Hounslow Safeguarding Children Partnership

Child Safeguarding Practice Review

Executive Summary

Child A

Lead Reviewer

Moira Murray

April 2022

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1. Introduction:
Background Summary

1.1.1 Child A first came to the attention of Children's Social Care in 2005 when she was two and a half years old. At the time there were concerns about Mother's mental health and domestic abuse. Mother refused to engage with Children's Social Care, maintaining that Child A was not present at the time of the domestic abuse incident and that she could protect her daughter. The case was closed.

1.1.2 Child A's father ceased to be involved with the family when Child A was four, and it seems from then onwards there was no contact with him. By this time, Child A was attending nursery, where speech and language difficulties were first identified. Concerns about Child A's presentation, behaviour and learning difficulties were also identified, which continued when she started Primary School. Child A's school attendance was poor and continued to deteriorate throughout her school aged years.

1.1.3 Mother and her extended family suggested that Child A needed to attend a Special Educational Needs School. An assessment by an Educational Psychologist found that Child A's cognitive ability was low, that she had high levels of anxiety and poor self-esteem. A referral was made to the Early Intervention Team however Mother did not engage.

1.1.4 In 2014, Child A transferred to a mainstream Secondary School. By this stage her attendance had further deteriorated, and she had become selectively mute. Concerns about Mother's mental health increased, and it became evident that this was impacting on Child A's wellbeing. Secondary School staff did their utmost to maintain a relationship with Child A and Mother to ensure that Child A remained in mainstream education.

1.1.5 In April 2015, because of Child A's poor attendance, the Secondary School made a request for intervention by the Education Welfare Service, and also raised concerns that Mother's mental health was resulting in Child A being at risk of physical and emotional neglect. In June 2015, the Secondary School was informed by the Local Authority that Mother had elected to home educate Child A and in September she was taken off the school role.

1.1.6 Following concerns that there was no evidence of home education taking place as well as the home conditions, the Elective home Education Team made a referral to Children's Social Care in January 2016. An Initial Assessment commenced in February 2016 and in August 2016, Child A was made subject to a Child Protection Plan under the category of neglect. By this time Child A was 14 years old.

1.1.7 The Elective Home Education Team ceased involvement and Child A was referred to the Continuing Access to Education (CATE) School. A referral was made to CAMHS, but Mother refused to engage with the service, nor did she engage with CATE.

1.1.8 During 2016 – 2017 attempts were made by Children's Social Care to gain access to Child A, at times requesting Police assistance, however, Child A remained in Mother's care. In October 2018, following a Review Child Protection Conference and Legal Planning Meeting, pre-proceedings were initiated with the intention of applying for a Child Assessment Order. This was not pursued, despite Mother's lack of cooperation. Although consideration was given to applying for an Interim Care Order, it was decided that as Child A was now 16 years old there was little chance of success.

1.1.9 Child A remained on a Child Protection Plan until March 2019 when a Review Child Protection Conference decided it should end. Following concerns raised with the Community Risk Panel, a Strategy Discussion took place in February 2020. A joint home visit with Police and Children's Social Care discovered that Child A and Mother had vacated their flat and had moved in with Maternal Grandmother and Maternal Uncle, who was a convicted sex offender.

1.1.10 In May 2020, Police and CAMHS practitioners took Child A to hospital under a s135 Mental Health Act warrant. Following an assessment in A&E, Child A was discharged home into her mother's care.

1.1.11 It was not until August 2020, that Police called at Maternal Grandmother's home in the early hours of the morning, having received an urgent call from a member of the public in the USA, with whom Child A had been in contact via social media. Child A was removed by Police Officers and having spent a significant period of time at the Police Station, was eventually placed with an emergency foster carer. The next day Child A was seen by the Community Paediatrician for a Child Protection Medical and was assessed as requiring immediate medical attention. Child A was taken to A&E and subsequently admitted to a paediatric ward, where she remained for four weeks.

1.1.12 On her discharge from hospital, Child A was placed with long term foster carers, where she remains. As she is now adult, Child A's care has transferred to Adult Social Care. After Child A's removal from her mother's care, Mother was sectioned under the Mental Health Act, 1983 and was diagnosed with paranoid schizophrenia. No criminal charges have been brought against Mother or members of the extended family.

1.1.13 Given that that Child A had been neglected for the majority of her childhood, the involvement of agencies with the family, Child A being subject to a Child Protection Plan and Elective Home Education, consideration was given by Hounslow Children Safeguarding 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 12 October 2020 that the case did meet the criteria for a Local Review to be commissioned. The Child Safeguarding Practice Review National Panel has indicated that the review is of particular interest nationally, given that Elective Home Education was a feature of the case, as well as the effectiveness of certain agencies in Child A's life (see below).

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 1 July 2021. Because of the Covid 19 Pandemic, the event took place virtually. The event proved to be worthwhile, with practitioners providing important information, engaging in helpful discussions and insightful suggestions for improvement of practice. Discussions arising from the event have informed the learning and recommendations arising from this review. The Lead Reviewer would like to thank all those who attended and the Safeguarding Children Partnership Team for arranging and facilitating the event.

Time Period under Review:

1.2.3 The review will explore the support and services working with the family from **January 2011 – August 2020**.

1.2.4 The review will seek to understand and evaluate responses in key areas of enquiry identified through the Rapid Review process and recommendations made by the National Panel.

Involvement of family members in the review

1.2.5 Mother was informed on 28 July 2021 that a Child Safeguarding Practice Review had been commissioned. Mother has not engaged with the review. Father's whereabouts are not known.

2 On 28 October 2021 the HSCP Service Manager and on 1 November 2021, the Lead Reviewer spoke with Child A's foster carer. Child A did not feel able to speak directly with the Lead Reviewer, however she was in agreement for her views on her past and current experiences to be relayed to the Lead Reviewer by her foster carer.

3 Learning arising from this Child Safeguarding Practice Review

3.1.1 The following learning for Partner agencies has arisen from this review.

3.1.2 Whilst it may be a parent's right to electively home educate their child, professionals need to consider whether there is a safeguarding risk posed to a child when they are removed from mainstream education. This involves ensuring that the parent has the

intellectual capability and resources to provide a suitable standard of education. Most importantly, the child themselves should be asked their view as to whether they agree to be home educated. There is no evidence that Child A was asked if she was happy and agreed to the proposal that she should be removed from her Secondary School.

3.1.3 The importance of collating information from agencies who know the child, especially the school they are attending, to ascertain whether there are any concerns about a child being removed from mainstream education is vital if children are to be safeguarded and their wellbeing promoted. In this case the Secondary School raised immediate concerns when Mother said she was going to home educate Child A. These concerns were made known to the Local Authority, and it is to the school's credit that they had made previous referrals to the Education Welfare Service and Children's Social Care about Child A's lack of attendance and Mother's mental health. This information was available to the Elective Home Education Team prior to the authorisation for Child A to be removed from the school roll. The need for professionals to collate and take account of information which raises concerns about the safety of a child being home educated is a **lesson learned from this review. Recommendation 1**

3.1.4 It is acknowledged that the Elective Home Education Team is insufficiently resourced and over stretched. However, when a member of the Team is concerned about the home environment and does not consider the work programme set by a parent for their child to be appropriate for their needs, such concerns need to be brought to the immediate attention of their line manager. **This is a lesson learned from this review. Recommendation 4**

3.1.5 When a child has a history of non-school attendance, as was the case for Child A, professionals need to recognise this as a serious safeguarding issue. Child A's school attendance was of concern from when she was at primary school and deteriorated when she transferred to secondary school. Prior to her being removed from the school roll, Child A had not attended school for five months. For Mother to then inform the Local Authority that she wished to electively home educate her child, should have raised immediate concerns, and provoked a comprehensive assessment as to whether Child A was at risk of significant harm. The fact the Child A continued to be home educated when she was subject to a Child Protection Plan, not least given Mother was refusing to allow professionals to enter her home, is deeply concerning. Such practice is not consistent with statutory guidance, Working Together to Safeguard Children 2018 and is indicative of systemic failure. **This is a lesson learned from this review.**

3.1.6 The review has highlighted the lack of reference to children who are electively home educated in statutory safeguarding guidance. The need to ensure that consideration is given to include children who are home educated in any future revision of Working Together to Safeguard Children is **a lesson arising from this review. Recommendation 3**

3.1.7 This report has detailed the deficiency of the Child Protection process in this case. Over a period of almost three years when Child A was subject to a Child Protection Plan, there were numerous opportunities for professionals to intervene to remove her from an increasingly volatile and dangerous environment. The necessity for agency representatives to challenge each other when there is indecisiveness and or inappropriate decisions being made during the course of Child Protection Conferences, including the basis of the legal advice provided, is vital if there are to be positive outcomes for children at risk and **is a lesson learned from this review. Recommendation 5**

3.1.8 Given that neglect is the most frequent category of abuse for children subject to Child Protection Plans, it could be anticipated that professionals would be knowledgeable of the signs, impact and negative outcomes for children who are neglected. It is apparent however, that there was a lack of recognition of the chronic neglect to which Child A was subjected. The tools to assess neglect are readily accessible to all agencies working in Hounslow and the Safeguarding Children Partnership is to be commended for the range of resources available to professionals. It is of concern that in this case such resources were not fully utilised. If the Quality of Care assessment tool had been used appropriately, the initial assessment undertaken by Children's Social Care would hopefully have been more robust and would not have taken five months to complete. The need to ensure that partner agencies use the resources available to assess neglect is vital if professional practice is to be improved and children protected. **This is a lesson learned, which is reflected in Recommendation 6.**

3.1.9 The review has exemplified the impact of a parent's undiagnosed mental illness on a child's health and wellbeing. As has been detailed, Mother's presentation to the GP and to the Mental Health Team was indicative of depression and anxiety. Yet there were indications of underlying paranoia, as evidenced by Child A's disclosure of Mother speaking of ghosts, keeping the curtains closed, her obsession that a neighbour's child was continually threatening her and Child A, refusing to allow entry to the home and her withdrawal into an enclosed home environment consisting of herself and Child A. The importance of sharing known information about a parent's mental health is crucial if children are to be protected.

3.1.10 In this case, the Police, the Secondary School and the GP did make referrals about Mother's increasingly disturbed behaviour, but it was not until Child A was taken into Police Protection that the full extent of Mother's mental illness was diagnosed. However, information was known about Mother's mental health by those involved in the Child Protection process. If such information had been collated into a chronology, then those agencies involved, including Legal Services, would have been provided with evidence-based knowledge of the seriousness of Mother's mental health and its impact on Child A's wellbeing. **This is a lesson learned from this review. Recommendation 6.**

3.1.11 Listening to children who are experiencing neglect and or abuse is of the utmost importance if they are to be safeguarded. Child A was provided with some opportunities to disclose what was happening to her, and it is significant that on each occasion she did so, she was in a safe place and Mother was not present. Child A was able to disclose at times, some of the abuse she had experienced by speaking directly to people she trusted. It is however also important that professionals working with children consider children holistically, which involves taking account of what is not said, the conditions in which they live and their physical and emotional presentation.

3.1.12 Appropriately, Child A was taken into Police Protection in the early hours of the morning when she was removed from Maternal Grandmother's home. However, it was inappropriate for her to be taken to a police station to await the identification of an emergency foster placement, a process which in the event took approximately twelve hours. The reasons why there was such a delay in finding a placement by the local authority have been identified, and the review has recognised the major challenges faced by Children's Social Care in finding placements for older children. Nevertheless, this situation was detrimental to Child A's welfare, as it would have been to any child. It is the responsibility of the Initiating Officer to ensure a child's wellbeing whilst under Police Protection and given the length of time which Child A remained at the Police Station, the situation required intervention and escalation. The review has found that consideration should be given to identifying a Single Point of Contact within Children's Social Care for the Initiating Officer to be able to discuss, share and if necessary escalate concerns for a child awaiting a foster placement whilst under Police Protection. **This is a lesson learned and is reflected in Recommendation 8**

4 Good Practice

4.1.1 The review has identified the following good practice:

- The action on the part of the Secondary School to take seriously the concerns about Child A's non-school attendance, the quality of her life at home and Mother's intention to electively home educate her daughter was good practice and is to be commended.
- The concerns raised by Police about Mother's mental health and the welfare of Child A was good practice.
- The questioning of the A&E doctors about Child A being discharged was good practice.
- The referrals to the Mental Health Team, CAMHS and to Children's Social Care by the GPs involved with the family was good practice and showed an effective awareness of safeguarding.

4 Conclusions

4.1.1 This review has been complex and of necessity detailed.

4.1.2 Whilst the majority of children who are electively home educated can be considered to have an enjoyable and rewarding experience, this review has highlighted the risks presented to vulnerable children whose wellbeing is compromised by such an arrangement. Therefore, the need to ensure that information is collated about the circumstances under which home education is to be provided, the history of a child's school attendance and any concerns about a child's welfare is a pre-requisite for agencies involved.

4.1.3 Child A was a child about whom teachers had sufficient concerns which resulted in referrals being made to the Education Welfare Service and Children's Social Care. The Secondary School recognised the risk presented to Child A if she was removed from the safe environment of mainstream education and made their concerns known to the Local Authority. Mother's decision to home educate Child A provided the means for her to remove her daughter from any form of regular monitoring concerning her health and wellbeing.

4.1.4 Child A was essentially lost to systems set up to safeguard and monitor children from February 2015 when she effectively ceased attending secondary school until August 2020 when she was finally removed from the care of her family. For part of this period of five and a half years, Child A was on a Child Protection Plan, and whilst seen on occasions, she remained under the care and control of her mother throughout. This was despite the deteriorating home conditions, no educational provision, isolation, Child A's significant weight loss, neglectful presentation and Mother's worsening mental health.

4.1.5 This review has concluded that the means were available through the legislative framework to safeguard children for Child A to have been removed much earlier from Mother's care. That she was allowed to remain in an unsafe environment for so long resulted in her suffering chronic neglect was due to systemic failure. This resulted in Child A losing years of her childhood and adolescence and may have affected her cognitive and physical development. It is fortuitous that a secure, caring long term placement has been found for Child A which will hopefully enable her to progress safely into adulthood.

5 Recommendations

The following recommendations are made for consideration:

<u>For the Department for Education</u>: **Recommendation 1** **The Department of Education to consider amending statutory guidance so that when a parent gives notice of their intention to Electively Home Educate their child, information should be collated from safeguarding partner agencies to ensure that there are no known concerns that may place the child at risk of significant harm. These checks should take place prior to the child being removed from mainstream education.**
<u>For the Department for Education</u>: **Recommendation 2** **The Department for Education to consider amending statutory guidance so that local authorities have authorisation to seek assurance that the parent has the intellectual capability and appropriate resources to fulfil the requirements to provide suitable home education to the child. Where such assurance is not forthcoming, the local authority can decide whether it is in the child's best interest to be Electively Home Educated.**
<u>For the National Panel</u>: **Recommendation 3** **The National Panel to take into consideration the importance of the need to include a section on children who are Electively Home Educated in any future revision of Working Together to Safeguard Children. commendation 3**
<u>For Hounslow Safeguarding Children Partnership</u>: **Recommendation 4** **If a visiting member of the Elective Home Education Team has concerns about the suitability of the education being provided by a parent, if appropriate and safe, such concerns need to be raised with the parent and also with their line manager.**
<u>For Hounslow Safeguarding Children Partnership</u>: **Recommendation 5** **Where there is disagreement about a Child Protection Conference decision or concerns about the way in which a Child Protection Plan is being adhered to, professionals should be confident to challenge each other and the Conference Chair, to ensure that the best interests of the child are at the centre of any decision making.**

For Hounslow Safeguarding Children Partnership:
Recommendation 6

Assurance should be sought that agencies are utilising the tools and resources made available by the Partnership to assess neglect and improve outcomes for children. Where it is evident that such assessment resources are not being sufficiently utilised, agencies need to be held to account.

For Hounslow Safeguarding Children Partnership:
Recommendation 7:

The use of multi-agency chronologies as part of the Child Protection process, especially in cases of chronic neglect, should be promoted as a means of collating information concerning parents and children.

For Hounslow Safeguarding Children Partnership:
Recommendation 8

When a child is taken into Police Protection:

(a) Consideration should be given, as to whether advice is needed (if out of hours from the Consultant Paediatrician on call 24/7 at West Middlesex University Hospital) to decide if a child protection medical and/or immediate medical attention is required.

(b) Consideration should be given by Partner Agencies to appointing a Single Point of Contact within children's Social Care for concerns to be discussed, shared, and escalated when a child is waiting for an appropriate care placement to be found, so as to ensure the welfare of the child is not compromised.

Appendix 1

Local Child Safeguarding Practice Review – Child A
Terms of Reference

1) Background

In September 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 Child A, now 18 years old, whilst in the care of her mother. She was removed from her home under Police Protection and admitted to West Middlesex University Hospital due to the impact of severe physical and emotional neglect. Prior to her removal from her home in August 2020, Child A had previously been subject to protection plans and the risk of significant harm considered within the legal threshold for removal from her mother care. In August 2020, Child A was discharged from hospital into a foster placement.

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.
- 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 the family, including the young person, 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 the support and services working with the family from **January 2011 – August 2020**. The review will seek to understand and evaluate responses in the following key areas of enquiry identified through the Rapid Review process and recommendations made by the National Panel:

- The focus on the child in all assessments and understanding how she became less visible to professionals. ***(Requested by National Panel)***
- What opportunities were created for the child to make disclosures.
- The assessment and consideration of undiagnosed parental mental health impacting parenting and ability to make and sustain positive changes.
- The effectiveness of decision making and assessment of risk, outcomes and impact within the Child Protection Case Conferences and multi-agency safeguarding meetings.
- Professional understanding of the reasons for Elective Home Education within the timeline of the child's life and how well it was explored and understood. ***(Requested by National Panel)***
- The understanding and consideration by all agencies of the impact of Elective Home Education on the child and its consideration in assessments of risk. ***(Requested by National Panel)***
- Professionals understanding and/or awareness of the indicators of neglect / abuse missed by multi-agency safeguarding system.
- De-escalation as a means of engagement and compliance when the family disengaged
- The effectiveness of interventions offered by all services throughout the timeline of the review
- The effectiveness of professional scrutiny and challenge across the network
- How well information was shared across the system and the effectiveness of the pathways to feedback to referrers
- The effectiveness of the role of GP, School Nursing Services and CAMHS in the child's life. ***(Requested by National Panel)***

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 Individual Management Reports (IMRs) evaluating their involvement with the family and other agencies, using agency standards and identify any lessons learnt, as a result of this review. The IMR should be completed 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.

The Lead Reviewer

Moira Murray is a social worker by training and has undertaken numerous SCRs, Learning Reviews and Safeguarding Children Practice Reviews. 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 a review for the Foreign & Commonwealth Office, reviewed the BBC post Jimmy Savile and undertaken safeguarding reviews of Premier League Football. Until recently she was the Senior Casework Manager in the National Safeguarding Team, Church of England.