Hounslow Safeguarding Children Partnership

Local Child Safeguarding Practice Review
Family X

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1. Introduction: background to the review

1.1.1 Family X first became known to Children's Social Care in 2013, following reports from concerned neighbours that the children were being neglected, were unkempt and unsupervised and the parents were misusing alcohol and cannabis. At the time, the family consisted of Mother, Father and three children, aged 8, 3 and 19 months. A fourth child was born in 2015. A daughter sadly died in 2009 after being born prematurely. The eldest child was Father's stepson. Following an assessment, the case was closed in 2014, as the concerns raised were considered to be unsubstantiated.

1.1.2 Between 2014 and 2017, the family's contact was primarily with health services and schools. During this period, the children were often not brought to medical appointments, including those for Sibling 2, who had significant problems with soiling and ophthalmic appointments for Sibling 3.

1.1.3 Father left the family home in 2015, and his contact with the children remained sporadic until April 2020 when all the children went to live with him. It seems that from the time Father left the family, Mother began to struggle in caring for the children, and she was offered parenting programmes and a Family Support Worker. When it became known that Mother was involved in a violent relationship with Mr M, a second assessment was undertaken by Children's Social Care in 2017, which recommended no further action.

1.1.4 Further reports were made to statutory agencies about Mother's involvement with Mr M. Concerns continued about Mr M's violent behaviour, substance and alcohol misuse, the general presentation of the children and the non-engagement by Mother in bringing the children to medical appointments, which resulted in a further assessment being conducted. In August 2018, the children were made subject to Child Protection Plans, under the category of Neglect. The plans remained in place until May 2019, when the case was stepped down to one of Child in Need.

1.1.5 It initially appeared that Mother was engaging well with services, and it seemed that Mr M was less involved with the family. However, from July 2019 onward concerns began to re-emerge, particularly in respect of Sibling 1 and in October 2019 an Initial Child Protection Conference was convened, which resulted in all the children being placed on Child in Need Plans.

1.1.6 A third Initial Child Protection Conference was held in April 2020, because of reports that the children were being hit by Maternal Grandmother when in her care, continued violence from Mr M towards Mother and the children being fearful of Mother's 'boyfriend'. For a second time the children were placed on Child Protection Plans, under the category of Neglect.

1.1.7 Shortly after the Child Protection Plans were in place, a joint child protection investigation was initiated after Siblings 2 and 3 disclosed that they were being physically abused by Mr M and that Sibling 4, aged four and a half, had suffered a burn to his hand. It was not conclusive from a Child Protection Medical examination as to whether the burn to Sibling 4's hand was non-accidental however it was apparent that medical attention was not sought for the injury until three days after the incident.

1.1.8 Following investigation, all four children were removed from the care of Mother and went to live with Father and his partner, where they remain.

1.1.9 Mother and Mr M were interviewed by Police, but no criminal charges of neglect or assault were brought in respect of either of them.

1.1.10 Given that the children had been neglected over a long period, the involvement of agencies with the family and the children being subject to Child Protection Plans when they were removed from the care of their mother, consideration was given by Hounslow Safeguarding Children Partnership as to whether the case met the criteria for a Child Safeguarding Practice Review under Working Together to Safeguard Children, 2018. It was decided on 8 June 2020 that the case met the criteria for a Local Review to be commissioned.

Terms of Reference, Methodology and Scope

1.2.1 Full details of the terms of reference and methodology for the review can be found in Appendix 1, as can details of the agencies involved, and the Lead Reviewer.

1.2.2 A multi-disciplinary Learning Event for practitioners was held on 11 February 2021. Due to the Covid 19 Pandemic, of necessity, the event took place using internet technology. 17 people attended of the 28 invited. The event proved to be worthwhile, with practitioners providing important information, engaging in helpful discussions and insightful suggestions for improvement of practice. The Lead Reviewer would like to thank all those who attended, especially during this difficult time, and also the Safeguarding Children Partnership Team for arranging and facilitating the event. Discussions arising from the event have informed the learning and recommendations arising from this review.

1.2.3 **The time period for the review is from January 2013,** when concerns about the children became known to statutory agencies **to April 2020** when the children went to live with Father.

1.2.4 **The review will seek to understand and evaluate responses from agencies in the following key areas of enquiry:**

- Voice of the child/children

- Effectiveness of communication and collaboration regarding Child Protection medicals
- Understanding and/or awareness of the indicators of neglect/abuse missed by the multi-agency safeguarding system on a number of occasions
- Understanding and/or awareness by all agencies of multi-agency Child Protection Plans
- Action taken by the multi-agency in response to missed health appointments and parents' failure to progress the health issues for the children
- Failure to meet thresholds for therapeutic support
- Decision making within the Child Protection Case Conference process
- Assessment of safety/controlling behaviours by Mother's partner
- Disguised compliance and professional curiosity
- Effectiveness of interventions offered by all services throughout the timeline of the review
- Effectiveness of professional scrutiny and challenge
- Opportunity for children to feel safe to make disclosures
- Extent to which efforts were made to engage the children's respective fathers in the Child Protection Plans.

Involvement of family members in the review

1.2.5 The parents were informed on 12 February 2021 that a Child Safeguarding Practice Review had been commissioned, and letters were subsequently sent, inviting them to offer their views to the review. No response has been received from Mother. Father did contact the Local Authority in September 2021 to state that he did not wish to contribute to the review.

2 Findings and Lessons Learned

Recognition of Neglect in children

2.2.1 The Hounslow Safeguarding Children Partnership (and its predecessor, the Local Safeguarding Children Board), has provided comprehensive resources for professionals to enable them to assess neglect in children. The impact of neglect on the wellbeing of children has been a longstanding concern of the Hounslow Safeguarding Children Board, as evidenced by a Quality of Care (QOC) Assessment Tool being in place since 2011.

2.2.2 The QoC is very much a working document, which has been regularly updated and improved since its introduction, and the Safeguarding Children Partnership has continued to raise understanding and awareness amongst practitioners of the importance of neglect on outcomes for children by promoting the use of the QoC Assessment tool through regular update bulletins and practitioner learning events.

2.2.3 In addition, the Hounslow Safeguarding Children Partnership website is an excellent resource for professionals from all partner agencies. The page

concerning neglect offers what is essentially a checklist to assist practitioners in recognising the signs and effects of neglect in children. Despite attempts by the Partnership to promote the importance of the use of the QoC as a tool for identifying neglect, it is disturbing that it was not used in any of the assessments of the children in this family, as a version of the assessment tool was in place from the time the family first came to the notice of Children's Social Care. Not only does this raise serious concerns for this review, but also brings into question how often such resources are used in other cases of neglect in Hounslow.

2.2.4 Government figures show that:

'*at 31 March 2019, 52,260 children in England were the subject of a child protection plan and 2,820 children in Wales were on the child protection register because of experience or risk of abuse or neglect; neglect was the most common category of abuse in England'*[1].

2.2.5 Such government information covers the period under review and not only exemplifies the prevalence of neglect in children it also reinforces the vital importance of professionals being able to recognise neglect and to intervene to safeguard children who are neglected. This review has demonstrated that in this case, there were only two instances when it was considered the threshold for significant harm was met and the children were placed on Child Protection Plans under the category of Neglect. There were however a number of opportunities for statutory intervention during the period under review. If the QoC had been used from the outset, as it should have been, in assessments which were undertaken over a seven year period, most especially in October 2019, it may have been possible to prevent the children experiencing ongoing chronic neglect, as well as physical and emotional harm.

2.2.6 It is apparent from the review that there was a lack of supervision and management oversight, as well as frequent changes of Social Worker, which resulted in the case being allowed to drift, to the detriment of the safety and wellbeing of the children.

2.2.7 This review has shown it is essential that professionals utilise the resources available to them to identify, assess and support evidence gathering of childhood neglect. It is a lesson learned arising from the review and is reflected in **Recommendation 1.**

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[1] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/childabuseinenglandandwales/january2020

Effective Communication and Information Sharing

2.2.8 The importance of sharing information between professionals, which relates to concerns about a child, is the basis of good safeguarding practice. It is clear that there were gaps in the knowledge agencies had about the children, as evidenced in the Junior School not knowing that Mr M was living with the family, Children's Social Care not being aware of the number of times the children were not brought to medical appointments, the impact of the withdrawal of health services due to non-attendance. and the significance of the criminal history and mental health of Mr M

2.2.9 Too often a finding of statutory reviews concerning the abuse and neglect of children is for the need for comprehensive information sharing within and between agencies. Unfortunately, this review is no exception and is lesson learned, which is reflected in **Recommendation 2.**

Disguised Compliance by Parents

2.2.10 Mother's behaviour is indicative of disguised compliance. The review has acknowledged the challenge for professionals in working with parents who are unwilling to fully engage and withhold information. However, at the centre of safeguarding practice must be the needs of the child. A lesson arising from this review is that professional focus was on improving Mother's parenting capacity, supporting her in managing the children and maintaining a relationship with her. This meant Mother was able to maintain that she was engaged and compliant with requirements put in place to safeguard the children.

2.2.11 In reality, this was not the case, as is illustrated for example by Mother taking the children to the Urgent Care Centre on numerous occasions, following injury, rather than attending Hospital A&E. Whether Mother was aware that by attending the Urgent Care Centre records of such attendances are not referred to the GP, as would be the case if she had gone to A&E, is not known. However, the number of visits and the type of injuries the children sustained are indicative of neglect. The review has been informed that recent practice has changed, and GP Practices are now informed when children are brought to Urgent Care Centres for treatment.

2.2.12 The review has evidenced that Mother was able to convince professionals that she was cooperating, until the point the children felt safe enough to disclose what was happening to them whilst in her care.

2.2.13 The necessity for professionals to take a holistic view of a case to ensure that parents/carers are fully engaged in improving the care provided to their children is a lesson learned. **This can be achieved by the use of multi-**

agency case chronologies, the importance of which cannot be overemphasised and is reflected in **Recommendation 3.**

Listening to Children: the Voice of the Child

2.2.14 The Social Worker allocated to the family when the children were on Child Protection Plans during 2018-2019 has provided a helpful insight into the children's lived experience. What emerges is that whilst the children were prepared to engage to a certain extent, with hindsight the Social Worker recognised that Sibling 1 was anxious and there was a lot of pressure on the children not to disclose.

2.2.15 At times, the children did disclose what had happened at home, for example that Mr M was frequently present, and that he had deliberately pushed Sibling 4 over whilst in his highchair, however Mother maintained that this was not the case. The children were also able to let their teacher know about the injury to Sibling 4's hand. The presentation of the children, being hungry and the lack of appropriate clothing, illustrated the level of neglect they were experiencing. More significantly, Sibling 2's frequent soiling could be said to be indicative of emotional anxiety, if not possible sexual abuse.

2.2.16 The GP referral for Sibling 2 was not accepted by CAMHS, as it was considered not to meet the threshold criteria. This decision could have been questioned by the GP and a re-referral should have been reconsidered at the Initial Case Conference in August 2018 when concerns about the children, including Sibling 2's behaviour, became increasingly apparent. Due to the refusal of CAMHS to accept the referral concerning Sibling 2, an opportunity was missed for the cause of his soiling to be explored in a therapeutic environment.

2.2.17 It is acknowledged that there is an overwhelming demand for CAMHS intervention, which is far greater than service capacity. This is a situation which is well known by practitioners when making referrals. It raises the question as to whether knowing that a referral is likely not to be accepted leads to a situation of resignation on the part of practitioners that little else can be offered in the form of expert professional intervention. It would have therefore been appropriate to challenge the decision that the referral did not meet the CAMHS threshold for intervention, and a re-referral should have been made when Sibling 2 was placed on a Child Protection Plan. This is a lesson learned. **Recommendation 4**

The Adequacy of the Child Protection Process

2.2.18 This report has discussed in detail the adequacy of the Child Protection process in this case. The conclusion reached is that the process lacked rigour and challenge, which resulted in the children suffering chronic neglect and abuse. It is evident that there should have been greater professional curiosity to ensure appropriate information was collated and shared between agencies

and to question why the QoC was not used as an assessment tool. If this had happened, an opportunity would have been provided for decisions to be evidence based, which could have recognised that the children were at risk of significant harm.

2.2.19 The way in which the Child Protection Medicals were conducted also raises some concern. It has been clarified that Sibling 4 did have a Child Protection Medical when his injuries were assessed at Hospital 2 and that the three other children were not immediately medically examined as there was no indication of immediate injury. These decisions were in line with policy and practice. However, whilst it was not conclusive that the burn to Sibling 4's hand was non accidental, it was evident that there was delay in seeking medical attention, which was indicative of neglect. Because of his low weight and limited growth, Sibling 2 was assessed as being malnourished and it was thought that there was a possibility that due to his soiling, he may have been sexually abused. However, no information is available as to whether it was considered appropriate to undertake an examination to ascertain whether this was the case. Given the trauma Sibling 2 had experienced, it is perhaps understandable that such an invasive examination did not take place.

2.2.20 A joint child protection investigation was initiated by Police and Children's Social Care following the injury to Sibling 4's hand. During the course of the investigation, it became clear that *'[Mr M] was residing at the family home and the boys were terrified of him.'* (Source: Police report). However, because both Mother and Mr M denied causing injury to the children, the Police Supervisor's review of the criminal investigation '*concluded that allegations of child cruelty against Mr M and wilful neglect by Mother would be difficult to prove due to evidential difficulties……. it was felt that as the children had settled well…..…little would be achieved by putting the children through the strain of criminal proceedings which may have a negative impact on their health and welfare.*' (Source: ibid).

2.2.21 Whilst recognising the need to protect the children from a criminal process, which could compound and exacerbate the abuse they had already experienced; the findings of the Police investigation that the children were 'terrified' of Mr M, together with Mother telling the children not to speak about how the injury occurred and not seeking medical attention for the burn for three days only serve to support the finding of this review that the children suffered prolonged neglect, emotional and physical abuse.

The importance of fathers

2.2.22 It is striking that Father was not included in the assessments and Child Protection processes which were undertaken during the timeframe of the review. This is not unique to this review and is unfortunately a frequent finding of statutory reviews. It is recognised that it can be problematic for practitioners to ascertain the whereabouts of fathers, not least when a mother is reluctant

or unwilling to disclose such information. However, there are means available by which the whereabouts of individuals can be ascertained, and this case is not an exception. Whilst Father may not have wished to engage with Children's Social Care, he should have been offered the opportunity to do so. If he had been included and participated in assessments and Child Protection Conferences, a more detailed picture of the children's lived experiences and changes in behaviour may have emerged, which could have resulted in the children being looked after by Father at an earlier stage.

2.2.23 The necessity for practitioners to endeavour to locate and attempt to involve fathers in the Child Protection process in order to gather as much information as possible to inform any assessment is a lesson learned from this review. **Recommendation 3**

3 Good Practice

3.2.1 The Quality of Care assessment tool developed by Hounslow Safeguarding Children Partnership is an exemplar of good practice, as is the designated page dealing with neglect on the Partnership website.

3.2.2 It was good practice on the part of the Junior School Head Teacher and the Deputy Head Teacher to provide a safe and supportive environment to enable the children to feel able to disclose what was happening at home. They are also to be commended for staying late into the evening on the day of the disclosures to ensure that the children were placed safely with Father.

3.2.3 The consistent involvement of the School Nurse throughout the time the children attended the Infant and Junior Schools was good practice.

4 Conclusions and Recommendations

4.2.1 This review has highlighted the challenges professionals often face when dealing with the neglect of children. It is complex, and as this case has shown difficult to reach the point where criminal proceedings can be brought. However, such considerations cannot and should not detract from agencies using the resources Hounslow Safeguarding Children Partnership have put in place to assist professionals to improve quicker identification and assessment of children who are at risk of neglect.

4.2.2 One of the most important findings of this review is the vital importance of chronologies, especially in cases of chronic neglect. By compiling a chronology, a professional is provided with the opportunity to collate information on a multiple- agency basis, view events and decisions taken and assess the outcomes for children. Whilst this may be considered a time consuming process, it is known that chronologies can save children's lives and prevent ongoing abuse and neglect.

4.2.3 Like many other statutory reviews this case has raised familiar issues and lessons for those involved in safeguarding children. It is acknowledged that safeguarding children is difficult, demanding and complex, however, the importance of maintaining professional curiosity to ensure that relevant information is collated, assessed and reviewed is essential if children are to be protected from neglect and significant harm.

5 Recommendations

The following recommendations are for consideration by the Hounslow Safeguarding Children Partnership.

Recommendation 1 **Hounslow Safeguarding Children Partnership should continue to facilitate its multiagency Quality of Care Assessment tool training programme ensuring that all partner agencies are using and contributing to the assessment of neglect and challenging any gaps in practice.**
Recommendation 2 **If not already in place, consideration should be given to compiling a checklist of required information to be provided to an Initial Child Protection Case Conference, to be subsequently updated for Review Conferences. This would ensure that the Independent Chair and those attending are confident that appropriate information has been collated and shared, to inform evidence based decision making.**
Recommendation 3 **The use of multi-agency safeguarding chronologies should be standard practice where there are concerns that a child is being neglected and/or in need of protection. The necessity to include details concerning both parents and relevant family members in such chronologies is of crucial importance.**
Recommendation 4 **Agencies are to be reminded of:** **(a) the importance of listening to children, being aware of what their presentation may indicate and taking serious account of what they feel unable to talk about, as possible indicators of neglect and abuse. Such information to be recorded, shared between agencies and acted upon.** **(b) the importance of challenging decisions where agencies are of the view that a referral does not meet the threshold for intervention, if children are to be protected from abuse and neglect.**

Appendix 1

Hounslow Child Safeguarding Practice Review Terms of Reference

1) Background

In May 2020 the Local Authority notified Ofsted of a Serious Incident following recommendation from the Cases Sub-Group of the HSCP, as a result of long-standing chronic neglect suffered by four siblings whilst in the care of their mother. Prior to their removal from their mother in April, all four children were subject to Child Protection medicals, following a burn sustained by the youngest child. All four of the children are now residing with the biological father of the youngest three children, with a Private Fostering arrangement in place for the oldest child.

2) Overall Objectives

The overall objective of the review is to review multiagency practice in how the system responded individually and together to address concerns, safeguard and promote the wellbeing of the children. It will understand strengths and any weaknesses in practice and service delivery and will identify organisational learning and improvements and, where relevant, the prevention of the reoccurrence of similar incidents.

Individual and organisational accountability is manifest through being open and transparent about any problems identified in the way the case was handled and demonstrating a commitment to seek to learn from and address the causes.

Recommendations will be made and translated into an action that will lead to sustainable improvements.

The review will be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children
- 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 information is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

The review will:

- Be proportionate
- Involve the professionals fully and invite them to contribute their perspectives without fear of being blamed for actions they took in good faith;

- Involve families, including children, where possible. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;

3) Review timeline and themed areas of enquiry and wider questions to be addressed

The review will explore support and services working with the family from January 2013 (when concerns about the children became known to statutory agencies) - April 2020 when the children went to live with Father). The review will seek to understand and evaluate responses in the following key areas of enquiry:

- Voice of the child/children
- Effectiveness of communication and collaboration regarding Child Protection medicals
- Understanding and/or awareness of the indicators of neglect / abuse missed by multi-agency safeguarding system on a number of occasions
- Understanding and/or awareness by all agencies of multi-agency Child Protection Plans
- Action taken by the multi-agency in response to missed health appointments and parents' failure to progress the health issues for all children
- Failure to meet threshold for therapeutic support
- Decision making within the Child Protection Case Conference process
- Assessment of safety / controlling behaviours by mother's partner
- Disguised compliance and professional curiosity
- Effectiveness of interventions offered by all services throughout the timeline of the review
- Effectiveness of professional scrutiny and challenge
- Opportunity for children to feel safe to make disclosures
- Extent to which efforts were made to engage the children's respective fathers in the Child Protection Plans

4) Method of enquiry (steps may overlap and may not occur in this order)

LCSPRs are required to be completed within six months and the final overview report and recommendations will be published on the partnership's website.

The methodology being used for this review is systemic seeking to understand the rationale for decisions and actions taken in the context of the agencies in which practitioners were working at the time.

The method incorporates:

- Oversight by a LCSPR Panel Chaired by the Independent Chair of the HSCP and led by an Independent Reviewer

- Each agency involved will provide a chronology created from agency records for the time period of the review.

- Single agency analytical reports evaluating their involvement with the family and other agencies, using agency standards and identify any lessons learnt, as a result of this review. The review should be undertaken by an experienced and independent senior officer, able to analyse the quality of the work and decisions, within the context of agency procedures, relevant research and any significant systemic issues which were current in the agency during the time period of the review. The report should be endorsed by a senior manager who is also a HSCP Board member for that organisation and who did not have direct involvement in the management of the case.

- Engagement with family members - the family will be informed of the review and invited to share their views about the agencies who worked with them; they will be offered meetings with the Independent Reviewer.

- Agencies should involve relevant practitioners in conversations about the work, decisions and actions when analysing the rationale for the work undertaken. The HSCP will invite them to Practitioner Learning Event/s, to seek the views of practitioners about the work and its context.

- The Panel may consider how to speak with any practitioners individually where appropriate.

- The Independent Reviewer may request specific case documents where they believe it would assist the understanding of the case; and any relevant agency policy or procedural documents.

- The review should refer to relevant law, guidance and research

- The Panel may seek legal advice if required

5) Areas excluded or limited in scope

The focus of the review activity will be on the areas that are considered to be the most important **(see section 3 above**). Additional items may be added to the terms of reference if significant new information emerges.

Methodology

Reports were received from each agency involved in the review.

A learning event was held for professionals.

Regular Panel Meetings were held to discuss the progress of the review.

Partner agencies involved in the review:

- Children Social Care (CSC)
- CCG
- GP
- West Middlesex University Hospital (WMUH)
- Hounslow and Richmond Community Healthcare (HRCH)
- Education Welfare Service (EWS)
- Victoria Junior School
- Springwest Academy
- Police

Moira Murray, Lead Reviewer: Is a social worker by training and has undertaken numerous SCRs, Learning Reviews and SCPRs. She has been involved in safeguarding audits for the NHS, the voluntary sector and local authorities. She co-authored HM Government *Safeguarding Disabled Children Practice Guidance, 2009* whilst Head of Safeguarding at the Children's Society. She was a non-executive board member of the Independent Safeguarding Authority for 5 years, was Safeguarding Manager for Children and Vulnerable Adults, London 2012 Olympics and Paralympic Games; has undertaken safeguarding reviews for the Foreign & Commonwealth Office, the BBC post Jimmy Savile and Premier League Football. Until recently she was the Senior Casework Manager in the National Safeguarding Team, Church of England.