Learning Lessons Briefing

Serious Case Review

In respect of Family ‘E’

Background

Family ‘E’ were well known to agencies and had first come to the attention of Children’s Social Care in 2006. The children were subject to a range of interventions including child protection plans, Child In need and support from early help services. The children were accommodated in 2014 following concerns that the youngest child had a non-accidental injury. The subsequent child protection investigation exposed the neglect the children had been subject to for which Father was given a prison sentence. Mother died in the autumn of 2014 from alcohol related conditions.

Please go to [www.wolverhamptonsafeguarding.org.uk](http://www.wolverhamptonsafeguarding.org.uk) for the full overview report, the integrated single agency action and the WSCB action plan.

This briefing is to inform how changes can be made within professional practice across all organisations to ensure effective safeguarding for the children of Wolverhampton.

Theme 1

There was a large, complex professional network, working with a large, complex family. The amount of professional involvement brought its own difficulties, including a lack of a unified view of the risks children were exposed to, difficulties in ensuring that all parts of the network were working in a cohesive way and that information was shared effectively.

Recommendations:

- Systems and procedures that exist to support practitioners in working such cases must be effective.
- Essential to keep the focus on the children despite parents at times being needy in their own right.
- ‘Think family’ approach must be embedded to ensure there is a joined up approach.
Theme 2

The neglect the children were exposed to was not effectively addressed.

**Recommendations:**

- Workers need to be aware of the **multi-faceted risk** to children caused by neglect.
- Practitioners need to be mindful of the risk that there may be ‘disguised compliance’.
- Practitioners should reflect on their **tolerance of neglect** when working in areas of high deprivation.
- Decision making must be made on an assessment of **cumulative risk of harm** as well as need.

Theme 3

The quality of plans (Child protection, Child in Need, CAF), were not SMART (specific, measurable, achievable, realistic and timely), and were superficial, addressing the symptoms but not the underlying cause of the family’s difficulties.

**Recommendations:**

- **All plans** must be SMART
- Plans must be focused on **what needs to change**.
- All professionals involved are accountable for the Plan and its progression

Theme 4

Inter-agency work was compromised by several factors:

- Poor attendance at child protection conferences and core group meetings.
- Not all meetings resulted in notes or minutes.
- Lack of clarity within the network about the threshold for specialist services.

**Recommendations:**

- Agencies and individuals must be aware of their **roles and responsibilities** for multi-agency working.
- Agencies and individuals need to ‘**own**’ and **share** the responsibility to action the child protection plans.
- Individuals are to **access** the WSCB Thresholds of support to Children and families in Wolverhampton guidance and the Escalation Policy –
seeking support from their agencies safeguarding leads for advice and support.

- All agencies are equally responsible for ensuring that the meetings are both attended and minutes are taken and distributed.

Theme 5

Members of the family were not seen as individuals. Children were seen as a composite group.

Recommendations:

- Consideration must be given to the role of both parents and their relationship with each other as well as the children.
- Staff need to have the time and the skills to get to know the children they are working with as individuals.
- There must be an understanding of the relationships with each member of the family, how each family member impacts on the others (including extended family).
- Need to think about the possible impact of a concern about one family member on the whole family in the house hold.