Kirklees Safeguarding Children Partnership

Serious Case Review

Child B and C

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The disclosure of information beyond that which is agreed, will be considered as a breach of the subjects' confidentiality and a breach of the confidentiality of the agencies involved

Contents

1. Context.
2. Introduction to the case and summary of learning.
3. Process.
4. Family structure.
5. Background prior to the scoped period.
6. Analysis of key practice episodes and the identification of learning.
7. Conclusion and next steps.

1. Context

1.1 The history and timeframe of this case relates to a period in which Children Social Care in Kirklees was under significant scrutiny. The concerns which led to the scrutiny, followed numerous inspections of Children Social Care by the regulator Ofsted in which services were described as inadequate, these are well documented elsewhere. The concerns, which primarily related to the leadership and management of services and the impact that had on the quality of front-line social work practice and the quality of partnership working are not the subject of this report. The documentation relating to Ofsted including inspection and monitoring reports are already in the public domain.

1.2 This report focuses on the learning for the wider children's system as a result of the engagement with the children, their siblings and family.

2. Introduction to the case and summary of learning

2.1 This review is in respect of twin girls born five weeks prematurely in November 2017, they are known as child B &C. Both girls suffered physical injuries six weeks after their birth. This included multiple fracture detected through a scan. The family were not unknown to agencies given a familial concern about neglect and its impact on two other children in the household.

2.2 There had been a history of working with the family to resolve the concerns prior to the twins' birth, improvements in home conditions were not maintained for any lengthy period. A pre-birth assessment was started but not finished at the time of the twins' arrival and so they were discharged home into the care of parents. A child protection plan was put in place for them, as part of the discharge planning. A plan was already in place for the older siblings.

2.3 The Learning identified from the Review is in relation to

- The need to recognise the impact of parents own history and Adverse childhood experience on parenting capacity
- The importance of effective multi agency pre-birth assessment in informing planning
- The need for Kirklees to develop a strong and robust response to Neglect
- Recognising and avoiding over optimism
- Understanding how difficult it is for a parent who has negative experiences of professional involvement to accept help
- The need for all agencies to effectively escalate concerns in a proactive way
- The importance of a strong and effective leadership at all levels to drive practice improvement, this includes supervision of front line staff.

3. Process

3.1 The process of reviewing this case has not been easy to complete, particularly given the improvement work already underway, which was tackling the very issues in multi-agency working identified by this review. It has been important to recognise this parallel process and to draw learning to support continued improvement, not allowing the practitioner and management events focusing on this very difficult case to undermine the rebuilding of services and the improvement in multi-agency relationships.

3.2 Any review must be based on a premise of not seeking to attach blame to any individual professional or agency for the injuries which were inflicted on the twin babies. On the contrary, this case review has been actioned to understand the rationale, impact and context of the agencies' response to the family of these children. The purpose of this is to strengthen and continue to improve child safeguarding practice in Kirklees and to compliment improvement work already underway. The safeguarding climate in Kirklees at the point of this review was markedly different from that which existed at the point of injury to these children.

3.3 Following consultation with the "National Panel of Independent experts on serious case reviews", Kirklees Safeguarding Children Board (KSCB) recognised that these circumstances met the requirements for a serious case review, as described in the prevailing statutory guidance entitled Working Together to Safeguard Children March 2015

3.4 The review was initially commissioned in March 2018 a series of multi-agency practitioner events were held using an independent reviewer and opportunities were given to agencies to comment on the initial drafts of the report.

3.5 The scoping exercise identified two key objectives:

- To gain an understanding of the multiagency response to the family of these two children, to extract any learning from this specific case, to strengthen safeguarding in Kirklees and to complement existing improvement work.
- To ascertain whether this case can also provide a "window" on the current, wider multiagency child safeguarding system, within Kirklees, from the perspective of the improvement plan and its implications for partner agencies.

3.6 This report is intended to reflect on the circumstances of children B and C and the fractures sustained by them while in the care of their parents. Given their age there is very little by way of historical context that involves them, there is however a considerable history relating to the care of the older children who are not the focus of this review.

3.7 The familial pattern of care of the older siblings of B&C are referred to in this case, however neither of those children were subjected to harm of a physical nature. The presenting concern was relating to neglect and it was for this reason B&C were made subject to child protection planning at birth.

3.8 Working Together 2018 paragraph 53 makes the point that highlights the importance of professionals considering the distinct issues for individual children and for this reason this review considers the issues relating to children B&C. The safeguarding partnership has received assurance regarding the key issue of neglect highlighted by the experience of the older siblings and the way in which learning has been implemented.

4. Family Structure

4.1 The relevant family members in this review are:

Family Member	**To be referred to as**
Subject Child	B
Subject Child	C
Older Sister	M
Older Brother	J
Mother to B, C, M, J	Louise
Father of B&C	Anthony
Father of older sister M	Stephen
Father of older brother J	Paul
Paternal grandmother of M	Irene
Paternal grandmother of J	Catherine

4.2 The subject children B&C, twin babies, were born in November 2017, five weeks prematurely. They left hospital to reside with older siblings, M and J who were aged 6 and 3 respectively. The family were known to services because of concerns regarding neglect. The father of the twins was living in the household and involved in daily life. The older children, who had different fathers, spent time with their respective paternal grandparents. Their ethnic origin is reported to be white British and there is no record of a specific religious/faith affiliation.

5. Background prior to the scoped period

5.1 This family was well known to services in Kirklees. Louise was known to have had a very poor childhood experience, witnessing domestic abuse between her parents as well as experiencing the impact of her father's poor mental health and her mother's substance misuse. The review has not considered the practice with the family during Louise's own childhood in detail, but she experienced what today would be described as Adverse Childhood Experiences.

5.2 Louise has a learning disability, which is recorded on several agency records, although any formal diagnosis of this and the specific impact it has on her ability to process and understand information is less clear. In addition, she has poor eyesight and often does not use her prescribed glasses.

5.3 Observations suggest a reluctance to accept advice or support from professionals and at times agencies report hostility and resistance. This meant that home conditions would improve, but such improvements were short lived and often occurred because of professional scrutiny or the involvement of her sister or friends.

5.4 Louise struggled to care for herself, records suggest issues were not limited to the conditions in the house, but related to personal hygiene, nutrition and managing her finances. Records suggest that this vulnerability extended to her actions online to meet a partner and included her opening her house to men and other adults, who simply 'moved in 'very quickly with little regard for her own or her children's safety. At times Louise allowed virtual strangers to have contact with, and sometimes to care for her children.

5.5 In the period of this review (November 2014 – January 2018) a range of services from a number of agencies has been involved. Most of the professional involvement has been at the level of "universal services" and "early help", with an emphasis on health and education. Family support through the services of Action for Children has also been given. Support from local authority children's social care has been intermittent, through the period of this review.

5.6 The greatest focus in the professional contact with Louise and her family has been the ongoing, chronic and severe neglect of M and J.

6. Analysis by Key episode and identification of learning

6.1 Key episodes are periods of intervention that are judged to be significant to understanding the work undertaken with children B&C. The episodes are key from a practice perspective rather than to the history of the child, so they do not form a complete history, but will summarise the significant professional involvements that informed the review. From the information gained from the agency reports, from the discussions at the practitioner events and from the insights of family members, the following analysis enables the identification of key learning for the KSCP.

6.2 It should be said at this stage that throughout this review Louise has remained consistently hostile to professionals involved in trying to support her in her parenting of the children.

Key practice Episode
The Parental history
Understanding of Neglect
The pre-birth assessment and planning for B&C
Listening to the lived Experience of children

The parental History

6.3 The abuse and neglect in a parent's background can potentially present a risk to a child. Louise witnessed significant domestic abuse between her own mother and father, alongside living amid her father's mental health difficulties and her mothers' substance abuse. Exposure to these kinds of adverse and stressful experiences, can have a long-lasting impact on the ability to think, learn and interact with others. These issues would have made Louise extremely vulnerable in her own right and would undoubtedly have had a significant impact on the support she required individually and as a parent.

6.4 Alongside the experiences of Louise as a child with her own parents, casework documents that she herself had some learning difficulties. The exact nature and impact of these is not understood and while documented, it appears that this was in the absence of a full psychological assessment.

6.5 The 2016 Triennial review of serious case reviews stated that adverse experiences in the parent's own childhood were often found to pose a risk to their children. This needed careful consideration in this case, as it was very likely that Louise's background, lived experience, learning difficulties and ongoing challenges would have an impact on her ability to safely parent her children. All professionals working with the family following the birth of B& C were focused on the issues of neglect but with insufficient information about the extent and the impact Louise's own childhood had on her ability to create effective and sustainable change.

6.6 Louise did not engage well with professionals working with her about the concern for her children. It is likely that for much of her own childhood her parents had sought to avoid interaction with professionals and encouraged her to do the same. There needed to be a robust consideration of how likely it would be for Louise to meaningfully sustain her cooperation with safeguarding planning for her existing children alongside the caring responsibility for two more babies born prematurely. These issues, alongside an understanding of her difficulty in accepting help and support were insufficiently explored.

6.7 Little was known about Anthony, father of B&C, he did disclose to professionals a previous incident of physically restraining a partner and of having a temper that resulted in him hitting walls rather than people. The former incident led to him being detained by the police. His own history was not well understood and despite Louise reporting that 'they fell out all the time' their relationship was largely not understood and untested by professionals. The pattern of Louise forming relationships with new partners and the circumstances of the commencement of the relationship with Anthony remained unexplored.

Learning
It is essential that professionals:
Establish and share a parent's full history including the father
Understand the impact that Adverse childhood experiences have on the ability to parent one's own children
Challenge themselves and others if they are over – optimistic in the light of a parent's adverse childhood experiences
Recognise how difficult it is for a parent who has had a negative experience of professional involvement to accept help

Understanding of Neglect

6.8 Between 2015 and the birth of B&C in 2017 there were several assessments planned to understand the impact of the home conditions on the children M and J. In May 2015, a number of concerns were being expressed regarding conditions for the children at home, these observations were supported by additional evidence that this was having an impact on both children at school. At this point support was offered to the family through Early Support. What followed in 2016 and again in 2017 was incomplete assessment work which failed to give professionals the detailed information to effectively plan a response to protect the children. The pre-birth assessment in respect of B&C is dealt with under the next section, but it is worth commenting that the incomplete nature of assessment activity contributed to effective multi agency decision making both for M and J, but also for the children subject to this review.

6.9 While M and J were subject to child protection plans in the category of neglect in October 2016, there is little evidence that this provided any improvement in the home conditions. Clear assessment activity, persistent curiosity by all professionals and creative information sharing is essential, this is lacking. Professionals other than social care have stated their concern regarding decision making and planning in this review process, and there is evidence that this was escalated to first line management, however the system oversight, strategic leadership and effective partnership assurance mechanisms were not in place. This context is in line with the Ofsted findings which have been widely reported.

6.10 The area of strategic leadership is particularly important in the case of neglect. Neglect (in contrast to other forms of abuse where specific and critical incidents can highlight significant harm), often presents with less tangible and more diverse indicators which make it harder to identify. Further differences of opinion about what constitutes “persistent failure”, “serious impairment of health or development” and “adequate”, make this definition, as with others, more open to interpretation, resulting in confusion and lack of consensus amongst childcare professionals about what neglect involves.

6.11 A consequence of the poor state of the partnership and of Children Social Care at the time of these events was an absence of an overall partnership response to neglect in families. The lack of a common language and strategic response to neglect, that included the key components of “persistent nature”,” act of commission or omission “, “the impact of Adverse Childhood experience on parenting capacity” meant that conversations between professionals were not sufficiently focused on finding a shared and common understanding of the problem. This when coupled with significant mistrust in Children Social Care at that time meant that decision making was not shared or indeed ‘owned ‘by the wider safeguarding system.

6.12 Furthermore the views of the children were not routinely incorporated into the decision-making process.

6.13 A number of reviews and analysis of Serious Case Reviews comment on the issue of understanding the role of fathers and the part they play in managing neglect. In this case the review highlights that the absence of clarity around the relationship between Louise and Anthony did little to deepen professionals understanding of the risk he posed or whether he provided protective factors. The same study explored the issues around ‘start again’ syndrome or ‘assessment paralysis ‘,

whereby assessment was viewed as the safeguarding intervention rather than the process to identify the most appropriate intervention.

Learning
It is essential that Kirklees:
Has a clear and shared framework to make decisions about Need and Risk
Develops a shared understanding of neglect and gives practitioners to tools to identify, assess and work with families
Has clear mechanisms for safeguarding assurance, including escalation and resolution of concerns

Pre-Birth Assessment and Planning

6.14 In September 2017 a pre-birth assessment was commenced in relation to the planning for the arrival of B&C. This was not completed nor were any interim findings presented to the multi-agency partners working with this family. B&C arrived early in November 2017; some five weeks premature. They were placed on a child protection plan at birth, in the same category as their older siblings.

6.15 In the work that was done with the family, Louise highlighted difficulties in the relationship with the children's father, suggesting that they regularly disagreed with each other, Anthony also confided that he had been previously arrested for the physical restraint of a previous partner. These issues, together with the concern regarding neglect were insufficiently explored.

6.16 In October 2017 a Child Protection Review meeting was held. At this time Kirklees used a 'scaling' methodology in conferences and reviews to understand issues of professionals' perceptions of risk. Despite the "scaling" by attendees at the meeting showing a deterioration in the care of the children since the previous meeting, a lack of pre-birth assessment for the unborn twins and acknowledgement that it is "*unknown*" whether Louise will be able to cope after the birth of the twins, the minutes concluded that there has been "*lots of improvements*". It was acknowledged by those who knew the family well that any improvements which had been made were through the efforts of Louise's sister and friend. There was no evidence that Louise herself had changed her parenting style. It was this meeting that agreed that the unborn twins would be placed on a child protection plan because of risk of neglect.

6.17 The subsequent child protection plan for all four children relied heavily on Louise being compliant. There was also an expectation that Louise would need to be proactive in seeking out additional support herself and her children.

6.18 One week following the Child Protection Review meeting, the decision was made that the twins could be returned to Louise's care, following their hospital birth. This plan was shared with health services. The decision was made by a social work manager and social worker, who have since left the department, obtaining their view has therefore not been possible in this review. What is clear is that the decision was made in the absence of a completed assessment and based on an optimistic view of improvement. Despite records suggesting the pre-birth assessment was to be completed, this was not actioned, nor is there evidence that a full discussion with multi-agency colleagues took place.

6.19 The 'rule of optimism 'in safeguarding decision making was first identified by Dingwall et al in 1983 and there have been several significant case reviews since where there have been findings about this issue. It must be recognised that safeguarding professionals are placed in a difficult position of having to maintain a healthy scepticism about what parents are doing and saying, while recognising it may harm their relationship with the family and the chance to turn things around for the child(ren). There were positives noted in Louise's care of the children and the home in the Child Protection Review meeting, however the significant gaps in information and incomplete assessments, together with an understanding of the pernicious nature of the neglect in this family made the prospect of Louise with Anthony offering good quality care in the long term for four children improbable.

6.20 In the two weeks prior to the premature birth, home conditions deteriorated leading to an emergency core group being held on the 27th November. There are no minutes of this meeting however the original decision to return the children post birth to Louise's care was implemented, suggesting that multi-agency contingency planning was weak.

6.21 At the time of their six-week developmental assessment by the GP, there was concern regarding the poor weight gain of one of the twins which was referred to the Heath Visitor for follow up. There were no symptoms of fractures or bruising on either of the babies.

6.22 Two days later Louise took one of the babies to hospital in the early hours, concerned about bruising on her face. A scan revealed the existence of fractures and consequently the second twin baby was examined, and evidence was found of multiple fractures also.

6.23 Both children and their older siblings were subsequently all taken into the care of a local authority.

Learning
Multi –agency coordination of assessment, support, care and planning is imperative to understand risk and need and to inform effective decision making
Plans must include effective contingency arrangements
In cases where there are multiple needs and risk there is a need for meetings to be called if there is a significant change in a plan
Decision making must be informed by an analysis of the cumulative risk and individual risk to existing children as well as new children
All professionals have a responsibility to effectively escalate risk, record that escalation and challenge decision making which they in their professional judgement disagree with
There is a need for reflection on cases to include the identification of over optimism and working with resistant families

Listening to the lived Experience of children

6.24 The requirement to listen to the "voice of the child" is written into all statutory guidance and local policies and procedures. This is a widely accepted requirement of all safeguarding and child protection practice. However, what constitutes the "voice of the child" is given a variety of interpretations.

6.25 This review has highlighted several opportunities when the older siblings of B and C were expressing their worries and fears about life at home. While clearly these were heard, they were not listened to, they had little influence on the plans being made for them nor indeed were they influencing the assessment or planning for their siblings.

6.26 Whilst this review has not focused on the older siblings they had valuable insight into life at home in the care of Louise, this was important because their new born siblings had no voice, for the older children this was their lived experience. This extends beyond simply incorporating 'the voice of children' to professionals putting themselves into the shoes of the child and asking, 'what is life like?'. Marion Brandon et al (2016) in the triennial review of serious case reviews highlighted that all too often agencies did not translate or interpret what children say into effective decision making to afford protection.

6.27 The assessment of Louise's ability with Anthony to parent their new babies, should have been informed not just through information gathering with parents but by the 'lived experience 'of the children already residing in their care. Research in Practice 2018 highlighted two significant practitioner insights valuable in this regard:

- Maintain professional curiosity – ask questions and observe the surroundings from a child perspective
- Maintain respectful uncertainty – remain sceptical of short-term improvement, check out explanations and use the multi-agency network to ascertain accuracy of facts.

Learning
Kirklees must:
Ensure that the lived experience of children is central to individual decision making and planning and that this is key to all strategic approaches
Ensure that professional curiosity and respectful uncertainty are key components of safeguarding training
Create opportunities for all professionals to learn from serious cases

7. Conclusion

7.1 Child B&C were injured whilst in the care of their mother and their father. They were living in a family arrangement with two older siblings and where there was a history of neglect. All four children were the subject of child protection plans.

7.2 The history of neglect in this family was lengthy and there were considerable concerns about the ability of Louise to improve home conditions and sustain those improvements. Neglect by its very definition is pernicious and persistent.

7.3 These events took place in 2017 following a period of considerable change after Ofsted had rated the service inadequate in 2016, and the monitoring visit of June 2017 continued to rate it so. The inadequacies described by Ofsted, poor leadership, inadequate planning, incomplete assessments, poor decision making, and lack of child focused interventions are all evident in this case. Many of those involved in the practice in this case have now left Kirklees and the robust improvement plan is delivering rapid, significant and sustained improvement.

7.4 For those practitioners involved in this case that remain, this has been a difficult and demanding case, at times frustrating and worrying. Lessons have been identified about how agencies worked together and they have been recognised in agency reports as well as this overview report. Much of this learning reinforces the response to improvement of practice in Kirklees and the partnership approach of driving forward work on issues of neglect, Adverse Childhood Experiences, recognition and avoidance of over optimism and timely assessment.