



Wolverhampton Safeguarding Children Board (WSCB)

Learning Lessons Briefing – Child M

The Review

This Learning Lessons Briefing is created as the result of a learning review undertaken by WSCB's Serious Case Review Committee (SCRC) into the experiences of Child M in 2013. It outlines the key themes identified by the review to inform how changes can be made within professional practice across all organisations to ensure effective safeguarding for children in the City of Wolverhampton.

Background Summary

Child M lived at home with her mother, step-father, 2 siblings and maternal half-sibling, who was the biological child of her step-father. She and her siblings had no contact with her father.

In late 2013, at the age of 12, Child M was admitted to the care of the Local Authority following a four year history of social services involvement.

Prior to her admission Child M had been reported by mother as being behaviourally difficult and self-harming. Mother stated that Child M had distanced herself from the family network and refused to engage. She reported aggressive behaviours, self-induced vomiting, persistent self-harming, poor hygiene and, most importantly, that Child M told lies.

Professionals were aware that Child M had been living in an unheated and unfurnished outbuilding for up to 12 months before being removed into care, but she was not taken out of that situation. It was taken as fact that Child M had chosen to live outside, and this was somehow acceptable. She had been witnessed taking food from bins and stealing food from other children. When Child M went into the care of the local authority she had no possessions: no suitable clothing, no suitable footwear and no toys.

Immediately after being taken into care, Child M was admitted to hospital for treatment of serious health problems which were a direct result of neglect she had experienced.

In autumn 2017 mother and step-father were convicted of Child Neglect following a guilty plea, and both received custodial sentences of 4 years and 3 months.

Key learning themes arising from the review

Theme 1: Adult Focused Approaches

Throughout their involvement, Child M's mother was considered by professionals to be a plausible parent – she shaped professional perceptions and judgements regarding her daughter which skewed their assessments and decision making. The narrative of adults was accepted at face value as Child M's mother was eloquent and appeared to be proactively seeking support; in turn, her explanations were not questioned or explored with others. Professionals had extensive empathy for mother due to her history of domestic abuse, but this meant they failed to focus on the needs of her children.

It is clear from the Police investigation that many professionals based their opinions of Child M, on hearsay. This information was initially provided to professionals directly from mother, and later passed between professionals as assumed fact, without any investigation. This in turn tainted the opinions of professionals and, on the limited occasions that the victim made disclosures, she was either challenged or not believed.

As was the case with Daniel Pelka, professionals did not think the unthinkable and as a result **the situation became Mother's story, not Child M's reality.**

Some professionals were able to identify elements of professional grooming by mother and the impact on how their agency responded; but they failed to raise their concerns outside their agency.

Theme 2: Disguised Compliance

Mother raised a variety of issues which implied that Child M was a risk to herself and others. However, when support was offered, **mother failed to consistently engage** citing Child M as the reason for non-attendance. The records show that mother contributed to delay in offering support to her daughter as she sought to reduce the level of professional concern when there was the potential for detailed professional oversight that may have provided a different perspective on Child M's circumstances.

Theme 3: Voice of the Child

Child M consistently requested that she be admitted into the care system, yet there is no evidence that anyone tried to find out why she should ask this, nor had any attempt been made to understand Child M's perspective of how care may have benefited her. Child M implied, and latterly stated, that her home circumstances were poor and she was treated differently to her siblings. Yet despite disclosure,

behaviour, and the physical indicators of neglect, **no one acted on or contextualised her concern.**

Professionals appeared to be influenced by the suggestion that Child M's prematurity may have impacted on her development (something that mother promoted and suggested had led to epilepsy and a learning disability) and this may have affected their confidence in effectively engaging with her.

Theme 4: Neglect

Child M's circumstances had all the hallmarks of neglect yet this was not recognised by any professionals. She experienced unexplained weight loss, prolific head lice, hunger in school, poor personal hygiene and sought inappropriate and unsafe adult attachments but professional focus was on behaviour; **physical causes were ruled out, but nobody thought to rule neglect or abuse in.**

Child M's lack of possessions, appropriate clothing etc. was never identified as neglect, in spite of the fact that the house was clean, tidy and well-furnished and the other children had appropriate toys and possessions.

Child M was singled out from her siblings. She wore substandard uniform and broken shoes. Whilst her uniform was not appropriate, her siblings always presented well. Child M was also prevented from participating in activities, whilst her siblings were not.

Theme 5: Assessment

The review found that the professionals involved failed to effectively share information, despite Child M and her siblings being subject of a number of assessments. Key family members were not spoken to at an early stage. When Child M's siblings were engaged they responded defensively as they sought to 'protect' their family unit.

Challenge and analysis was lacking in the assessments due to concerns about affecting what was seen to be a positive relationship with parents; in turn, professional curiosity was lacking. It is evidenced that **professionals normalised the perceived behaviours of Child M and in so doing failed to question her daily lived experience.** It should be noted that in 2011 CAMHS determined Child M had no psychiatric disorder but this did not influence professional attitudes.

Once Child M was settled in care she made allegations of severe physical abuse against her step-father. Throughout the family's involvement with services there is little evidence of full assessment of her step-father's role in the family, or the

consideration of the increased risk of harm to Child M of living with a non-biological parent.

Theme 6: Safeguarding Procedures and Thresholds

Child M was subject of a Child In Need plan but CIN meetings were **not progressed in line with procedure** and when professionals raised concerns about this that were not responded to, they **did not escalate their concerns**. It is clear that despite there being no evidence of improvement in Child M's presentation, professionals failed to follow 'step-up' procedures even though there was a plan to do this should matters not improve.

There are clear expectations regarding responses to child abuse but the records show delay in responding to potential non-accidental injuries or considering abuse as influencing the presentation of the child.

Recommendations

1. WSCB to review the current CIN guidance in line with safeguarding procedures.
2. All agencies to ensure that where drift is identified in CIN cases that these are discussed in supervision and peer support processes with a view to escalating concerns as appropriate.
3. Where there is an allocated social worker, professionals identifying new safeguarding concerns must put these in writing to the social worker and copy in their line manager.
4. To ensure that the increased risk from step-parents is always recognised and taken in to account and that step-parents are included in the assessment of risk to children.
5. WSCB to revise the Neglect Strategy and implement a Neglect Toolkit that can be used to evidence a child's lived experience and inform next steps.

Take some time to think about what these key messages mean for your practice.
Ask yourself:

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?