quality & effectiveness of assessment, planning and intervention

5.2.1. Having identified above that there were indicators of abuse, maltreatment and neglect in respect of Child A yet often contrasting indicators in relation to Siblings 1, 2, 3, 4 & 5 it is important to explore the quality and effectiveness of any assessment work conducted, plans made and interventions. Statutory guidance[36] in place at the time stated that *' … local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families … [and] … to share information with other professionals to support early identification and assessment … in particular, be alert to the potential need for early help for a child who is disabled and has specific additional needs, has special educational needs, is a young carer … is in a family presenting challenges for the child … [and] … is showing early signs of abuse and/or neglect …'*.

5.2.2. The following assessments are noted:

- Social work assessment completed in December 2014 due to Child A's behaviours and the behaviour of the Mother. This resulted in the children being subject to Child in Need plans.
- Social work assessment completed in July 2015 due to Child A's access to education and the parents not engaging with professionals. This resulted in a decision that the children's needs could be met by universal services, the level of service was stepped down and Children's Social Care closed their involvement.
- Social work assessment completed in August 2015 in respect of Sibling 1. This resulted in a decision that the children's needs could continue to be met by universal services and that Children's Social Care would close the case. It is noted that the content of the August 2015 assessment report is exactly the same as the content of the July 2015 assessment report despite this being about different children.
- Social work assessment completed in November 2016 citing multiple concerns. This resulted in a decision that the family could be supported via an Early Help offer.

[36] Working together to safeguard children, p. 12, HM Government, March 2015.

- Assessment work completed by Midland Partnership Foundation Trust (CAMHS) with Child A over the timeframe under review.

5.2.3. In all of the above social work assessment reports information was sought from other sources and professionals, the provision of suitable housing was a persisting theme and Child A's behaviours and not being in school remained in focus. Issues connected to neglect are only really highlighted as being the main focus of concern in the December 2014 report and relate to Child A and concerns from CAMHS. The plan from this report identifies three goals; to re-house the family to permanent accommodation, all the children to be attending school and to consider respite care. The plan (or actions) makes no links to the referring concerns identified by CAMHS about Child A's dishevelled appearance, his experience of being bullied, possible self-harming by Child A, neglect and the parental non-engagement and missed appointments. The December 2014 report also makes clear reference to the need for a pre-birth assessment. This would have been an opportune time to consider undertaking a comprehensive multi-agency assessment, pre-birth. There is evidence that an early help assessment was considered but no evidence of a multi-agency pre-birth assessment being considered by the Shrewsbury & Telford Hospital NHS Trust Maternity Services or taken forward by Children's Social Care. Concerns were raised about the Mother's plans to give birth in a hotel which promoted a meeting to be convened. Invitations for this meeting in February 2015 were sent to the allocated Social Worker, the Supervisor of Midwives, the Community Midwife Manager and the Health Visitor; however, the Social Worker and Health Visitor did not attend. The outcome was to circulate the minutes of the meeting – which is an administrative task that had no impact. Overall, this was a significant lost opportunity for the multi-agency network to come together, evaluate the totality of the information and assess whether intervention was appropriate. The explanation provided is that the assessment work already completed was considered to provide a current and accurate evaluation of the family's circumstances and further assessment was not deemed necessary.

Learning point: 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

5.2.4. Records of Core group meetings which followed (at the time Shropshire Children's Services described multi-agency meetings for children subject to Child in Need processes as Core Groups) from July 2015 to July 2017 continue in the same vein and the only reference to Child A at-all comes in the March 2016 Core Group notes. This reflects a failure to consider Child A throughout this time period of all of the children being subject to a Child in Need plan, with the focus being on his siblings, despite the originating referral raising concerns about him. The reasons for this are that all professionals involved at this time knew the siblings but did not know Child A.

5.2.5. There is no evidence of any specific assessment tool being used to assist professionals identify abuse, maltreatment and neglect until the use of a Graded Care Profile 2[37] in May 2018 as a result of the children becoming subject to a Child Protection Plan. The Graded Care Profile 2 was introduced to Shropshire in December 2017 meaning that practitioners did not have a specific assessment tool available to use prior to this date. Having reviewed the social work assessments and Core Group notes it becomes apparent that neglect was not seen as the priority issue; therefore, using a specific assessment tool to assess neglect was viewed as unnecessary.

[37] The Graded Care Profile 2 is an assessment tool designed to support practitioners assess and identify neglect - Graded Care Profile 2

5.2.6. The social work assessment completed in November 2016 is a comprehensive and well-written piece of work that clearly demonstrates a thorough approach to the assessment task, yet the focus remains on housing and the challenges faced in finding a suitable education provision for Child A. It states *'… the children's basic needs are being met by both parents; both Mother and Father has displayed a good bond with their children in visits. The home conditions were clean and appropriate on home visits, there was food in the kitchen and the property was of an acceptable standard. All children had clean and dry bedding and their own bed … Schools have no concerns …'*[38]. On the basis of these findings the decision to close the case and step down to Early Help can be viewed as rationale.

5.2.7. One Early Help action plan has been located following this decision to step down, dated July 2017. The document template is not user-friendly and seems to provide a narrative account of relevant issues with actions being lost in the narrative. The gap in beginning Early Help work from the point of the decision to step-down up to the action plan created in July 2017 cannot be accounted for.

5.2.8. In reviewing information submitted from the Early Help Service, Midlands Partnership Foundation Trust, Children's Social Care and Shropshire Community Health NHS Trust, a number of barriers to conducting assessments have been highlighted;

- As a result of the house moves, the parents were living separately in two properties making it more difficult to engage both parents in any assessment process, and meaning it was unclear what the children's actual day to day arrangements were and what a plan for stabilising their care arrangements would look like.
- As a result of moving into new houses and different areas, new professionals often became involved resulting in a lack of continuity but also, as some practitioners have described, providing the parents with opportunities to 'start again' with a new set of professionals.
- Consent to conduct an assessment, at the Early Help level, had only been secured from the Mother yet all contact by the Family Support Worker was with the Father. The Father was reported as frequently creating barriers to working with the Support Worker and would often have a plausible response to questions raised. There was no consideration about whether there was any control being exercised over the Mother or the children, or the impact of this on their welfare. The Father essentially appeared to act as a gatekeeper to the family.
- Parental engagement was inconsistent throughout the whole time the Early Help Service were in contact with the family, and this was replicated with all other agencies. Access to the family home by some professionals was often denied by the Father.
- Following the birth of Siblings 4 & 5 the Mother was observed to be appropriately caring for the new born infants which may have had the effect of assuring hospital staff that any concerns were lessened. Although the Mother had low mood which was exacerbated by the housing crisis, the Social Worker offered reassurance that a house was available – again providing a level of comfort to mitigate any worries staff may have had.
- One Health Visitor has described attending one meeting where she felt like the lone voice expressing concerns about the home conditions and reflecting to herself *'… I must be wrong …'* and the consensus of the group over-riding her thinking.
- The Father was described by some professionals e.g., Learning & Skills Service and Midlands Partnership Foundation Trust, as intimidating and controlling and would make threats by saying how he had got people sacked and was viewed as having a reputation for complaining about professionals. He was described as well-informed, competent and manipulative of those agencies which he felt could be of benefit to him e.g., housing and CAMHS. It has been reported that he would often appear to inhibit or manipulate interactions e.g., being at all

[38] Children's Social Care, submission to the review.

appointments and speaking for the children, not accepting of professional opinion and delaying diagnoses when not getting the diagnosis he wanted by requesting second opinions, threatening to take legal action (and taking legal action), escalating issues to managers, speaking over the Mother and refusal to give consent to progress certain areas of assessment. This hampered assessment work. Although, and importantly, Shropshire Community Health NHS Trust and the Police reflected that their practitioners and officers did not feel intimidated by him.

- Child A's formal diagnosis by CAMHS during the time frame under review was Obsessive Compulsive Disorder (OCD) and anxiety. However, it has emerged following Child A coming into local authority care that this has been re-evaluated and that he has also been diagnosed with autism, gender disorder, anxiety issues, obsessive disorder and an eating disorder. The former diagnosis was not shared with the professional network because the Father had not given CAHMS permission to release this information. Clearly, this refusal to share a diagnosis which may have then supported Child A having access to appropriate support and services is at odds with the behaviour one might expect from a parent who wishes the best for them.

5.2.9. As a result of these barriers, the following practice issues have been captured;

- Child A was never seen by a professional from the Early Help Service because he was out of school and was not seen by other professionals in the same way as Siblings 1, 2, 3, 4 & 5 were. Any assessment work that was completed excluded Child A meaning that Child A was, effectively, invisible to the professional network until the Strategy discussion in February 2018.
- Supervision records from the Early Help Family Support worker are limited, lack analysis, reflection and clear direction. The frequency of supervision has also been noted to be not to the expected standards.
- Shropshire Community Health NHS Trust have reflected that at the time of the children becoming subject to a plan it felt like *'… being in a washing machine …, going round and round, over the same things with no progress despite practitioners repeated* [internal] *escalations ... to the safeguarding team …'*[39]. This has highlighted a need to review the effectiveness of the internal escalation process for Trust practitioners.
- The inconsistent parental engagement, but in particular the varying levels of commitment displayed by the Father have been described by many practitioners as disguised compliance[40]. The Learning & Skills Service, for example cited *'… the Father would initially agree to attend and or meet professionals then would contact them to cancel or re arrange. This made it very difficult to carry out assessments and interventions within preferred timescales and caused drift and delay …'.*
- The impact of bias and influence of group think on professional assessments and decision making. One example of this is the sympathy felt by some professionals towards the Mother given her circumstances. The downward shift in standards, referred to in 5.1.37. is a common symptom of bias and sympathy.
- The need to consider power and control in the family and the impact this might have on the children's welfare.
- The lack of consideration about Child A being the family scapegoat.

Learning point: 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.

[39] Shropshire Community Health NHS Trust, submission to the review.

[40] Disguised compliance has been described by Pearson, R., 2013, Guide to working with disguised compliance, Community Care On-line, as *'… patterns of 'closure' or 'flight' when families need to reduce their contact with the external world in an attempt to regain control by shutting out professionals. Often when professionals took a more controlling stance, this was defused by apparent co-operation of the family, the effect of which was to 'neutralise the professional's authority and return the relationship to … the previous status quo …'*, based on work by Reder, P., Duncan, S., & Gray, M., Beyond blame: Child abuse tragedies revisited, 1983, Routledge.

Learning point: 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.

Learning point: 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.

Learning point: When faced with one parent who appears to take control it is important to explore the impact of this behaviour on children. Research[41] 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 …'.*

Learning point: 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.

Learning point: 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.

5.2.10. School C were aware of Sibling 1's self-harming behaviours at the point she joined the school in September 2017 as the family were thought to be engaged in the Early Help process. However, the parents had, in fact, failed to engage in this process and it created a false sense of assurance that the family were some-how participating and benefitting from some oversight. Nonetheless, the school responded appropriately to the presenting issues for Sibling 1 monitoring her behaviour, attendance and presentation. Pastoral support was immediately offered to Sibling 1, a referral was made to the School Nursing Service and the school participated in Early Help meetings.

5.2.11. Regulatory Services completed assessments based on their regulatory responsibilities. Having reviewed their involvement, they have been judged as proportionate and in line with expected procedures. Information was shared in a timely manner with the FPOC between 2016 and 2018. Regulatory Services attended and contributed fully in multi-agency meetings, for example, in November 2016 and March 2018, and have reflected, *'… Investigating officers sent correspondence to the Safeguarding team by email asking if it would be useful for Regulatory Services to investigate further the use of powers conferred under the Public Health Act 1936 … No response was received. No information was provided at any time from other agencies to suggest a warrant would be granted for Regulatory Services to enter the property. No other service came forward asking for assessment under the above Act when they had any programmed visit to the property. Analysis of the case suggests that officers attempted to move this agenda*

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

forward and provided opportunity for other agencies to feed in information which may have led to a different conclusion occurring but had no response. With no information coming forward the decision not to carry out work to gain a warrant to enter the … property … was considered appropriate ...'[42].

5.2.12. Shropshire Community Health NHS Trust have reflected that Siblings 1, 2 & 3 received appropriate support services from their services at a universal level, however it was not until the use of the Graded Care Profile 2 tool was used was it possible to evidence their unmet needs and neglect. Due to the level of need, Sibling 4 was seen by multiple professionals with evidence based developmental tools being used, such as the Ages & Stages questionnaire[43], physiotherapy assessment tools and paediatric review. Sibling 5 was assessed in a similar manner.

5.2.13. However, there is learning from the Trust on these assessments in some appointments were not attended, or there was a delay in appointments being attended, such as Sibling 5's two-year review being six months overdue. Whilst these were known about at an individual service level there was no oversight of all missed appointments.

Learning point: 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[44].

5.2.14. Children's Social Care have examined the quality and effectiveness of assessments conducted in December 2014 and reflected many of the issues already identified above, noting that a more comprehensive assessment could have been considered at an earlier stage of their involvement.

5.2.15. The later assessment completed by Children's Social Care in November 2016 *'… did consider the allegations made by neighbours to be possibly malicious and that the parents had been described as being targeted by neighbours. No concerns were raised regarding the basic care of the children and as it was felt that the family's needs were focused on housing, no role was identified for children's services ... The social worker was innovative in gathering the children's wishes and feelings, seeing them alone and ensuring that their voice was heard. However, there was not full exploration of the allegations of neglect for Child A, or the impact of the family's lifestyle on all children …'.* Following the referral by the Ambulance Service in January 2018 *'… a section 47 assessment was completed … This was a more thorough assessment than previous assessments, which considered historical concerns for Child A and his siblings; the children were seen alone and able to clearly express their wishes and feelings and appropriately identified abuse for Child A and some recognition of abuse for Sibling 1, 2, 3, 4 & 5. Prior to this assessment-taking place, all relevant information had not been pulled together and analysed appropriately. However, the assessment is mainly focused on Child A, with little information gained on the siblings ... At this point it is noted that professionals had not raised concerns with regards to the presentation of Child A's siblings …'*[45].

5.2.16. From reviewing the above accounts from agencies, a number of practice issues become apparent;

[42] Regulatory Services, submission to the review.

[43] Ages & Stages questionnaires are screening tools designed to assess developmental needs in children.

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

[45] Shropshire Children's Social Care, submission to the review.

- Concerns that were raised by neighbours in September and November 2015, January 2016 and April 2016 were not discussed or explored with the parents or in Core group meetings.
- Despite assessment work being completed at Child in Need level, there is no evidence of intervention which had an impact until the acute episode resulting in the children to become subject to a Child Protection Plan.
- Records support a view that the parents shifted the focus away from the children to housing issues many times.
- The Father's account of Child A's diagnosis, plus Siblings 2 & 3 having autistic traits, and the Mother having Asperger's Syndrome, is never challenged or triangulated by contacting other agencies. This is not confirmed until the Review Child Protection Conference in May 2018.
- Historical information, captured in chronologies, is not used to inform assessments and decision making.
- The value of using a standardised risk assessment tool to gather information and evidence neglect.

Learning point: 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.

5.2.17. From a Police perspective, given their 27 call-outs to the family for child welfare related issues they acknowledge that there was inconsistent curiosity by Officers about the underlying reasons for some of the issues being reported, and that many of the concerns were taken at face value. This is evidenced by some 'no crime' reports or incidents being labelled as' anti-social behaviour'. As their specialist Protecting Vulnerable People Unit did not have oversight of these incidents it reduced the impact of Police involvement and failed to provide an alternative perspective to the cumulative impact of the incidents attended. Although a Risk Management Plan was put in place this did not happen until January 2018 it was not used to best effect and did not link to previous incidents.

5.3. Opportunities to hear, and understand, the daily lived experiences of the children in the household

5.3.1. Statutory guidance[46] in place at the time stated *'… Every assessment should be child centred … every assessment must be informed by the views of the child as well as the family … Children should, wherever possible, be seen alone … and every assessment should reflect the unique characteristics of the child within their family and community context …'*. Agencies involved with the children and family have reflected on their opportunities to hear, and understand, the lived experiences of the children.

5.3.2. Information provided in section 5.1 from the schools' perspective clearly shows that Siblings 1, 2 & 3 were able to apply themselves to the school environment and form friendships. Whilst School E expressed some concerns about all three Siblings, Schools A, B & D did not have similar worries. The schools were well placed to see, hear and understand the children's daily lived experiences and information submitted clearly indicates that they achieved this. School C has confirmed that Sibling 1 was provided with 1:1 pastoral support and encouraged to express her wishes and feelings; these were reported back to the Early Help and Child in Need meetings and was child focused.

Learning point: 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.

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

5.3.3. The children were not spoken to by any of the RSPCA Inspectors and were only ever seen in either a pram or the Mother's arms. The conditions of the properties were never judged to be of concern regarding the children's welfare. When Housing Options undertook home visits Siblings 1, 2 & 3 were at school; records make no reference to Siblings 4 & 5. Child A, whilst in the house, would not be present in the room when the Support Officer visited. From the Regulatory Services perspective Officers had no direct contact with the children and no children were seen, or spoken with, when carrying out monitoring visits. From these three services it would not be unusual for staff not to see children during the course of them conducting their business.

5.3.4. From the Police perspective, Child A was spoken with by an Officer in May 2016 following a call-out. No specific concerns were noted during this interaction. Child A was seen again by Officers during further visits, but again, no specific child protection concerns were observed.

5.3.5. Early Help Services have reflected that *'… opportunities for the Family Support Worker allocated to this case to hear, and understand, the daily lived experiences of the children in the household were significantly limited as the family did not engage with the support offered. The Family Support Worker did not enter any of the properties occupied by the family to enable an assessment of the home conditions to take place and for an understanding to be obtained of what impact the home conditions were having on the children. At no point is it recorded in case notes that the … Worker attempted to make professional contact with the schools that the children attended, health professionals (including CAMHS) who were involved with the children or any other professionals or agencies, such as Public Protection, Housing or Library staff, all of whom attended the ASBRAC meeting in November 2016, and may have been able to provide an insight into the children's lives. … [the worker] could offer no additional information around any partnership working or explanation for why this was not undertaken ...'.*

5.3.6. This is in contrast to the later involvement of the Early Help Service in July 2017 where there is evidenced contact with other agencies who had been involved with the family in an attempt to explore the children's lived experience. Information was also provided via a neighbour who was concerned about the children's welfare. This information was utilised to support the Early Help multi-agency plan cited above in July 2017. The practitioner briefly met with Siblings 2, 3, 4 & 5 and provided an opportunity to observe their interactions; siblings 4 & 5 were described as *'... smiley and happy and interacting with the others around the table, appearing curious and exploratory …'*[47]. However, there is no evidence to indicate that any direct work with any of the children was completed and there is no evidence to indicate the children were invited to attend or contribute to Early Help meetings or the Early Help plan; this was due to the Father's control of access to the children.

5.3.7. The Learning & Skills Service have examined their contact with Child A and the Father, noting that one Educational Psychologist was able to build a relationship with Child A for a period of time until 2016. At this time the Educational Psychologist was more probing in his questions of the Father's intention to home educate Child A the Father requested a new Educational Psychologist to be allocated. This resulted in the relationship between the Educational Psychologist and Child A ending. The Father's wish for a new Educational Psychologist has now been viewed, with the benefit of hindsight, as a diversionary tactic. Child A was seen at home by four professionals from the Learning & Skills Service during the timeframe under review. The view of the four professionals was however consistent in that they saw no evidence of abuse although interactions between the Father and the children was noted to be transactional, compliant and cold.

[47] Early Help Services, submission to the review.

5.3.8. The Shrewsbury & Telford Hospital NHS Trust Maternity Services have noted that during the pregnancy Midwives have limited contact with the siblings, but have reflected that *'… When considering the lived experience of the siblings, they had three house moves in a very short space of time; they were living in cramped accommodation without cooking facilities, dining in the hotel restaurants. They had lost most of their personal belongings when they were evicted, they were put in a taxi daily to go to school, the sibling with learning difficulties was being schooled at home … The household had the potential for being very chaotic and the stress that the parents were experiencing would have had some impact on the psychological wellbeing of the other children … In terms of the opportunities to understand the lived experience of the twins in utero, Mother did attend most of her antenatal appointments so Mother and Babies were monitored however, some of the reasons given by father for not attending appointments were questionable and the … [the birth in the hotel was] … against medical and children's services advice placed the babies at significant risk of harm ...'*[48].

5.3.9. During the latter part of the time-frame under review the Health Visitors completed home visits and were able to see what life was like for Child A noting his bedroom to be in a *'… squalid state with minimal belongs. On both home visits Child A was wearing the same soiled clothing and the smell in the room was acrid. Child A communicated with [the Health Visitor] mostly by nods and minimal sounds but was able to make clear responses to questions. … [the Health Visitors were so concerned they] … escalated their concerns via the safeguarding team as they felt the social worker was not responding to the concerns they raised …'*[49]. They have also reported that the family were openly critical about Child A and him being the source of many of the family's problems however this information is not then used to inform assessments and decision making.

5.3.10. Midlands Partnership Foundation Trust have reflected that opportunities were limited to understand Child A's lived experiences as he was always accompanied by the Father during meetings with Psychiatrists. In these meetings the Father was described as controlling and dominating sessions making it hard for Child A to offer a different perspective. During a meeting with one member of staff Child A was able to express his view about having a diagnosis of ASD and it causing him distress.

5.3.11. Further examples of where professionals heard, and listened to the children's daily lived experience include;

- During the health needs assessment and assessment work using the Graded Care Profile 2, for Sibling 1, 2 & 3 during which information emerged about Sibling 1 doing most of the cooking, self-harming and life outside of school. Sibling 1's bedroom was seen during a home visit in 2018 where it was noted that she had no bedding and the dogs were using pads to urinate on. Sibling 3 was able to voice her concern about Sibling 5 doing tasks for Child A i.e. take him food, and that her friends often did not believe things she said. Creative assessment tools were used to elicit responses from Sibling 2 to support her expressing her feelings given her selective mutism. Opportunities to gain Sibling 4's perspective were limited by her young age however examples of interactions and experience are noted, including those from the Nursery where *'… she looked at mum a lot … the girls responded to mum very warmly, very genuine … she played with the girls' normal interactions ...'*.
- Shropshire Children's Social Care have reflected that reviewing their records and conversations with workers that *'… it is of concern that Child A was not able to establish a trusting relationship with any individual throughout the time period of this review, to express his wishes and feelings. His parents were able to utilise their parental control to disconnect Child A from professionals to whom he began to express concerns to in 2014. Child A was also not*

[48] The Shrewsbury & Telford Hospital NHS Trust Maternity Services, submission to the review.

[49] Shropshire Community Health, submission to the review.

represented at multi-agency core groups meetings, which meant that his views could not be represented by any professional …'.

5.4. The quality and effectiveness of multi-agency working

5.4.1. Statutory guidance[50] in place at the time stated *'… No single professional can have a full picture of a child's needs and circumstances and, if children and families ae to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action* …[and] … *The assessment of neglect cases can be difficult. Neglect can fluctuate both in level and duration. A child's welfare can, for example, improve following input from services or a change in circumstances and review, but then deteriorate once support is removed. Professionals should be wary of being too optimistic …'*.

5.4.2. Information presented so far has revealed that, at the time, individual agencies had differing perspectives about the standards of care given to Siblings 1, 2, 3, 4 & 5 for the whole timeframe under review, where-as the concerns about Child A were more even and consistent.

5.4.3. From a system thinking the concept of emergence[51] is relevant. Emergence is a key property of complex systems – of which the multi-agency child protection is one. The strength of a complex and self-organising system can often be tested against its ability to respond to emerging issues which cannot be controlled, predicted or easily managed. Emergence as a concept is therefore relevant as it allows us, often with the benefit of hindsight, to better examine system weaknesses – rather than purely concentrating on the efforts, or errors, of individual practitioners. Research[52] notes the impact of negative emergent practice in children's services stating '*… a danger that can arise in such situations is cultural normalisation and professional desensitisation. This maybe a very appropriate coping mechanism by professionals overwhelmed by the volume and complexity of their task, but can result in vulnerable children being left without adequate assessment of their needs'.* The challenge for the multi-agency system in this case was to meaningfully join together and respond to the situation at a time when the standards of care for the children hovered in a grey and slippery threshold zone. The clear weight of evidence in existence from individual agencies about the poor standards of care for Child A, especially given his non-attendance at an educational provision, was not seen as the catalyst for this happening. The inability of the multi-agency network to come together prior to the acute episode in January 2018 therefore warrants further examination.

5.4.5. Some agencies had a consistent interest in this family due to the volume and frequency of information being passed, or available, to them; this included the RSPCA, Regulatory Services, and Housing Options. These agencies held contextual information that was highly relevant from a child welfare and safeguarding perspective. Contextual safeguarding, in the broadest sense relates to wider environmental factors that may be present in a child's life that may impact on safety and welfare. Information held by Regulatory Services and Housing Options was provided to Children's Social Care on an ongoing basis; information from the RSPCA about the totality of their contact with the household was not known about until January 2018. Children's Social Care have confirmed that it was not until February 2018 that the totality of information held by all agencies began to emerge.

[50] Working together to safeguard Children, 2015, p. 9 & 26, HM Government.

[51] Seel, R., Emergence in organisations, 2006.

[52] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, p. 149, University of Warwick & University of East Anglia, May 2016

5.4.6. The RSPCA worked with the Police, when necessary to do so. As already stated though, no child welfare concerns were noted during the RSPCA visits so at the time, this was a proportionate and rational approach to take.

5.4.7. Regulatory Services have reflected valuable insights from their involvement in terms of the quality and effectiveness of multi-agency arrangements and sharing information, *'… multi-agency forums were attended by Regulatory Services and relevant information relayed in respect of child welfare concerns to other agencies through agreed pathways including FPOC referrals and email to officers. The FPOC referral route has been highlighted by officers as problematic in that it is cumbersome to pass on information through this route every time information comes to light. Regulatory Service officers had direct access to a safeguarding officer to pass on information to ensure that communications were maintained. This is considered a very positive factor in this case. Residents complaining about the family did not have direct access to an officer. They were required to pass on information through FPOC every time they had information. There is no feedback loop to individuals who make FPOC referrals to inform them of the use of the information provided, level of detail given (too much or too little), worth of evidence etc. The residents informed Regulatory Services officers that they did not find FPOC referral useful. They continued to pass on information to Regulatory Services who passed on relevant information to a safeguarding officer ... should Regulatory Services not have had ongoing involvement there could have been a situation where relevant information stopped coming in to the relevant service for safeguarding due to residents on the ground finding the FPOC referral route unsatisfactory. Residents' concerns of the FPOC referral route were that they did not know if they should refer after every individual concern or sum up a period of time, if the level of detail was sufficient, if the information provided was useful, if they were sending too much information or not enough. They felt like this as there is no feedback to the reporter. Analysis of the complaint and reports from residents and officers suggests that a learning point may be to consider FPOC referrals and if improvements could be made … Having reviewed the case and actions from the meetings it is noted that follow up actions were carried out. However, the actions could be considered to lose sight of the biggest risk factor which was concern over child safeguarding. Analysis of the actions that came out of multi-agency discussions may suggest that a lead officer from the service where the greatest risk lay may have been appropriate at these forums …'*[53].

5.4.8. Other services involvement was consistent and continual i.e. schools, the Learning & Skills Service and Midlands Partnership Foundation Trust. For these services it is clear that there were a number of distractions.

5.4.9. As discussed above in section 5.1 during the more recent timeframe under review, Schools portrayed a relatively acceptable picture about the welfare of the siblings, taking action to remedy pastoral concerns when necessary. They were involved in Early Help support and were not aware of Child A's circumstances.

5.4.10. From the perspective of Midlands Partnership Foundation Trust had relatively consistent contact with Child A concerning his mental health over a period of many years. This Service was well placed to gain insights into the quality of the relationship between Child A and the Father, as well as wider family functioning. However, the style of engagement the Father adopted with mental health professionals was problematic. Engagement was inconsistent with appointments being cancelled or not attended, medication for Child A was used erratically with the Father stating that symptoms had changed. Having initially requested an assessment of Child A being on the autistic spectrum, the Father then delayed returning assessment questionnaires resulting in drift to securing a diagnosis. The Father did not accept the opinion of mental health professionals and made threats to take legal action of certain actions were not taken, he escalated his concern to managers and demanded changes in workers seeing Child A. Alongside this, the Service

[53] Regulatory Services, submission to the review.

experienced challenges with staff changes as a result of staff turnover; this resulted in Child A seeing six different Psychiatrists between August 2014 and May 2018, four of which were between June 2015 and May 2016. This significantly impacted on the ability of the Service to provide continuity but also track, and learn to manage, the Father's style of engagement. At the time there was a considerable waiting list of five months for therapy for Child A, and the Service did not have a clinical psychology resource which limited a wider exploration of family dynamics. It is arguable that all of these factors, or problematic emergent dynamics, distracted the Service from focusing on the safeguarding aspects of their involvement with this family, and resulted in them working in a relatively insular manner, not sharing the information with a wider professional audience to sense check what else might be happening.

5.4.11. The Learning & Skills Service experienced a similar set of potential distractions as outlined above, particularly in respect of the Father's style of engagement and attitude. This was exacerbated when legal action was taken in connection to unauthorised absence in 2017.

5.4.12. The impact of these distractions for the Learning & Skills Service and Midlands Partnership Foundation Trust appears to have been one of stepping back from engagement with the wider network of agencies that could have been involved with the family, and working in relative isolation. Consequently, this meant that information about Child A was not shared; they did not come forward with information, and they were not approached either.

5.4.13. Calder[54] considers challenges for practice when working across a multi-agency safeguarding system, noting barriers and blocks to identifying and managing risk as being a key factor. He notes that *'… the decoy of dual pathology; information may be missed if the receiver is decoyed by a different problem; it is difficult keeping an eye on several issues at the same time …* [and] *… focusing on just one problem and missing the oblique one that's more important …*'. Both of these barriers, or blocks, are pertinent to this case given the level of control, authority and distraction exhibited by the Father to the majority of the professional network but especially the Learning & Skills Service and Midlands Partnership Foundation Trust.

5.4.14. When coupled with other human factors that have emerged through this review about the way some professionals viewed the family situation, such as over-optimism about the ability to sustain improved standards of cleanliness in the house, and sympathy bias often displayed towards the Mother by some professionals, it is possible to begin to appreciate how the response by the multi-agency network was fragmented and faltered. The bias that the family were overwhelmed with the housing situation and having to transport the siblings to different schools, whilst valid as a factor that had to be considered, was self-confirming for those professionals involved every time the family moved. Evidence that might have supported another view point i.e. that Child A was actively being neglected and harmed as a result of the family dysfunction, was discounted up until May 2018.

Learning point: 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.

Learning point: 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

[54] Calder, M., Risk in child protection: Assessment challenges & framework for practice, p.96, 2016, Jessica Kingsley.

safeguarding perspective but also from an organisational, system perspective so as to avoid fragmentation and silo working.

5.4.15. The above factors go some way to account for the response by other services', who's involvement ebbed i.e. Early Help, Children's Social Care, and community health services. These services were never seeing the full extent of concern and information and it was not until early 2018 that information meaningfully collided that it was possible to develop a coherent multi-agency response. One factor that appears to have contributed to this is an assumption by the Early Help Service workers that Children's Social Care Social Workers had access to the Early Help information database, and could therefore see, the recordings about the family; this was not the case.

5.4.16. Coordination and information sharing are themes that have emerged and reflective of a fragmented information exchange process; some agencies were not approached therefore those agencies also did not think to share. Shropshire Community Health NHS Trust have reflected their view that joint working with Children's Social Care was poor up until the acute episode in 2018. The Trust practitioners escalated their concerns on a number of occasions. On one occasion it was noted that following an escalation attempt a Social Worker had stated that Child A *'… was safe in his room and would be more of a risk if he wasn't in his room. The father had said that Child A was 'so damaged' and the trauma we would cause him if he was removed from the home would be even more detrimental to his wellbeing …'*[55]. Another example cited was there being a gap of four months between core groups in 2016 where there was no communication between health staff by social workers despite messages being sent; when a core group meeting was called, health workers were not invited.

5.4.17. The Learning & Skills Service have identified that there was evidence of effective communication and joint working between services within their own service e.g., between the Education Access Service (EAS) Engagement Officer and Special Educational Needs Caseworkers, there were gaps in communications between other services. Two examples of this are firstly; in June 2015 the EAS Service Manager attending a legal planning meeting, chaired by Children's Social Care, whereby it was identified that there was a role for including workers from the EAS in all future Child in Need meetings and that this should be an urgent action. Additionally, the Learning & Skills Service have no records of any Child in Need meetings held from 2015 indicating that although not attending the meetings they were also not provided with information, and secondly; the EAS Engagement Officer was not formally invited to the January 2018 Strategy discussion despite the Service holding significant information. It has not been possible to find a reason for these omissions.

5.4.18. Housing Options have reflected that they initially attended Child in Need meetings which were established in 2015 but following the change of a Social Worker they were no longer invited. Again, it has not been possible to find a reason for this omission.

5.4.19. The Shrewsbury & Telford Hospital NHS Trust Maternity Service have reflected that they were unclear when Children's Social Care first became involved with the family, only becoming aware at the point the family were evicted in early 2015 and they were invited to the Strategy meeting. A community Midwife attended the Strategy Meeting and a different Community Midwife attended the subsequent Child in Need meetings. Positively, obstetric risks and midwifery information was shared with another local area Maternity Service in case the parents decided to attend another hospital for the birth.

[55] Shropshire Community Health NHS Trust, submission to the review.

5.4.20. The Early Help Service have considered their involvement and noted that multi-agency working arrangements as being ineffective because the Family Support worker failed to make contact with other professionals known to be involved with the family. The reason given for this points to perceived limitations of the role, working in relative isolation despite the availability of the Social Worker who had been involved with the family to discuss the case, and the lack of robust management guidance and oversight on case management. The involvement of the Strengthening Families Locality Development Officer in November 2016 appears to have been a positive step in terms of attempts to focus intervention however due to problems with the allocation and case management processes at this time the potential for impact was lost, with seven months passing between another Family Support Worker being allocated and the first meeting being held. This significant delay in coordinated support being delivered was a missed opportunity to gain an entry into better understanding the daily experiences of the children, especially given that during this timeframe there was a house move, change of schools and attendance problems, change of friendship groups for the children and challenges accessing health services.

6. Identified good practice

6.1. This review has identified a number of areas which can be highlighted as good practice. It is important that good practice is recognised and shared. Examples include;

- Midlands Partnership Foundation Trust have highlighted that Child A's non-attendance at therapy sessions was followed up by phone calls to ascertain what was happening. Additionally, the therapist took the case to a multi-disciplinary discussion slot to gain ideas about how to meet Child A's needs and engage with the family.
- Midlands Partnership Foundation Trust's response to Child A to not have his diagnosis of ASD in writing. Child A's wishes were respected as he was deemed competent and the implications of this were explained.
- The Learning & Skills Service's tenacity and attempts to providing Child A with opportunities to attend educational establishments and engage the parents in the process. The use of legal routes to deal with non-school attendance despite the intimidation from the Father.
- The recording, handover of information, and use of meetings (vulnerable family meetings) by the GP Practices.
- The response by Children's Social Care at the point of holding the Initial Child Protection Conference and the subsequent case management arrangements.
- The use of recording equipment by Regulatory Services to capture valuable insights in the Mother and Father's behaviour and the impact of noise on neighbours.
- The recognition of potential safeguarding issues by Regulatory Services and using additional resources by the Service given the accumulating concerns expressed by neighbours.
- The flexibility and vigilance offered by the Shrewsbury & Telford Hospital NHS Trust maternity services to the Mother during the pregnancy.
- The use of the Graded Care Profile 2 assessment tool by practitioners from Shropshire Community Health NHS Trust which enabled an evidenced based assessment of the children's care and welfare.
- The use of safeguarding supervision and escalation by practitioners from Shropshire Community Health NHS Trust, and their home visiting to aid assessment work.
- The level of curiosity exercised by the Police and insisting to the Father that the children were spoken with alone, and seeing the children's bedrooms.
- The recognition and response by West Midlands Ambulance Service crew by identifying safeguarding concerns, which prompted the pathway to protection for all the children in 2018.

- The prompt actions by School D contacting the Education Welfare Service when Sibling 1's attendance at school dropped.
- The identification of concerns, and response to the children's situation by School E.
- The contributions by School A's Social Inclusion Manager to monitoring the siblings attendance and following up on non-attendance with 'safe and well' checks.
- The tenacity and commitment by the Social Worker prior to the Initial Child Protection Conference, and then work following in taking the case forward and through the Court process.

7. Conclusions

7.1. This review has considered the circumstances of professional contact and involvement with six children, aged between 2½ years to 16½ years who experienced varying levels of neglect and maltreatment. Of note, the eldest child experienced the greatest level of neglect, abuse and maltreatment and ultimately resulted in him being removed into local authority care for a period of time. The remaining five children left the country with their mother before removal into care became possible.

7.2. The review has benefitted from the input of practitioners and managers involved at the time from across the safeguarding partnership. It has also received information from all single agencies involved with the children. Good efforts were made to seek the contributions of both parents. The Father was able to contribute via a phone call with the Independent Reviewer but it was not possible to gain the Mother's perspective due to being out of the country.

7.3. The decision to conduct this review was taken because there were concerns about the way in which agencies had worked together and that they had failed to respond to the needs of the children and that abuse or neglect was known about, or suspected. The review has examined four areas of interest to the safeguarding partnership, namely the recognition of abuse, maltreatment and neglect; the quality and effectiveness of assessment, planning and intervention; opportunities for the professional network to capture the children's daily experiences, and; the quality and effectiveness of multi-agency working.

7.4. The review has exposed and captured a number challenges and dilemmas encountered by professionals involved. These include; effectively tracking and monitoring standards of care for children who frequently move location and the professional trap of starting afresh with assessment work; the ease at which children who are removed from formal school education can become less visible to the professional network and welfare concerns becoming lost; the power and influence parents can exert over professionals resulting in distractions and diversions away from thinking about children's safety and welfare; the human contribution to working with families where there are elements of resistance, non-engagement and false compliance, but also professional bias which unwittingly diverts attention away from fully considering the children's welfare. These issues carried particular weight when combined, especially so when any concerns that professionals may have had did not appear to be persistent. As is frequently the case in such situations, it was not until an acute episode had occurred that the professional response became more robust and authoritative. In this case, the paralysing and desensitising effect on workers of dealing with the dynamics and dysfunction of the family's own lifestyle significantly impacted on why the professional response – over time – was not as robust as it might have been.

7.5. The review has captured a number of learning points for frontline practitioners, managers and trainers; the findings and learning from this review should be widely distributed to all relevant professionals across the local area. The report concludes with recommendations.

8. 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. It is the role and responsibility of the Safeguarding Partnership to scrutinise and challenge progress against single agency action plans. 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.