SERIOUS CASE REVIEW
USING THE SIGNIFICANT INCIDENT LEARNING PROCESS
OF THE CIRCUMSTANCES OF THE
FAMILY 'E'

FINAL REPORT

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1. Introduction to the Significant Incident Learning Process (SILP)

SILP is a learning model which engages front line staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in Working Together to Safeguard Children published in March 2015.

1.1 The SILP model of review adheres to the principles of

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

1.2 SILPs are characterised by a large number of practitioners, managers and safeguarding leads coming together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the overview report, and to contribute to the learning and conclusions of the review.

1.3 Working Together 2015 states that Serious Case Reviews and other case reviews should be conducted in a way which

- recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

1.4 This serious case review has been undertaken using the SILP model, which ensures that these principles have been followed and provides a systems review of the case.

2. Terms of Reference

The review considers the period of time from when the children were first subject to child protection plans in July 2010 until they were accommodated by the Local Authority in June 2014. The full terms of reference are attached at Appendix 1.

3. The Process

3.1 A meeting for authors of individual agency reports was held on 15th July 2015 where the SILP process and expectations of the agency reports were discussed. A full day Learning Event took place on 8th October 2015. A wide range of staff from different agencies attended the Learning Event including some of the agency report authors and a number of the staff and managers who had been involved during the period under review. Most of the agency reports were available and circulated to attendees before the Learning Event.

3.2 Prior to a Recall Day held on 19th November, the first draft of the overview report was circulated to those who had attended the Learning Event. The agencies that attended the Learning Event were again represented at the Recall Day and participants were able to provide feedback on the

contents and clarify their role and perspective. All those involved contributed to the conclusions about the learning from this review.

3.3 Father and Grand Parents have been written to, informed of the review process and invited to contribute but have not taken up this opportunity. The older children have been given the opportunity to speak with a known adult to give their perspective on the services their family had received. Maternal Aunt has provided comments to the Review Chair.

3.4 The review has been chaired by Donna Ohdedar and the overview report author is Jane Scannell. Donna is Head of SILP and is a safeguarding advisor and trainer and has been involved in both children's and adults' safeguarding and domestic homicide reviews. Jane is an independent child protection social work manager and consultant as well as a SILP associate reviewer. Both are entirely independent of Wolverhampton Safeguarding Children Board and its partner agencies.

3.5 The Department for Education expects full publication of Serious Case Reviews unless there are serious reasons why this would not be appropriate. This report has been written following a decision taken by Wolverhampton Safeguarding Children Board to remove all information that renders identification of the family possible with the expectation that it will be published on this basis. Any media strategy will be devised by the Wolverhampton Safeguarding Children Board prior to publication.

4. Introduction to the Family

4.1 The eldest of the children who are the subjects of this review was aged 14 when the children were accommodated by the Local Authority in 2014 and the youngest child was under 2 years old. Their parents are called Mother and Father in the report and other family members are referred to by their relationship to the children e.g. Maternal Grandmother. The family were believed by agencies to be British and there was no information available about their religious beliefs.

5. Reason for review

5.1 The family were well known to agencies and had first come to the attention of Children's Social Care in 2006. The children were subject to range of interventions including child protection plans, Child in Need[1] and support from Early Help[2] 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. The children have remained in care and Care Orders were obtained in 2015.

6. Key Practice Episodes

6.1 The period under review has been divided into a number of key practice episodes. Key practice episodes are episodes that are judged to be significant to understanding the way that the case developed and was handled. The term 'key' emphasises that they do not form a complete history of the case but are a selection of the activity that occurred, and include key information to inform the review. To contextualise the key practice episodes, this section of the report starts with a brief

[1] S 17 Children Act 1989 states the duty of Local Authorities to safeguard and promote the welfare of children who are in need.

[2] Early Help refers to services provided by a number of agencies which provide a 'bridge' between specialist services such as Social Care and universal services such as schools and the NHS.

overview of the understanding of the professionals involved of events prior to the review period.

Background

6.2 Prior to the period under review Children Social Care had twice been involved with the family because of concerns about home conditions and the care the children were receiving. On both occasions - in 2006 when there were five children in the family and again in 2009 (by which time more children born to the family) – the social work involvement had identified a need for a child protection case conference but on neither occasion was one held.

Period under review

6.3 The first key practice episode covered the period from July 2010, when, following Children's Social Care receiving further referrals about home conditions and other concerns, an initial child protection conference was held and the children became subject to child protection plans. At the second review conference a recommendation was made that the Public Law Outline[3] (PLO) process should commence and was started in the following year when around the same time Mother confirmed that she was pregnant. A month later, a decision was made not pursue the Public Law Outline process further due to reported improvements the family had made.

6.4 However at a core group meeting, held shortly after the review Public Law Outline meeting, it was made known that Mother had told the Midwife she was drinking a significant amount of alcohol a day. Alcohol had not previously been identified as a significant issue affecting the parents' ability to care for the children.

6.5 The features of this key practice episode were:

- there was evidence that the concerns that had been known about this family previously had not reduced and with the birth of more children those concerns had increased
- although concerns about the children being made available for health care existed, input from the GP practice was limited
- the Local Authority started, stopped and restarted the Public Law Outline process within the space of a few weeks apparently unaware of Mother's problems with alcohol until established by the Midwife
- despite effort from the social worker, housing providers were not assisting in addressing the severe difficulties the family were experiencing with the fabric of their home.

6.6 During the time covered by the second key practice episode a pre-birth case conference was held to consider the risks to the then unborn where the recommendation was made that the baby should be removed from the parents' care at birth. When the baby was born the child had a positive drug screening indicating maternal use of cocaine, heroin and amphetamines.

6.7 Late in 2011 the Local Authority issued an application to the court for Care Orders on all the children. At the first hearing the immediate removal of all the children was not supported by the Guardian and they were made subject to Interim Supervision Orders. Parents agreed that the new baby should be cared for by the paternal grandparents which is where the child remained

[3] The Public Law Outline (2014) places a 26 week time limit for the completion of care and supervision proceedings. It therefore places an increased emphasis on pre-proceedings work to ensure that necessary assessments etc have been completed before the court process starts.

until the child returned to the parents' care in late in the following year and soon after the family moved house, a significant event due to the very poor fabric of their previous rented home.

6.8 At the final hearing early in 2012 the Court felt that the support and protection could be afforded by an effective child protection plan and that the threshold for Supervision Orders was not met, so no orders were made.

6.9 The features of this key practice episode were:

- the birth of baby indicates that Mother has multiple substance misuse issue
- the Local Authority decided that the life-changing decision to apply to remove the children from their parents' care but there is little evidence of the risk assessment that informs that decision
- the time of the house move is remembered as happy time by the children
- the Children's Guardian and the Court express reservations about the quality of intervention the family received.

6.10 Shortly after the final court hearing, during key practice episode 3, the children "stepped down" from child protection plans to child in need plans. Although the recommendation of the review case conference that Child in Need meetings should be held 6 weekly this was not adhered to. In the summer of 2012 three of the children changed school in order to attend schools closer to their new home. The new school did not receive any information from their previous school and were not made aware of the relatively recent child protection and court action.

6.11 The Child in Need meeting early in 2013 concluded that the poor home conditions had been addressed and the case was closed to Children's Social Care shortly afterwards. However there was a delay in when the first Common Assessment Framework[4] meeting held. Following a second Common Assessment Framework meeting, referrals were made to a number of support services including Young Carers and Family in Focus[5]

6.12 The features of this key practice episode were:

- whether the rationale that child protection plans were no longer needed was robust
- concerns about the effectiveness of the "step down" processes
- there was little evidence of the children's voices being heard

6.13 Virtually all the Common Assessment Framework meetings held during the next key practice episode between July 2013 and March 2014 resulted in contact with Children's Social Care because of concerns that were identified at the meetings. Children's Social Care received a total of seven referrals. None of the concerns were felt by Children's Social Care to meet the threshold for their involvement. Referrers were advised to use the Common Assessment Framework process to address their concerns.

[4] The Common Assessment Framework provides a process for gathering and recording information about a child for whom a practitioner has concerns, identifying the needs of the child and how the needs can be met and is used by Early Help services.

[5] At the time under review Family in Focus was part of the Early Help offer and was provided by a third sector agency.

6.14 The second time the Health Visitor contacted Children's Social Care during March 2014 her referral *was* accepted and two social workers were allocated to undertake an "assessment with a specific focus on the parent's capacity to change". The conclusion of the assessment was that the case should, again step down to Common Assessment Framework. Health Visitor "complained" to the Team Manager about this and children were still open to Children's Social Care when the following events took place.

6.15 The features of this key practice episode were:

- evidence of different understanding of the threshold for Children's Social Care involvement
- practitioners were struggling to differentiate between collusion and engagement from Father
- little evidence of the children's voice

6.16 In June the youngest child, having been seen by a Health Visitor, Social Worker and GP was taken to hospital with a burn on his foot. At some point a s47[6] enquiry was initiated as Hospital staff felt the injury was not consistent with the explanation and that the amount of bruising on the child indicated, at least, a lack of appropriate supervision. The police used their Powers of Protection and all the children were placed in foster care that night. The parents subsequently agreed to s20[7] accommodation.

6.17 The features of this key practice episode were:

- children had been seen by a number of professionals that day - school staff, Family in Focus worker, Social Worker - none of whom thought the threshold for s47 was met in terms of the children's presentation or the home conditions
- questions were raised about whether the s47 enquiries could have been managed differently and in a more child-focussed way

7. Analysis by Themes

7.1 It was apparent from the agency reports and from the number of participants who attended the Learning Event that a significant investment in terms of agency capacity and energy had been focussed on the family over a number of years. However it was recognised that this amount of professional involvement bought with it its own difficulties, including a lack of a unified view of the risks the 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. This was a large, complex, professional network working with a large, complex, family and the review process has exposed how some of the systems and procedures that do exist to support practitioners in working with such cases were not effective.

7.2 Viewed from a systemic perspective it is apparent how these difficulties influenced and impacted on each and contributed to the eventual outcome. This is illustrated by how ineffectiveness in one part of the system, for example the dissemination of the of the escalation policy, impacted on other aspects of the system and contributed to the "concern, despair and frustration" (Health

[6] Under s47 Children Act 1989 an enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

[7] s S20 Children Act 1989 states Local Authorities' duty to provide accommodation for children in need.

Trust agency report) felt by an individual in another part of the system.

Understanding neglect and managing risk

Perception of risk

7.3 "Neglect is the most common reason that children are made subject to a child protection plan with neglect featuring in 60 per cent of all Serious Case Reviews" (Action for Children 2013). This case illustrates the complexity of the work of children and family professionals. The work involves the constant balancing of factors in a number of areas. Firstly, in cases such as this, it is essential to keep the focus on the children despite the parents being very needy in their own right whilst acknowledging that, unless the adults' needs are addressed, they will not be able to achieve the changes needed. Workers also need to be aware of the multi-faceted risk to children caused by neglect and be prepared to act decisively to address it but also take into account any observed warmth in the relationships between the parents and children and the evidence that the parents *are* able to provide good enough care at times. Practitioners also need to be mindful of the risk that there will be "disguised compliance" (Reder, Duncan and Gray 1993). Disguised compliance involves a parent or carer giving the appearance of co-operating with agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention. However, there was not consensus among staff represented at the Learning Events as to whether parents' "inconsistent compliance" *was* an effort to distract professionals or was, instead, more reflective of Father's "wanting things on his own terms".

7.4 Wolverhampton Safeguarding Children Board developed a Neglect Strategy 2013 - 2016 following an Ofsted Thematic Inspection of Neglect in June 2013. The strategy identifies four strategic priorities and a comprehensive action plan to address them. Many of the actions are now completed, however most are in the early stages of implementation and therefore not yet embedded, and were not referred to in the agency reports and practitioners. The review was informed that the Safeguarding Board is also currently revising the Practitioner's Guide to Neglect (due to be launched during the summer 2016) as it was felt to be "too long and complex".

7.5 At the Learning Event it became apparent that there was dichotomy between how the Police and Hospital based staff felt about the level of neglect the children were experiencing compared with community -based staff. Both agencies' representatives at the Learning Event spoke with feeling about the children's physical condition the evening they were accommodated. They graphically described the head lice, the filthy spectacles, ill-fitting clothes – shoes so much too small they were causing the child to have sore feet, the engrained dirt on the children's feet and necks. They were obviously horrified to see children so neglected.

7.6 It can be assumed that at least some of the children was in school the day that the Health Visitor made a home visit and saw the burn on the youngest child's foot. She spoke with Children's Social Care about the burn - not about the child's or the home's physical condition – as she felt it indicated lack of parental supervision. A social worker also visited the home following the Health Visitor's contact and, again, although they were concerned about the burn, they did not raise any other concerns. The child had been taken to the GP, who again was concerned that the burn was indicative of underlying concerns but, did not make any comments about the child's physical presentation.

7.7 This dichotomy suggested the hypothesis that child care staff working "in the community" are more inured to the children living in comparatively neglectful circumstances. This raises the question of whether community based staff are sufficiently alert to the potential of children

suffering significant harm through neglect. On the other hand, it is possible that hospital-based staff, not exposed on a daily basis to the reality of how deprivation impacts on families' and children's presentation, saw a not unusual level of poor physical presentations and over reacted. At the Recall Day School reflected that the children's presentation "did not stand out" (as particularly neglectful). They estimated that approximately 50% of their pupils presented at times as unkempt and reflected on what this meant about their tolerance of neglect. Hospital based staff also reflected that the fact that the fact they saw eight of the children together for child protection medical examinations because of concerns about neglect influenced their interpretation of what they saw.

Front-line practice

7.8 Child protection cases 'rarely comes labelled as such' (Laming 2009) and that is particularly true of neglect cases. Risk is more difficult to identify when there is a chronic component. Decision making must be based on an assessment of cumulative risk of harm as well as need. Children's Social Care's responses need to take account of the repetition of previous concerns and the cumulative impact on the children.

7.9 There is evidence in the Children's Social Care agency report that no effective assessment of the family existed. The report identifies several occasions when decisions were made to undertake certain action, for example to undertake a core assessment, which were never actioned. The Children's Social Care report author surmises that that the assessment produced when the Local Authority initiated care proceedings was produced to support the application rather than critically analyse both the strengths as well as the needs in the family. The social work practice as evidenced in the agency report was reactive with little evidence of purposeful intervention.

7.10 The author of the Children's Social Care agency report identifies that the introduction of the changes to the electronic recording system in July 2013 and the introduction of the Single Assessment Record, which requires the worker to comment on progress against the child's plan, supports workers to produce more strengths-based assessment. Additionally the Recall Day was told that as of September 2016, the Local Authority's plans to use a "strengthening families" model in child protection case conferences. This suggests that there has been recognition of the need for an underpinning methodology that supports focussed, strengths-based practice involving direct work with families to achieve change.

7.11 At the Learning Event practitioners expressed some discomfort about the amount and meaningfulness of involvement the Guardian had with the children and amount of contact the Guardian had with professionals working with the family. However, it would appear that the Guardian identified that the intervention the family had received from Children's Social Care had not been focussed on identifying the family's strengths so that they could be supported in addressing the deficits in their parenting. Instead the work was focussed on monitoring and compliance (a supervision note "instructs.....the social worker to check the property for alcohol at each (weekly) visit", an unsophisticated way of managing risk posed by substance misuse). The Guardian's opinion was further strengthened with the improved home conditions that occurred when the family moved house in the November.

7.12 The Legal Services agency report summarised that there is "a fine line between the timing and length of intervention: the support and intervention must be timely in that a lengthy period of time should not be spent supporting and putting in resources without seeking protective measures but at the same time parents must be given a fair opportunity to work and engage with services". This is a good synopsis of the dilemma practitioners face. The children's time scales are

the all-important feature. Social workers need to have the skills, knowledge and support to pro-actively intervene to help parents change while managing the risks.

7.13 The quality of plans, child protection plans in particular, were criticised both in agency reports and also at the Learning Event. The Safeguarding Service Agency report identified that the child protection plans were not SMART (specific, measurable, achievable, realistic and timely) and it was apparent that there were similar deficits in the Child in Need and Common Assessment Framework planning. Staff at the Learning Event discussed how the plans that were made were superficial – addressing the symptoms but not the underlying causes of the family's difficulties. This would have compounded not only the social worker's difficulties in providing relevant and understandable (to the parents) support. It may have also contributed to the "professional helplessness" of the core group identified by Children's Social Care agency report author.

7.14 The Participants at the Learning Event also identified that there is a risk that if the if plans are too vague and not sufficiently focused on the what needs to change, when cases are "stepped down" there is a risk that further assessments will be done and different targets set meaning that there is lack of clarity for families about what they are trying to achieve.

Role of GPs

7.15 One of the significant concerns throughout the review period – and from their earliest involvement with Children's Social Care – was the missed medical appointments. Health professionals' practice is to copy GPs in to information missed appointments and hospital treatment therefore GP practices potentially have an overview of the totality of missed appointments and health care concerns. It is not clear from the agency report whether the GP practices involved (the family were registered with two practices during the review period having changed practice when they moved house) have robust systems for identifying the totality of health care concerns and passing those concerns on as necessary.

7.16 Missed appointments, commonly referred to as DNAs (Did Not Attend) in health services, have been recognised by SCRs as a potential indicator of neglect and the practice of withdrawing services as a result (which happened to one of the children in relation to the Paediatric Hearing Service) compounds the risk to the children involved. The real issue is children not being taken to appointments and the suggestion that re-framing DNAs as WNBs (Was Not Brought) as suggested in the Briefing for GPs and Primary Healthcare Teams (NSPCC 2015) focusses on the need for carers to proactively ensure a child's health care needs are met.

Supervision

7.17 At the Learning Event some Health Service staff noted that, at the time under review, if the case was not subject to child protection plans they did not receive supervision. The situation has now changed with, joint supervision being available to Health Visitors, School Nurses and Community Midwives and practitioners reflected that had this been available during the time under review there may have been a more "joined-up" approach – at least in their sharing of concerns with Children's Social Care.

7.18 Regular, reflective and skilled supervision is important to all staff but has a particular relevance in cases of chronic neglect. Supervision – whether provided 1:1 or by group reflective discussions – provides an opportunity to supportively challenge whether a worker is clearly identifying risks and progression, or not, against plans. In neglect cases, where there is a risk of becoming desensitised to a family's particular circumstances, supervision provides an independent challenge to keep the focus on the child and the adequacy of parenting over time.

Inter-agency working

7.19 It was recognised that, at times, the dysfunction in the family was mirrored in the professional system working with them. In fact, some of the inefficiencies in the system relating to the family were also reflected in the SILP process. For example the agency report from the original school the children had attended prior to moving to School was not available until the Recall Day and the Original School was were not represented at the Learning Event. This mirrors the fact that no information about the children was passed on to School when the children joined them in 2012. Although School "chased up" to get information to inform the transfer process they were not successful and were therefore initially unaware of the family's history.

Case conferences and core groups

7.20 Inter agency working was compromised by several factors including poor attendance at core groups and case conferences. A notable example of this occurred at the review child protection conference held in 2011. This conference was being held when the new baby was a matter of a few weeks old and the concerns for the well-being of the children were at such a level that the Local Authority was instigating care proceedings on the children. Only four professionals besides the chair and the allocated social worker attended. In discussion practitioners did not feel that it was the arrangements – timings, venues etc. were responsible for poor attendance at case conferences. Practitioners felt that relatively recent initiatives such as using email for invitations to case conferences supported agencies to attend. The Safeguarding Service is in the process of introducing further modernisation including the use of video and teleconferencing which staff thought would help include the input of professionals such as GPs who find the traditional timings of conferences incompatible with their clinical responsibilities.

7.21 At the Practitioner Event staff who had been committed to attending core group meetings expressed their frustration that in general, these meetings also had not been well attended. Additionally there were meetings which did not result in any minutes or notes. It is accepted that formal minuting of core group meetings is unnecessarily bureaucratic but it is essential that brief notes are made and shared to confirm progress against the plan and actions agreed. Children's Social Care representatives informed the review that there is a template for recording the notes of core groups and front-line practitioners present did not identify any problems with the template which impacted on its usefulness.

7.22 For core groups to be effective in addressing the identified risk and in ensuring the family is provided with meaningful intervention to help them achieve change, agencies who have committed to providing support need to members need to "own" and share the responsibility to action the child protection plan. Even where an agency is not a member of the core group it is essential that any action they have agreed to as part of the protection plan is undertaken and where there are difficulties in achieving the required outcome it is shared with the core group. While it is understandable that Family Centre would not continue to hold places open if they were not being used, it is not acceptable to not to inform the social worker of the intention of withdrawing the places, given attending them was a condition of the plan.

Think Family

7.23 There was evidence that the "Think Family" message was not embedded across all agencies in Wolverhampton. A Think Family approach ensures that there is a joined up approach to families' needs and improves the identification of children in need and in need of protection through awareness of the impact of an adult's problems on their children's lives. It also ensures those

adults' needs as parents and carers are properly assessed and supported. Mother had significant health needs, was very vulnerable and received support in her own right. She was admitted to hospital in 2013 and again in 2014 and was known to substance misuse services and mental health services. It is not clear if or how many of the numerous agencies involved with the children being aware of the hospital admissions and there is no evidence that the staff treating her gave any consideration to her role as a parent. For many families, especially those with numerous children, the absence of the mother causes considerable disturbance and upset. The fact that it did not seem to do so in this case should have sparked some professional curiosity among those who were aware. Children's Social Care representatives at the Learning Event discussed how the new MASH (Multi-Agency Safeguarding Hub) due to be implemented at the beginning of 2016 and which will bring together a range of professionals from Early Help, Children and Adults Social Care, Police, Health, Education, Housing and Probation will have the potential to mitigate against services working in "silos". However, in the context of the concerns identified by the review, the planned merging of the children and adult safeguarding teams at the Hospital would seem to offer hope that in future a similar case would prompt a more joined up approach.

Systems and procedures

7.24 The Community Health agency report identifies that, even within just the health services involved, there was no way of bringing their concerns together in order to come to a clear understanding of their service's view of the family's situation and it is apparent that this situation was repeated across the professional network. None of the systems that *do* exist to "bring concerns and support together" - the Common Assessment Framework/Early Help arrangements, Child in Need and child protection systems – effectively assisted practitioners in coming to an understanding of all the risks the children were exposed to or support them to come up with a coordinated actions to address the concerns. In effect professionals worked within their own "silos" - addressing concerns as they saw them and expressing frustration within their own organisations when they felt progress was not being made or risks were not being recognised by others in the network.

Thresholds and Step up/down processes

7.25 A pervasive issue identified both in agency reports and at the Learning Event was that of thresholds and the transition between the various levels as articulated in Wolverhampton's Threshold Model. It was apparent that there was some lack of clarity within the network about the threshold for specialist services' involvement as well as, within Children's Social Care, the thresholds for gaining statutory orders.

7.26 Staff at the Learning Event spoke of their unhappiness with the processes for stepping cases up (to Children's Social Care) and for stepping cases down from Child in Need plans to Common Assessment Framework arrangements. The problems with stepping up appeared to be primarily about differing professional opinions about the threshold for Children's Social Care involvement. Staff spoke of their frustration of contacting Children's Social Care because they felt that situations warranted statutory involvement only to be advised that they should be continued to be managed by the Common Assessment Framework arrangements. This was a particular issue during the early months of 2014 and the agency report for the Health Trust articulated the attempts – and frustration felt – by the Health Visitor in attempting to get Children's Social Care to become involved again.

7.27 The Children's Social Care agency report identifies that at the time the Duty and Assessment Team were coping with high levels of staff absence, were relying on agency staff and were struggling to allocate cases for assessment. This was a likely factor in the high threshold decisions

made – as was the fact that there was an established Common Assessment Framework plan in place. Although it is apparent that agency checks were completed before a decision was made that concerns did not warrant Children's Social Care involvement, it is not clear that the decision was made with due regard to the history of the case. Seen in the context of long standing concerns of a similar nature – which had warranted child protection services and which had prompted the Local Authority to issue care proceedings – the decision does not appear defensible.

7.28 At the Learning Event practitioners reflected on the Local Safeguarding Board's relaunched Threshold Model. There was agreement that it was useful and accessible. School identified that they use it to articulate and map concerns when making referrals to Children's Social Care and so enables them to be specific about the concerns they feel meet the threshold for Children's Social Care involvement.

7.29 The problems with stepping cases down from Children's Social Care also included some disagreement about thresholds as, at times, the network felt that Children's Social Care was closing the case prematurely. However this concern was exacerbated by not adhering to the step down process that was in place at the time. This involved the Child in Need meeting agreeing who was going to do what under the Common Assessment Framework, and agreeing a date for the step down to take effect. The social worker was then supposed to write to the family and professionals involved to confirm. Practitioners at the Learning Event confirmed that this system had not worked effectively, and has subsequently been amended although there was not universal confidence that the revised system worked substantially better.

Local Safeguarding Children Board procedures

7.30 Agency reports generally identified that, although there were, at various times, concerns within the network about decisions made which were evidently discussed within agencies, no use was made of the Local Safeguarding Children Board Escalation Policy. The current policy was updated in January 2014 and so was in effect during the penultimate and last key practice episode. It was apparent from the discussion at the Learning Event that its dissemination had not been effective as some staff was not aware of it, or it was not yet embedded in practice. Local Safeguarding Children Board representatives informed that it was being highlighted in all multi-agency training being delivered but, given that it has been in place for over eighteen months, the lack of knowledge of it was disappointing.

7.31 Staff at the Learning Event reflected that sometimes what they needed was access to advice when they were concerned about a potential safeguarding issue and that if they could have conversations with Children's Social Care staff that could obviate the need to use the escalation policy. Staff need to make use of the Safeguarding leads in their organisations to have these conversations and the Safeguarding Leads can not only assist on individual cases but is then in a better position to identify if there are any systemic issues that they need to bring to the attention of their agency's Local Safeguarding Children Board representative.

7.32 The Wolverhampton Safeguarding Children Board's Child Protection Procedures contain procedures to inform staff who are working with parents who misuse substances. There was little evidence, in either the agency reports or in the discussions at the Learning Event, that staff had referred to or made use of this procedure. While offering some indicators of potential risk that can be caused by parental substance misuse this, and the procedure on neglect were both were limited in scope. The procedures do not appear to offer any guidance on working with families where there is resistance or on working with large families.

7.33 The anomaly of the pre-birth conference that was held considering only the needs of the unborn child rather than all of the children in the family was commented on in the Children's Social Care agency report and the Overview Report writer agrees with their recommendation that where a pre-birth child protection conference is requested, and other children in the household are on child protection plans, consideration should be given to bringing forward their review conference. The pre-birth conference procedure includes the requirement that if the baby is subject to a plan once born, there needs to be a review conference within four weeks of the birth and it would appear that the needs of all the children were considered at this conference, although by this time a decision had been made to seek Care Orders.

7.34 Interestingly the discussion at the Learning Event around the theme of policies and procedures identified several issues that the report writer feels would be more relevantly reflected as skills and knowledge. Policies and procedures are only effective if they are implemented by practitioners who are skilled, knowledgeable, emotionally intelligent and able to use their professional judgement and are supported to do so by systems that provide reflective supervision and challenge.

Voice of the family

Voice of the children

7.35 At the Learning Event time was taken to considered professionals' views and knowledge of each individual child. The event chair hypothesised that the children had been seen as a composite group and not as individuals. In the Children's Social Care agency report the author notes when referring to a core assessment undertaken in September 2011 (and informing the Local Authority's decision to issue Care Proceedings) that "there is no sense of the children as individuals despite the social worker having known them for over twelve months". As part of their preparation for the review, Children's Social Care held a meeting to "capture information about the family that was not evident within the children's case records" and as part of this exercise composed brief pen portraits of each child. The outcome of this commendable exercise confirms that despite the length of time these children were known to Children's Social Care, who were at times involved, at least theoretically, very intensively in their lives while social workers came to the conclusion that were unable to safely live with their parents, they appeared to be little more than caricatures to the social work practitioners involved.

7.36 It was apparent that some agencies had a much more rounded picture of each child as an individual but, from a systemic perspective, what was missing was an assessment of the how each family member impacted on the others and how the family system interacted with others. There is no evidence that basic systemic tools such as genograms and family history chronologies were utilised by any of the practitioners involved with the family. The use of such tools with families enable discussion to take place about relationships and events which reveal not only underlying patterns of behaviour but also where there are gaps in professional knowledge of the family and where more inquisitiveness is needed. Had such work been undertaken it is possible that some understanding of the role that the extended family members played in the family's life would have been obtained. As it was, the knowledge of the extended family was so limited that when the baby was discharged to the care of his grandmother, the Hospital notes did not identify whether it was paternal or maternal grandmother.

7.37 There are many ways in which children's views can be obtained. There are a "range of adults that have both the opportunity and the information to help the child be 'seen' and 'heard'..... For very young children, this may be by simply sharing their perceptions and observations" (Ofsted 2011).

Behaviour can also be a way of children communicating their feelings and views, and practitioners need to have the skills to be able to interact with and relate to children, the knowledge of child development that enables them to understand the child in the context of their age and experiences and, crucially the time to build relationships.

Working with men

7.38 Studies of Serious Case Reviews (Brandon et al 2011) have consistently identified that professionals have not sufficiently involved and taken account of men's roles in the lives of children subject to review. This cannot be said in this case where Father is central to much of the activity but there seems to have been little professional curiosity about the parent's relationship with one another, with their extended family, their beliefs and values. There appeared to be a recognition that Father could "up his game" sufficiently to appease concerned professionals but the reasons why he could not sustain it is not explored to any extent. Knowledge of other men in the family is consistent with Brandon et al's findings in that there is no information about any grandfathers, uncles etc.

8. Conclusions and Lessons Learnt

Conclusion

8.1 This review has identified that, despite considerable professional concern and effort, the neglect these children were exposed to was not effectively addressed. It is not possible to know whether, if the family had received more skilled and coordinated intervention in a timely way, these parents could have been helped to understand the impact their neglect was having on the children and been supported to change their behaviour sufficiently to avoid the need for the family to be broken up. It is possible that, even with skilled and intensive intervention, the parents' needs and resistance was overwhelming and change would not have been possible within the children's time frames.

8.2 Although the review has attempted to avoid hindsight bias which "oversimplifies or trivialises the situation confronting the practitioner and masks the processes affecting practitioner behaviour" (Woods et al 2010) there are a number of key areas which contributed to the failure of the multi-agency response to this family's needs. Despite the efforts of some individual practitioners there is little evidence of a whole system approach to addressing the family's identified problems.

8.3 The main reasons for this was the lack of effective information sharing across the system, and professionals not thinking about the implications of their concern for the whole family system. This was compounded by a marked lack of professional curiosity. A number of questions raised by the review remain unanswered because, although they would seem to be very pertinent to the understanding of the family, they appear not have been asked. There were numerous examples of where the report writer's curiosity was aroused but issues remain unexplored as a similar level of curiosity was not apparent in the practitioners involved. One obvious example of this is the fact that no practitioner appeared to have ever discussed with them, the parent's motivation for having such a large family or considered whether religious beliefs, or family of origin expectations, or another reason may have been a factor. The fact that none of the agency reports mentioned the family's ethnicity or religion demonstrates more than just an assumption that because a family appear white and speak English they do not have cultural or particular spiritual needs. It reflects a lack of depth of approach to understanding the family.

8.4 It is apparent from the School's comment about the prevalence of their children evidencing signs

of neglect, that staff need to have the skills to identify those children whose care is impacting on them to the extent it is causing them significant harm. This highlights the need for skilled, thoughtful practice with a sophisticated understanding at all levels in the professional network. Confident, mature, partnerships between front line practitioners need to be established, as such relationships mark the distinction between a fragile system and a strong sustainable system

Learning

8.5 The commitment to the SILP from agencies, and particularly front-line staff to examine their practice – and to identify learning both from an individual as well as an organisational perspective was significant. The learning that has emanated from this reflects that some of the "best learning from serious case reviews may come from the process of carrying out the review" (Brandon et al 2012).

8.6 Effective intervention in families' lives depends on skilled assessment and planning, both underpinned by a theoretical model, and on practitioners' skills in engagement. Plans at all levels of intervention need to be specific, timed and focussed on what needs to change. The role of reflective supervision in supporting and challenging staff is key to effective assessment and intervention and there are a number of ways including group/peer supervision, action learning sets, that can play a part in providing such support – especially for those practitioners for whom individual supervision is limited. Reflective supervision can play a role in identifying issues within families that are unexplored and support workers to be confident in their ability to be respectfully curious in their work with families.

8.7 Staff need to have both the time and the skills to get to know the children they are working with. There are challenges in being able to know children well enough to be able to understand their world – especially when involvement is short-lived or the child is very young. Nevertheless it is incumbent that staff develop the skills and to be aware of tools that can help them understand the lived experience of the child.

8.8 Staff identified that the "Think Family" message – including in relation to the other children in large families – was key learning from the review. This reflects an acknowledgement that, although information-sharing *was* an issue, as important was the need to think about the possible impact of a concern about one member of the family on the rest of the system.

8.9 The systems did not always support staff to deliver effective intervention. Of particular concern was the step/down processes which have changed since the time under review but about which there was still some professional uncertainty. Although attendance at multi-agency meetings such as case conferences and core group meetings had been identified in the review process as an issue with attendance not being prioritised by all professionals, review participants welcomed information about proposed initiatives to use technology to improve participation.

Good practice

8.10 There were some examples of good practice both by agencies and by individuals. It was apparent that the quality of the relationship Schools had with four of the children, especially one child, was particularly strong. School were diligent in following up when there was lack of clarity whether the family had "stepped down" from a Child in Need plan and were proactive in taking on the responsibility in organising the subsequent Common Assessment Framework involvement.

8.11 Despite not being aware of the formal escalation process some health practitioners, both community and hospital based were tenacious in raising their concerns with Children's Social Care despite referrals not being accepted. Progress has been made to involve GPs in case conferences

and the innovation of an on-line child protection bulletin sent to GPs is an enterprising attempt to include this group of practitioners.

8.12 An impressively wide range of services and practitioners were available to support the family and many of those practitioners displayed considerable commitment to improving the care the children were receiving. The fact that this was not effective was due to the systemic issues identified rather than lack of effort and commitment by some individuals.

9. Recommendations

It is recognised that actions have already been made in relation to some of the individual agency's identified learning. In addition agency reports included a number of recommendations which this review endorsed. The purpose of providing additional recommendations is to ensure that all professionals in the partner agencies of the Wolverhampton Safeguarding Children Board are confident that the areas identified as of concern in this review are addressed.

Recommendation 1

WSCB satisfies itself that practitioners' use of both the step up/down and the escalation processes are underpinned by clear application of the various thresholds and are robust and understood by agencies.

Recommendation 2

WSCB reviews systems for disseminating information e.g. policies, practice guidance etc. and considers how to evaluate the success of any such dissemination and its effect on practice.

Recommendation 3

WSCB ensures that designated safeguarding leads in schools are aware of their responsibility to ensure a robust handover of any child concerns and that child protection files are transferred to the new school/college when a child leaves their school/college

Recommendation 4

WSCB reviews the training provided on neglect to assure itself that it provides sufficient focus on identifying risk, that all relevant staff have received recent training and that there is system in place to review the impact on practice.

Recommendation 5

WSCB considers how the message “Think Family” is further promoted and embedded in practice.

Recommendation 6

WSCB satisfies itself that that agencies have systems in place that become aware of, and flag, children/families of concern/ subject to child protection plans.

Recommendation 7

WSCB explores with partner agencies options for the provision of supervision for those staff who do not currently receive it.

Recommendation 8

The Board reviews the Agency Reports submitted to the review, considers the identified actions/recommendations and uses this information to both consider agencies' progress in implementation as well as what further training needs to be provided to both report writers and to managers who approve agencies' reports.

References

Brandon M, Sidebothan P, Bailey S, Belderson P **A study of recommendations arising from serious case review 2009-2010** DfE 2011

Behind Human Error Woods D et al (2010) quoted in Munro Final Report

Learning from SCRs Briefing for GPs and Primary Health Care Teams. NSPCC 2015

Laming H. **The Protection of Children in England: a progress report**. The Stationary Office 2009

Reder P, Duncan S and Gray M **Beyond Blame: child abuse tragedies revisited** Routledge 1993

The voice of the child: learning lessons from serious case reviews. A thematic report of Ofsted's evaluation of serious case reviews from 1 April to 30 September 2010 Ofsted 2011

The state of child neglect in the UK Action for Children 2013.

Appendix 1

TERMS OF REFERENCE

FRAMEWORK

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

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings

(Working Together para 10, March 2013)

SCOPE:

Those to be considered in the review are the children in the sibling group.
Time period:
14 July 2010 (date child protection plan began) to 19 June 2014 (when the children came into care)

AGENCY REPORTS TO BE COMMISSIONED

1. Children Social Care
2. Early Years (Children Centres)
3. Police
4. GP
5. Hospital (paediatricians)
6. Royal Wolverhampton Trust
7. Safeguarding Service
8. Legal Services
9. Education
10. CAMHS
11. Aquarius
12. YMCA
13. Education Psychology
14. CAFCASS
15. Spurgeons
16. Base 25

An anonymisation key will be used to anonymise family members.

TERMS OF REFERENCE

1. How was the family history incorporated into assessments?
2. Was planning coherent, consistent and reflective of threshold?
3. How well were changes analysed for potential impact in the context of planning?
4. What was the effect of some children in the sibling group being dealt with by a different social worker?
5. Were the older children considered less at risk on the grounds of them being more resilient?
6. Please comment on the sufficiency of challenge amongst professionals in the multi-agency network and any points at which escalation was or was not pursued.
7. Please provide a rationale around your agency's decision making at key points, with particular regard to the interface with the court process.
8. Was the children's role as carers for each other recognised?