Children's Safeguarding Assurance Partnership

Blackburn with Darwen - Blackpool - Lancashire

Child Safeguarding Practice Review

Overview Report

Ava, Lucas, Harper and Chloe

Author: Amanda Clarke

Date: 21st July 2021

Publication Date: 5th October 2021

Contents

1. The reason for the Child Safeguarding Practice Review

1.1 In late 2019 information was received by children's social care that two young children had "been injected with heroin to make them sleep". There were two older siblings also living within the same family. Child protection medical examinations took place of the two youngest children and subsequently results indicated a positive opiate test for both children. A rapid review meeting concluded that the serious harm threshold had been met due to the suspected chronic neglect that all four children had experienced for a long period resulting in child protection plans and a public law outline[1] (PLO) process. It was decided that a Local Child Safeguarding Practice Review of the case was necessary to identify learning to improve arrangements to safeguard and promote the welfare of children.

2. The children and their family

2.1 The children at the centre of this child safeguarding practice review remain living in the north of the country. They no longer reside with their parents. The names below will be used to protect the true identity of the children.

Name to be used in the review	**Age at significant incident (late 2019)**
Chloe	1.5 year
Harper	2.5 years
Lucas	9 years
Ava	16 years
Mother	34 years
Father (of Chloe and Harper/ stepfather to Ava and Lucas)	37 years
Maternal grandmother	51 years

[1] The Public Law Outline (PLO) sets out the duties that local authorities have when taking a case to court

3. Legal framework and methodology for the review

See appendix A for information.

3.1 After consideration of criteria in *Working Together to Safeguard Children 2018* a panel of senior multi agency professionals was convened but the first meeting of the Panel had to be delayed from March to June 2020 due to the Covid 19 pandemic. At this time an Independent Author had been commissioned. See appendix B for membership of the Panel. Due to unforeseen circumstances the Author was replaced and a different Independent Author was required to continue work on the review. That Author, Amanda Clarke, met with the Panel in November 2020.

3.2 Amanda Clarke is an independent safeguarding advisor with no connections to the local area or any of the organisations involved in the review. Her career history includes working as an investigator within police public protection, and inspection and audit for the NSPCC. She currently chairs a Safeguarding Adults Board and a Safeguarding Children Partnership. She also provides safeguarding advice and support for a Diocese in the Midlands. She has authored several case reviews and domestic homicide reviews.

3.3 The Panel with the Author, due to time elapsed and working restriction relating to the Covid 19 pandemic, made the decision to refocus the delayed review on a shorter period leading up to the significant incident in late 2019. This decision was considered proportionate under the circumstances. Therefore, the main timeframe of the review was identified as September 2018 to December 2019.

3.4 It was agreed that the experience of the children and family and service delivery during the timeframe would be explored relating to key learning themes which the Author and Panel had highlighted from the large quantity of multi agency information gathered in the initial stages of the review. The key themes, listed below and the timeframe were the focus of a practitioners' meeting held to inform the review enabling professionals with direct involvement with members of the family to contribute.

3.5 Panel members and the Author were clear that other significant episodes relating to the children and family which occurred prior to the timeframe would also be considered and discussed by the Panel and by practitioners. It was agreed that non recent events in the lives of families are often significant and can impact upon and shape what occurs in the future.

3.6 The practitioners meeting took place virtually in January 2021 and was attended by 13 professionals.

3.7 The involvement of children and families in reviews, and in this review particularly, was acknowledged by the Author and Panel as very important. The Author spoke by telephone to the parents, to be known as Mother and Father, and their views are included where relevant throughout the report. Extensive efforts were made to engage the eldest two children. Lucas eventually provided brief written feedback via his foster carer but Ava understandably did not want to revisit her experiences. She did however give permission for any feedback given by her to professionals and recorded during the course of the timeframe, and immediately after, to be used.

3.8 It was the intention of the Author and Panel as much as possible to complete the review with the children always at the centre of every key theme explored, to ensure the children's experience and perspective was not lost. All thoughts and comments from the children are reflected in the report in *blue italics* to ensure they are clearly visible.

3.9 Due to the review taking place during the Covid 19 pandemic all work was conducted virtually.

4. Overview of what happened, key circumstances and background

4.1 The four children had been subject to a child protection plan under the category of neglect since October 2018. The neglect of the children, which included at different times all six identified aspects of neglect[2] was underpinned by domestic abuse, parental mental health, substance and alcohol use, and offending behaviour.

4.2 In November 2019 an older child (not within the family but who has the same father as the two youngest children Chloe and Harper), alleged that Father had been injecting both children with heroin to get them to sleep. Safeguarding medicals were undertaken for Chloe and Harper. Positive opiate tests were eventually returned for both children, although there was no evidence of an injection site at the safeguarding examinations. However, when one of the children attended nursery three days later a potential injection bruise to the thigh was seen.

4.3 As a result of the reported information care proceedings commenced for all four children and they were removed from the care of Mother and Father.

[2] Aspects of neglect- medical, nutritional, emotional, educational, physical and lack of supervision/guidance: all subsumed under the term 'failure to meet a child's basic physical and/or psychological (and/ or emotional) needs,' The Local Area's Neglect Strategy 2019

4.4 Concerns for the family are in agency records from 2006 (when the family appeared to move to the area where the review is hosted). The family were known to numerous services up to the significant incident in late 2019. Issues within the family included neglect, domestic abuse, parental mental health and substance abuse. The children spent periods in the care of their maternal grandmother, although she was known to have her own mental health and substance misuse problems. She also had care of a child (now a young adult). Both maternal grandmother and that child were identified as in need of local family support services but the suitability of maternal grandmother to provide care for her grandchildren was never formally assessed.

4.5 During Mother's pregnancy with Chloe (born in 2018) there were concerns about Mother's drug use and all children were referred to children's social care by the specialist midwife when Mother was 30 weeks pregnant. The baby was born with neo-natal abstinence syndrome (NAS)[3] and there were concerns about Mother's ability to care for the baby, including un-safe sleep concerns. An initial child protection conference held after the birth focussed mainly on un-safe sleep issues, rather than considering the whole spectrum of neglect. A decision was reached to place the new baby on a child protection plan and her elder three siblings on child in need plans. Despite evidence of the parents' ongoing substance use a decision was made to end the child protection plan 10 weeks later.

4.6 In September 2018 (the start of the review timeframe), a violent domestic abuse incident was reported involving both Mother and Father. Both parents sustained serious injuries and were noted by attending police officers to be under the influence. Weapons were also recovered from the home address. There was no evidence that any of the children were physically present, although the eldest child Ava was aware of what had happened.

4.7 In the following days there were more concerns about Father including him attending Lucas' school significantly under the influence. Within days Father made a serious suicide attempt at home and after this incident the children again went to stay with maternal grandmother. However, concerns were raised about her ability to provide basic care for her grandchildren and about her own mental health. These concerns resulted in the children returning to the parents, although Ava refused to go back and elected to live with an aunt.

[3] NAS is a constellation of symptoms occurring in a baby as a result of withdrawal from physically addictive substances taken by the mother

4.8 Ava subsequently disclosed that she was aware of her stepdad's (Father's) suicide attempt and had witnessed Mother overdosing as a result. Ava said she had been unable to sleep due to fearing that *she would wake up to find both parents dead and have to care for her siblings*.

4.9 As a consequence of the events occurring from September 2018 all four children were made subject to a child protection plan on the grounds of neglect.

4.10 The children remained subject to child protection plans throughout 2019. During that year there were ongoing concerns about both parent's alcohol and substance use, mental health and criminality (both were subject to probation supervision and Father spent a period of time in 2019 in prison). It was suspected that both parents prioritised their substance use over the care of their children, both in terms of their availability to provide care and emotional warmth, and in their use of financial resources, which resulted in times when the children did not have adequate food or warmth.

4.11 There was significant multi-agency involvement with the family (21 professionals attended the ICPC) many who had continuing concerns. The case progressed to Public Law Outline pre-proceedings in March 2019, but the children mostly remained in the parents' care until the significant incident in late 2019 leading to the review.

5. Key themes of the review

5.1 Under the central theme of voice and focus on the children and their lived experiences the key themes which will be examined within the review are as follows:

- Understanding the lived experiences of each child and impact of parents'/carers' behaviour and lifestyle upon them
- Responding to neglect
- Processes – Child protection/ PLO/ placements
- Adult services' work with parents and incorporating a Think Family approach
- Multi-agency working and communication
- De-sensitisation and professional culture

5.2 The four children in this case will remain at the centre of the review and all analysis of services provided will be presented, where possible, with the perspective and experience of the children in mind.

5.3 There is limited evidence whilst the children remained living within the family, with the parents or with maternal grandmother, that they were regularly asked about their wishes and feelings. For the younger children Chloe and Harper this is understandable due to their ages.

However, Ava and Lucas were well able to provide an opinion about their daily lives but this opportunity for them to share their thoughts was not consistently provided to them, despite them being in contact quite frequently with different professionals. Examples of the views of Ava when asked about her situation are below (taken from agency records and used with the permission of Ava):

On a child protection visit to Ava at her aunt's address, she is clear about mother keeping her off school to care for her siblings. She spoke of her Mother's ongoing heroin use and that she would "rather go into care than return home".

Ava disclosed that Father has been talking about hanging himself in front of Mother, and Ava had witnessed her Mum overdosing.

When the family had a sudden move to a new address- Ava states she has been to the address and "it is a hovel" and "social workers should take her brother and sisters into care".

5.4 Other thoughts of Ava regarding her parents' behaviour and her having to care for her siblings were reflected earlier.

5.5 Prior to the significant domestic abuse incident records show Lucas as late for school and *he told staff it was because he was looking after his siblings. Some weeks before Lucas had said that Mum (Mother) doesn't get up in the mornings and Ava takes him to school/gets him ready.*

5.6 Many reviews have referenced the importance of focussing on children and listening to their voices. In several cases this does not happen as frequently as it should particularly when children remain living in possible neglectful conditions as happened with this family. Ava was at an age where she could articulate exactly what life was like for her and her siblings, as the quotes above demonstrate, but this focus on the children to gather thoughts and feelings did not occur as often as it should. Professionals allocated to the case from children's social care through the time frame often changed and there was little opportunity for trusting relationships to be built with children's social care workers. As a contrast, the allocated Families in Need (FIN)[4] support worker did remain consistent.

[4] As part of FIN- Family Support Workers were allocated to undertake specific pieces of work within Child Protection Plans and several Family Support Worker staff were co-located within the Children Social Care Teams. This changed in late summer 2019 to ensure the allocated social worker developed a relationship with the families and took the lead role in supporting the children subject of CP Plans (and their families).

5.7 It is also important to recognise that some children communicate through their behaviour, rather than speech. Those working with them should endeavour to analyse the behaviour to inform overall assessment of the child's situation and their needs.

5.8 Professionals in the area can access a *Safeguarding Partnership 7 minute briefing titled Voice of the Child (2019)* which highlights the importance for every professional 'to put ourselves in that child's shoes and think 'what is life like for this child right now?' The Partnership may wish to revisit this resource and explore ways of refreshing and re-promoting the key messages.

5.9 In the latest analysis of national case reviews[5] it was noted *'*the complexity of some families' situations and the large volumes of information held can get in the way of identifying the risks faced by children. Practitioners need to be aware of this and to constantly come back to seeking to understand the lived experience of the child*'.*

5.10 In the case of the four children this was certainly the position in terms of the amount of information which existed about service involvement throughout the children's lives. Despite that, there was little evidence of questioning relating simply to 'what it is like to live as a child in this family,' which is discussed further below.

(i) Understanding the experiences of each child and impact of their parents/carers lifestyle and behaviour upon them

5.11 The 'child's voice' does not only refer to what children say directly, but to many other aspects of their presentation. The lived experience of the child includes what a child sees, hears, thinks and experiences on a daily basis, all of which can impact on their personal development and welfare whether that be physically or emotionally.

5.12 Professionals needed to look deeply into the lives of each child in the family and ask the question 'what is it like as a child living every day within this family setting?' There was some evidence in the timeline of individual professionals trying to act for the children on identifying the harmful environment in which they lived. However, a coordinated multi agency and timely response was required and this did not happen.

5.13 Mother and Father both had a long history of parental mental ill health, substance misuse and domestic abuse, previously referred to in other reviews as the 'toxic trio', although Mother

[5] Complexity and Challenge: a triennial analysis of SCRs 2014-2017 (March 2020) Marian Brandon, Peter Sidebotham et al

herself denies any abuse from Father saying abuse only occurred from other partners. Criminality was also a feature in their lives as were other adverse childhood experiences. The daily lifestyle of Mother and Father impacted considerably on the children. Caring responsibilities were often shifted to the older children (particularly Ava), all children witnessed (or experienced the aftermath) of harmful events involving the adults, normal family routines were not in place and there was a general absence of emotional stability.

5.14 When discussing the case at the practitioner's meeting, including looking back on some of the specific experiences of the children, the participants could clearly see the unacceptable environment in which the children had been living. However, the cumulative harm with which they lived had not always been apparent at the time of services being involved as professionals responded to each crisis point in isolation. The ways in which professionals reacted and shared their collective concerns did not lead to substantial positive action for the children. Several times after incidents of concern the children were taken to stay with Maternal Grandmother, who had her own support needs. This was only a marginally better and safer option for the children's care and there is little evidence that the older children were asked if this was where they wanted to be. Short term placements and other processes are explored below.

5.15 The lifestyle of Mother and Father in this case was described as 'mostly chaotic' and affected by their own personal needs. This overshadowed the needs of the children and professional responses to concerns within the family often became focussed on issues relating to the adults, such as their substance misuse and mental health. At the practitioners' meeting there was a suggestion that some professionals may have held the view 'if the parents could be helped this would in turn help the children'. However, positive outcomes for the children were mostly not evident even after extensive efforts at supporting Mother and Father. There were some attempts to explore the children's experience by professionals who were involved with Mother and Father for predominantly adult facing work. This is positive especially as this was not the core business of the practitioners involved, for example the probation officer working for the Community Rehabilitation Company.

5.16 Scrutiny of the child protection plans for the children showed an approximate equal split between actions focused on the parents and actions focused on the children. This was clarified as possibly due to the previous model of working for the local area. The previous model was described as more risk focused, which explains why there may have been more focus in actions on parents and carers.

5.17 Adult focus generally will be examined in more detail later. The new model of working will also be discussed.

5.18 The work conducted to fully understand the lived experience of all the children by lead professionals whilst the children remained at home was impacted by sickness and changes in personnel. There were substantial gaps in contact with the children and adults in the family by children's social care. The Families in Need service (explained earlier) did undertake visits to the family which included seeing the children but it is unclear if significant liaison took place between families in need workers and children's social care over what was being observed. It was positive to note that several case notes were entered by FIN practitioners. Both FIN and children's social care use the same recording system but case discussion between involved practitioners should still have occurred.

5.19 A review[6] from the same local area in 2021, and many other reviews, highlight the importance of *building and maintaining trusting partnerships with families. This is crucial when parents or carers have unstable emotional health* or face other challenges*.* A trusting relationship is more likely to be developed when workers are involved long term especially in complex cases. Stability and routine was lacking in most areas of the children's lives therefore a permanent worker for the case may have enabled trust to be established and as a consequence a greater understanding of the children's experiences within the family. Frequent changes in worker allocation should be minimised, whenever possible.

5.20 The position regarding staff sickness which impacted on the children's social care response to the family was explained in detail to the Panel. During the timeframe of the review and when the children were on child protection plans two social workers allocated to the case and a manager were on sick leave for long periods. FIN family support workers continued involvement with the family during these times and children's statutory child protection visits were undertaken by temporary agency staff. It is acknowledged that not all visits were recorded by the temporary staff on the children's social care records.

5.21 Staffing changes and shortages across children's social care and in other agencies were discussed at length with the Panel. There was acknowledgement that this was a local and national issue. The current position regarding staffing locally is discussed later.

5.22 On speaking to Mother and Father separately the Author heard they were confused and disappointed by the changes in workers allocated to the family. This also created an element of suspicion for them as to the reasoning behind some staff changes. Mother did speak positively about

[6] Serious case review - Child CD, published February 2021

one social worker who she said she "got to know a bit better and who listened". This was a practitioner involved before the start of the review timeframe.

5.23 Reference to a child's behaviour being an indication of trauma they may have experienced was evident in observations made since the children were brought into care. Harper's behaviour included *her demonstrating a high- pitched scream regularly and for long periods, taking food and hiding food to gorge eat and presenting as frightened that food would be taken away*. Chloe's behaviour was described as similar to Harper's *with an additional extreme fear of water and bath times in particular.*

(ii) Responding to neglect

5.24 Neglect of the children was evident throughout the review timeframe, and before. It was clear from what Ava said when she did get chance to speak to professionals, that neglect was a factor in all of their lives.

5.25 The child protection plans applied to all four children after the September 2018 incidents were under the category of neglect which is positive that the cumulative risks for all children were acknowledged.

5.26 Professionals involved with the family over the first half of the timeframe did not see or report circumstances often traditionally seen as the first indicator in a family affected by neglect. The home conditions were not generally described as poor, apart from some safety issues and repairs which were required. The older children, Lucas and Ava who were seen quite regularly at school at that time were not described as neglected in their appearance.

5.27 Indicators of neglect for the children were linked more to emotional factors which included experience of living with domestic abuse, parental mental health issues and substance misuse, and the uncertainty and fear which will be continually present for children living in those settings. *Lucas in his written feedback for the review said he didn't like feeling scared (when living at home) and he didn't like it when his mum (Mother) and Ava argued.*

5.28 In addition, Lucas was noted to be often tired at school and Ava had caring responsibilities especially for Chloe and Harper, and at times for her parents. There had also been concerns from birth and before regarding the parents' care of the younger children. A substantial quantity information was available in agency records for the period prior to the identified review timeframe relating to Chloe and Harper.

5.29 Neglect continues to be the main type of maltreatment recorded in official data on safeguarding and often, as in this case, it can lead to serious harm. In the *Serious Case Review Analysis (2014-2017)* referenced earlier, it was stated "neglect based cases are systemically difficult as sometimes there is not a 'single' index incident to focus the review upon" compared to physical abuse and sexual abuse cases. Neglect, as in this case impacts directly on children's lives every day.

5.30 Responses to neglect can often focus on young children in the knowledge that neglect during a child's early years will often lead to poor outcomes for those children as they grow up. Younger children are more vulnerable by reason of their age with no ability to look after themselves. This was evidenced when the youngest child (Chloe) was placed on a child protection plan at birth but the older children were seen as child in need level. Unusually, Harper who was still just an older baby at that time was also categorised as child in need. Whilst the decision was questionable for the older children, Ava and Lucas, the rationale for Harper as a baby herself not being seen by professionals as at similar risk to her younger baby sister is unexplained, apart from an apparent focus on the un-safe sleep concerns for Chloe as a newborn baby. Child protection processes are discussed later.

5.31 Adolescents living in situations of neglect may be particularly vulnerable to having their needs, and the risks they face, overlooked. For Ava, the more usual adolescent concerns now more identifiable to professionals such as going missing and being exploited were not known to be a key risk for her at that time. The emotional harm, which she was regularly experiencing at home was a significant risk, including to her transition to young adulthood, but this often went unnoticed possibly due in part to being less obvious than other concerns.

5.32 It is important to recognise that in the *Ofsted 2018 inspection of the Council area's children's social care services,* findings for the area meant that 'many children were not having their needs responded to in the right way or at the right time'. Ofsted reported that 'as a result, some children live in situations of chronic neglect for long periods of time. Their situations do not always improve and, for many, they deteriorate, resulting in poor outcomes and increased risk. For some children, the impact is serious, with children suffering additional harm that affects their health and development'.

5.33 The timeframe under review was the same period when Ofsted inspected local services and the children in this case did continue to live with neglect until the significant incident later in 2019 led to their removal. In the two months leading to the alleged injection of Harper and Chloe records show professionals noted several indicators of neglect, all whilst the children were on child protection plans for neglect. These included Ava's school attendance declining and having no money

for the bus to school, Lucas upset at school but not saying why, Lucas requiring urgent dental extractions, Harper and Chloe looking "grubby with wet soggy nappies" and the parents reporting no money for nappies and food. In addition, the house was noted as cold and the parents admitted to using drugs at home. Both parents also experienced mental health crisis points during this time.

5.34 There was no evidence whilst conditions and circumstances deteriorated that neglect assessment tools were used to help identify the escalating risks.

5.35 In response to the Ofsted findings, and specifically relating to neglect, the local area has undertaken considerable work which is detailed in the area's *Neglect Strategy Implementation Plan*.

5.36 The neglect strategy for the area was agreed in autumn 2019 and launched by the Safeguarding Children Partnership in March 2020. Within the strategy is a section which summarises the main impacts of neglect at each stage of a child's development[7] .

5.37 Action taken on the implementation plan includes training and awareness sessions delivered for *'Recognising and Overcoming Child Neglect'*, together with ongoing *'Graded Care Profile 2' (GCP2)* training and *Refresher training for GCP2.* This is the agreed neglect assessment tool for the area.

5.38 Furthermore, specific training regarding identifying the six forms of neglect, the impact on children's daily lived experience and responses was provided to 249 Children's Services' practitioners from February to September 2020. Further data was provided of training attendance from January 2020 to February 2021 with a total of 130 training sessions taking place within children's services, totalling almost 2000 attendees. Much of the training related to practice issues relevant to this review including neglect, restorative practice, assessing brothers and sisters, outcome based planning, using analysis and critical thinking, and safety planning. As in many areas the training has continued to be delivered on a virtual basis during the Covid-19 national restrictions throughout 2020 and 2021.

5.39 Partner agencies have been supported regarding their identification and response to neglect and the expectations of each agency at different levels of the continuum of need, which includes the use of multi-agency assessment tools. It was suggested at the practitioners' meeting the use of assessment tools which help to enable consistent identification of neglect continues to be area for development within the area.

[7] Neglect strategy 27.09.2019/ includes Jan Horwath Child Neglect- Identification and assessment, 2007

5.40 The training data is positive in terms of uptake and as expected all activity on the neglect strategy implementation plan is subject to regular review which includes audit activity to scrutinise responses. The Principal Social Worker undertook a series of baseline neglect audits during late 2020 and has provided reflective feedback to involved practitioners. There is a plan for audit of five cases a month on an ongoing basis with feedback to both involved children's services' practitioners and multi-agency partners and with involvement with the individual family. The Author was told reports are provided to senior leaders and shared at a monthly Neglect Champion Group, consisting of service managers across children's services. The themes of lessons learned from via these audits are now also being shared within the Safeguarding Children Partnership.

5.41 Another local review for the same area published in spring 2021 has a focus on the neglect of three children[8]. Action relating to the concerns about neglect for these three children was provided by the same local agencies as for Ava, Lucas, Harper and Chloe. Neglect in the other case for the three children may have been more obvious in terms of their living conditions and presentation but similarities are evident in the responses by professionals in terms of action taken and the 'naming of neglect' as a concern in its own right.

5.42 A recommendation was made that when the Local Safeguarding Children Partnership disseminates the learning from the *R, N and A children review*, "*the opportunity is taken to highlight the response to neglect in (that) case and further embed the Council Area's Neglect Strategy and the use of Graded Profile 2".*

5.43 Findings for the review of Ava, Lucas, Harper and Chloe would reinforce the need for the recommendation detailed above in the R, N and A children review.

5.44 Performance data regarding child protection processes shared with the Panel indicated that identification and responses to neglect was now more effective in the local area. However, there may be a need for more information around evidencing the positive impact of early help processes relating to neglect and its early identification.

5.4.1 **<u>Recommendation 1</u>**

The Children's Safeguarding Assurance Partnership should examine the current position relating to neglect in the local area including analysis of data across the continuum of need, examination of audit findings and other relevant performance information to reaffirm the Partnership's responsibility and priority to respond more effectively to children and families believed to be

[8] Local CSPR- Ryan, Nathan and Amelia, May 2021

affected by neglect, including specific attention to the position for young carers and the delivery of the early help offer across the local area.

(iii) Processes – Child Protection/ Public Law Outline (PLO)/ Placements

5.45 The decision was made by the Panel that the processes relating to child protection conferences, Public Law Outline and short term placements would be the focus of the review as these were the key process related elements of the case with most relevance to what had happened for the children.

5.46 The children were subjects of child protection processes for the majority of the review time frame leading to the significant incident in late 2019. All were placed on child protection plans in autumn 2018.

5.47 A revised model for child protection conferences, in accordance with the area's principles from the new model of working, was introduced in early 2020. Professionals in conferences are expected to work with families to help them understand the concerns that they have. Joint plans are developed to build on existing strengths and support parents make the changes that are needed to keep their children safe. A new partners' report to conferences has been launched which enables professionals to structure their information in the same way that it will be presented in the conference. The new model for child protection conferences is enhanced by a revised children and family assessment tool, a child protection plan outline template, and a core group recording template.

5.48 The revised core group meeting template ensures all core group members are recorded. Therefore as in this case where absence of allocated social workers impacted on some core groups, in the future in the eventuality of the allocated social worker being off work unwell, their manager and another social worker would be able to identify key core group members as active involvements in a child's plan.

5.49 Examination of records associated with the child protection plans of the four children from late 2018 show core groups were mostly held regularly with multi disciplinary engagement but on three occasions were not attended by a social worker. It was said at that time there was a high turnover and change amongst conference chairs in the area which made it difficult to escalate issues from core groups such as non attendance or concerns relating to lack of progress. The current experience at core groups, as outlined above, was described as improved by some attendees at the review's practitioners' meeting.

5.50 According to some participants at the practitioners' meeting held in January 2021 the new model for child protection conferencing was working well but had been impacted to an extent by Covid 19 restrictions and virtual working arrangements. At the time of the review it was said the use of advocates was being embedded to assist children's involvement but wasn't able to be utilised in this case.

5.51 Voice of the child was included in the first conference during the review timeframe. It was reported that *Lucas said he has been scared when his mother was shouting at his sister. He said that he had been late for school because he has been looking after his baby sisters.* Information was also shared that *he was upset when his mother has said things and he had been increasingly saying he has stomach-ache and is feeling unwell. He has been weepy and upset in school.* The views of Ava were also represented.

5.52 There was limited input from the children in the review conference in January 2019. Lucas was not wanting to speak to the social worker. *Ava was "wanting to stay at her aunt's"* (where she had been living).

5.53 At the second review conference in July 2019 the notes state no children had completed the conference pack. It was recorded *Ava had given brief feedback that she is happy to be back home but wants to be left alone.* Ava had returned home from staying with her aunt at this point. *Lucas had said he is happy in his new home and likes playing football – he is glad that his dad is back* (Father had been in prison).

5.54 It is positive that the parents attended and contributed to all three conferences (except the second review conference when Mother attended alone). In feedback to the Author both parents separately shared the view that there seemed confusion in meetings between the different fathers of the children as all three fathers coincidentally had the same first name. Mother was open about being a survivor of domestic abuse by one of the men but said professionals complicated that male with her current partner (Father) who she claimed had not been abusive towards her. Father gave the same account.

5.55 After the first review conference a further assessment was completed in February 2019. The assessment explored the needs of the children and the impact of parental substance use upon them, recommending the possible issuing of legal proceedings.

5.56 A care planning meeting took place in early March with the decision that the children were to remain with the parents. Agreement for Public Law Outline process (PLO)[9] followed soon after with an initial PLO meeting held mid April 2019 where the schedule of expectations was signed by Mother. A review PLO meeting was held in early July 2019 but apart from Father signing the schedule of expectations in August 2019 after release from prison no further activity occurred relating to the legal process until the urgent care proceeding in early December 2019. PLO should not go on longer than 16 weeks.

5.57 In the Ofsted inspection of the local children's social care services (2018) an area of improvement was the oversight of pre-proceedings work and placement- with- parent practice to address drift and delay. In response, a review of cases where families were subject to PLO processes was undertaken to address concerns about risk, drift and management oversight.

5.58 In the summer 2019 a newly appointed senior leadership in children's services established management oversight panels, one of which tracked children subject of PLO pre-proceedings. The weekly panel chaired by the assistant director reviews all children subject of pre proceedings with the allocated team manager and service manager, to ensure any drift is identified at the earliest opportunity, tracked and addressed. A revised PLO procedure and associated documentation was launched in October 2020.

5.59 Recently published *Best practice guidance: Support for and work with families prior to court proceedings March 2021, Public Law Working Group* suggests that "the purpose of the PLO pre proceedings process is to be a genuine opportunity to work closely with families by offering help and support to address their recognised needs in a bid to negate the need to issue care proceedings". Whilst there was little evidence that such work took place with the family in this case improved management of pre proceedings in the local area is said to be now in place. It should be an aspiration that the wishes and feelings of children who are subject to pre proceedings will be prioritised as an integral part of the process in order that thoughts about their own future can be properly considered.

5.60 Discussion at the practitioners' meeting regarding PLO processes indicated there was some lack of understanding and awareness of the general process and requirements. Despite PLO being local authority driven it was suggested it would be useful for a short briefing to be developed to explain the purpose and function of PLO pre-proceedings to wider partners in order that there is a

[9] The Public Law Outline (PLO) sets out the duties that local authorities have when taking a case to court

better understanding of a process which sadly becomes integral to many safeguarding cases in which partners are involved.

5.61 **Recommendation 2**

The Director of Children's Services in the local area should provide assurance to the Children's Safeguarding Assurance Partnership that PLO processes are being conducted in a timely way and any delays and risks are addressed immediately.

5.62 **Recommendation 3**

The Children's Safeguarding Assurance Partnership should consider opportunities to ensure a partnership approach is the aspiration in supporting families involved in PLO proceedings and related matters, including raising the awareness of professionals about the process, timescales and responsibilities.

5.63 On several occasions in the review time frame and at times in the past the children were often placed in Maternal Grandmother's care for short periods of time including overnight stays. The reasons were mainly due to crisis points for the parents when the children needed to be accommodated elsewhere.

5.64 Maternal Grandmother (MGM) was never formally assessed as a suitable carer to look after Chloe, Harper, Lucas and Ava. Whilst there is no suggestion of harm being caused to the children by MGM there is information to indicate that she faced challenges of her own in terms of her own mental wellbeing and alleged use of illegal substances. Information gathered as part of the review highlighted safety and space issues at MGM's address where the children went to stay, particularly regarding sleep settings for the youngest two children. Additionally, the relationship between MGM, Mother (MGM's daughter) and Father was often volatile leading to the children being removed from MGM's care by the parents unannounced despite a short term placement having been agreed.

5.65 The impact of the MGM placement on the children's emotional wellbeing in terms of the lack of stability and at times them witnessing hostile behaviour between adults over whether they should stay there would have been detrimental. *Ava had disclosed after the domestic abuse incident in autumn 2018 witnessing Mother and MGM arguing over Mother's refusal to allow Chloe and Harper to stay with MGM whilst agreeing that Ava and Lucas could go.*

5.66 It is important to note that during the review's timeframe all four children were mostly on child protection plans for neglect when attempts were ongoing to resolve the complications of

where they should stay after a crisis episode had occurred. The emotional impact of the uncertainty will have added to the trauma which all of the children were known to have experienced.

5.67 Records showed concerns were expressed by MGM herself regarding her capacity to care for all the children together due to her own physical and mental health. Other history known to services about MGM's capacity to parent and additional support she might need was never properly explored.

5.68 Circumstances which arise when children need emergency short term accommodation are a challenge to manage, often occurring out of hours and in stressful situations. However, a priority should remain that the safety and welfare of the children involved is the most important consideration. From records available for the timeframe of the review there is limited evidence that MGM was assessed as being able to provide appropriate temporary care for the children. Furthermore, apart from provision of some basic equipment to help MGM look after her grandchildren in her own home there is little note of what other support she herself was offered whilst undertaking the role of family carer.

5.69 It was noted that when children's social care is required to find a short term placement it is rare for them to enquire into the health records of the person being considered as the short term placement carer. Police held information and intelligence is often known about the carer but relevant health issues are mostly unchecked, as in this case.

5.70 In the local area's *Social Work and Safeguarding Service Procedures Manual* there is a chapter on *Family and Friends Care (3.4).* The local authority does have a general duty to assess all arrangements where children are living with their wider family or friends' network where it appears that services may be necessary to safeguard or promote the welfare of a Child in Need (which was the position for Ava, Lucas, Harper and Chloe who were all on child protection plans so met the threshold of need).

5.71 Within the chapter, also referenced is the *Initial Family and Friends Care Assessment: A good practice guide developed by Family Rights Group in partnership with an expert working group, February 2017*[10]*.*

[10] The guide is a response to the lack of any minimum standards as to how such assessments, commonly called viability assessments, are conducted. Viability assessment are often used by local authorities to decide whether a family member or friend might be a potentially realistic option to raise a child who cannot live safely with their parents.

5.72 In the local area the foster service now has a connected carers team. This team undertake the full connected carer assessment[11] and has a process in place to track and monitor all progressions of assessments being undertaken. The assessment tool has been revised and is a comprehensive report, including a police national computer check and questions about the health of the family member (the proposed carer). In emergency situations an initial viability assessment considers the suitability of a family member.

5.73 In many areas the need for short term placements to be arranged quickly may be a recurring issue. However, the urgent task of finding children somewhere to stay should not lose sight of the need to ensure the placement is assessed as safe, is in a child's best interests, and for children old enough to communicate an opinion on their care to be consulted.

5.74 The Panel discussed opportunities for contingency planning for children in terms of involving families and children in discussions in advance regarding their preference for a short term placement should an emergency need arise. The Author was told that work is already underway in the local area to update genograms for families and develop safety plans which are accessible to emergency duty team staff. This was not considered as setting up families to fail by expecting a crisis to occur but being prepared to respond to any emergency, including a sudden illness.

5.75 **Recommendation 4**

The Children's Safeguarding Assurance Partnership should require a multi agency audit to be undertaken of the content and quality of genograms and safety plans for families to ensure relevant information is on record with appropriate assessments completed to inform decisions for emergency short term placements.

(iv) Adult services' work with parents and incorporating a "Think Family" approach

5.76 From the wealth of information available for the timeframe of the review, and for significant events before, the involvement of predominantly adult facing services with the family was considerable.

5.77 Professionals from a range of different adult services were regularly seeing Mother and Father. Police involvement was usually at times of crisis with officers taking appropriate action.

[11] Regulation 24 of the Care Planning, Placement and Case Review (England) Regulations 2010, effective from April 2011, relates to immediate placements of children with relatives and friends not previously approved as foster carers.

Services working with the parents longer term included the substance misuse team and probation (the community rehabilitation company). Domestic abuse support services did try to offer support to Mother after the incident at the beginning of the timeframe.

5.78 Both parents also accessed support for their own health needs including from the GP and mental health services.

5.79 Involved professionals from some of these services were able to contribute to the practitioners' meeting.

5.80 The overriding sense from the adult facing professionals was that there was an understanding of the need to be aware of the children of Mother and Father when working with them as adults. This was evident in conversations which took place in the practitioners' meeting. Professionals had differing levels of awareness and experience of safeguarding children requirements but all appeared aware of the importance of trying to respond to any concerns presented during their work with the parents.

5.81 A challenge raised was high workload which is a common issue within all organisations. Adult workers, an example being drug support services were managing very large caseloads meaning core business in seeing adults allocated to their case list was a priority. Any additional work, for example regarding children, generated as a result of supporting adults was followed up but there was very little free work time to devote to such tasks. When problems occurred in trying to call to update multi agency colleagues by phone to share information, frustration was a feature due to time pressures. Multi agency working and communication is discussed below.

5.82 The engagement of adult facing services in the child protection processes ongoing through most of the timeframe was generally good. Professionals attended conferences and core groups which demonstrates the commitment and focus from adult workers involved in this case to the safeguarding of the four children. Records show many professionals including adult focused workers did try to raise concerns about the children at core groups.

5.83 Specific good practice to highlight from records was the involvement of the CRC probation officer who undertook several home visits enabling her to observe and record relevant information about the children in conjunction with her work with the parent. There was evidence of numerous calls between the CRC officer and other involved multi agency partners when the position for the children as well as the adults was discussed.

5.84 The substance misuse support worker also demonstrated positive wider thinking in terms of the children by noting on a home visit that "the house was cold and that Ava was upstairs looking after the younger children".

5.85 The adults in the case did sometimes fail to attend appointments but they also did seek out services for themselves. At GP appointments and with other professionals Mother in particular, appeared to be open about her own challenges, for example her drug use, including how and when she was using. The impact of this on the children through the timeframe was sometimes but not always considered. The GP did make a referral to children's social care in spring 2019 after Mother admitted using heroin. The CRC practitioner also tried to share conversations between CRC and Mother when Mother admitted to regular drug use at home. See below reference to communication.

5.86 A lack of detailed knowledge of illegal drugs, their impact and other drug related awareness linked to safeguarding children (and adults) was highlighted in the practitioners' meeting by some attendees. There was an assumption it seemed that all professionals, when working in a locality where drug use was thought to be common, had a sound knowledge of drug related information to inform their own work but this was not the case, apart from for specialist workers. An example was given that most GPs would not have additional specialist knowledge relating to illegal substances and its impact on children. Whilst many GP practices now have safeguarding leads the wider awareness of specific drug related issues was generally not available.

5.87 Addiction, as in this case, is often likely to impact on a parent's capacity to prioritise the children's needs and general family functioning. Furthermore, addiction can impact on the adult's risk taking behaviours, such as drug seeking behaviour and sometimes criminal activity to ensure their addiction is fed.

5.88 An opportunity for learning more about drugs, addiction and other safeguarding related issues in a multi agency forum would be a useful exercise to equip more professionals working across children and adult services with more confidence and awareness to respond more effectively to families where drug use is a serious concern. The Author was told that similar training had occurred in the past but capacity to facilitate the training on top had become a challenge.

5.89 **Recommendation 5**

Public Health on considering the findings of the review should revisit the public health substance misuse service commissioning arrangements to re-implement the provision of training by the provider to the multi-agency workforce to ensure a broader confidence and knowledge base exists

across the partnership for professionals working with families significantly affected by substance misuse.

5.90 Regarding neglect as the main area of concern for the children in this review, within the report from the *Ofsted joint targeted area inspection programme July 2018, Growing up neglected: a multi-agency response to older children* there is a reference relevant to all four children in the case, not just the older two:

5.91 "For services to be effective in identifying the neglect of (older) children, there needs to be a whole-system approach. This includes adult services that work with parents where professionals are well placed to identify risks parents may pose to children because of adult mental ill-health, substance misuse or offending behaviour*".* For Ava, Lucas, Harper and Chloe many professionals were in that place to see risks as a result of their work with the parents. What they do with concerns about children identified through their work with adults is a key point; systems for obtaining professional advice, sharing information and making referrals should be as simple as possible to ensure risks are shared and not lost.

5.92 There should also be wide promotion of escalation processes should the appropriate response not be received when information has been shared between services. This will ensure professional challenge is recorded and hopefully resolved.

5.93 The ability of adult facing workers to identify children's safeguarding issues (and vice versa) does to an extent depend on how well individual practitioners understand the need to look wider than their specific area of work. 'Safeguarding is everyone's business' has been a well- used slogan across safeguarding strategic partnerships for a number of years but should perhaps now evolve into 'Safeguarding everyone is everyone's business'.

5.94 A more joined up approach to safeguarding is the aspiration of many local safeguarding children partnerships and safeguarding adult boards. In the local area there is collaboration in terms of there being one business unit for the children's partnership and the three safeguarding adult boards and progress is being made for a more all age approach, an example being for contextual safeguarding.

5.95 The action plan implementation group in response to the 2018 Ofsted inspection of local children's social care services includes membership of adult facing services and health providers who cover the whole age range. Therefore, service provision from an adult perspective and how this links and supports children's safeguarding should be considered.

(v) Multi-agency working and communication

5.96 There was positive multi agency engagement in the case as evidenced in analysis of available records and in the information shared for the timeframe of the review. As highlighted earlier, professionals representing all agencies involved in the case attended the strategy meeting, child protection conferences and reviews, and core groups.

5.97 A challenge in complex cases with numerous professionals involved is the amount of people that families are requested to see and respond to. This must feel more difficult for children when many different people are attending their home. Both Ava and Lucas in being asked to participate in the review said they *did not want to talk to another person about what had happened*. Ava and Lucas throughout the timeframe saw numerous professionals from several agencies and at times were expected to answer questions from people who they possibly saw as strangers. The professionals with long term involvement with the older children were from school, which is common in most cases. Fortunately, school staff were an integral part to the child protection processes which occurred throughout 2018 to 2019. Lucas in his feedback via the foster carer for the review said *the school advisor gave him the best help*.

5.98 The younger two children may not have been of an age to articulate their thoughts but seeing numerous different adults in their home, would be challenging for any small child and especially for a child who had had the additional experience of living at times in an unstable and volatile environment.

5.99 Joint visits were not a regular occurrence despite being suggested as a possible route into the family, for example discussion took place between the IDVA and social worker but a visit dd not take place. School designated safeguarding leads did visit jointly with the educational welfare team. School staff also attended with a FIN practitioner to follow up on school absence.

5.100 Sometimes Mother and Father were not responsive to visits or appointments. They reported themselves that they “did not take kindly to most professionals”. In families when professional relationships are sometimes strained practitioners should try to be creative in planning opportunities to visit, joining up with other disciplines where possible. The younger children were being seen by health visitors as routine which could have been a chance to try to link visits if properly explained to the family. It was noted at the strategy meeting in autumn 2018 that Mother had a good relationship with her then health visitor, which was seen as unusual for Mother who rarely engaged positively, possibly due to years of her own adverse experiences. Circumstances such as that, however uncommon, should be used to try to develop other sound working relationships.

5.101 The most challenging relationship described by both Mother and Father was with children's social care which is not unusual or unexpected in cases where involvement has been longstanding and complex. There was a complete lack of trust from the parents with children's social care staff, not helped by the turnover and sickness of practitioners involved with the case.

5.102 It is not evident from the review timeline how often temporary agency workers covered the statutory responsibilities for the children as the visits and core groups undertaken by agency staff do not appear to have been fully recorded. Core groups and recent developments were discussed earlier.

5.103 Regarding management oversight of the case the team manager was very new in the social care team manager role. The strengthening and supporting families (SSF) service which at the time had responsibility for children supported by longer term child in need plans, child protection plans, PLO and care proceedings had management vacancies at all levels. The SSF service during the timescale reviewed was predominantly overseen by one service manager, which would have been a challenging context for any individual to manage. Recruitment to all roles within the SSF service, including for experienced social workers was said to be a difficult at the time.

5.104 Significant attempts have been undertaken to recruit to roles within the specific area of children's services with targeted recruitment under regular review. Attractive benefits have been agreed for new staff which include pioneering new ways of working.

5.105 Additional leadership roles in SSF were appointed to by late summer 2020 and core responsibilities for the SSF have been adjusted[12]. The staff sickness rate has significantly improved, all of which has positively impacted on performance especially regarding statutory visit timeliness and core groups being undertaken in accordance with expected practice standards. These were issues at times for the case under review.

5.106 The new model of working in the local area (mentioned above) states *"understanding how children and families want us to work with them is fundamental to forming effective working relationships and supporting families to keep children safe".* [13] The opportunity for children and

[12] During 2019 the SSF service had responsibility for supporting children via Child In Need Plans, Child Protection Plans, Pre-Proceedings PLO and Care Proceedings. A decision was made to move the responsibility for supporting children during care proceedings to the Supporting Our Children Service (SOC). In April '20 all children who had care proceedings commenced became allocated to the SOC Service at the Initial Hearing, with the SSF service remaining responsible for completing all the children's Care Proceedings which had commenced prior to this date.

[13] This uses the 'Heads, Hearts, Hands' model of social pedagogy and is not based on the needs of agencies and practitioners.

families to feedback on their experience of the new model of working is featured in the implementation plan.

5.107 Partner agencies are said to have agreed that the new local model of working should underpin how children are worked with at all levels of need. This includes the changes to formal processes mentioned earlier to support the model, including how child protection conferences and plans are facilitated. At the practitioners' meeting for the review some frontline professionals outside of children's social care had limited knowledge of the new model, by its name or by their recent experience. Others were encouraged by their experience of the model's different way of working and impact on child protection conferences in particular.

5.108 It was confirmed a multi agency implementation group has helped with communication about changes and expectations across the whole partnership therefore any gaps in awareness of the new model should be small.

5.109 A video and other promotional material about the model is available and in use across the local area.

5.110 Regarding multi agency communication between professionals, conversations did take place between partners about the children and adults within the immediate family, and about MGM. Examples include the contacts between the substance misuse service with the CRC. FIN staff did try to communicate with involved partners but they did not hold social work responsibility for the children.

5.111 Some professionals reported difficulties in communicating with children's social care, including speaking to the named worker by phone or email. Contacts went unreturned. Mother and Father both said children's social care rarely responded to their calls.

5.112 Other challenges in multi agency communication were reported when partners were trying to report new concerns for the children, for example Lucas' school reporting Father in attendance at school whilst appearing drunk and when the GP referred Mother admitting to using heroin. Partners said they were unclear if concerns had been received and what action had been taken. There is evidence to show that these concerns were on record.

5.113 When the information about the significant incident (the allegation about the younger children being injected) was shared in late 2019 the initial information was received by the business support service for the SSF service. This was due to the children being allocated to the SSF service at this time. The business support staff member emailed the message to the social worker allocated for the children not knowing the social worker was on sick leave, hence the delay in the concern being

addressed. The email was not copied to the social worker's team manager or a duty social worker for the team.

5.114 A review was undertaken regarding the incident and a new process has been put in place by the SSF service manager and lead for the business service. When telephone calls are received by business support service resulting in email messages being sent to a social worker, an email is also copied to their team manager. Additionally, when a member of staff reports going off sick from work, the IT service is contacted to put an 'out of office' reply on their email account. This ensures that people emailing a particular social worker are aware the social worker will not be accessing the email and there will be no response from the worker.

5.115 An essential question to remember for all professionals supporting families, however large or small their part may be in the multi agency response, is what is life like for the children living in these circumstances? This focus should be a question that professionals from different disciplines regularly ask themselves and each other when trying to support families including whenever multi agency communication opportunities take place or when communication is difficult. This did not always happen in the case of Ava, Lucas, Harper and Chloe.

5.116 Multi-agency supervision for complex families, such as in this case would enable all professionals working with a family to come together to discuss the risks, roles and responsibilities and the lived experience of children including what the children may have said or what their behaviour demonstrates. It would also provide an opportunity for respectful challenge to occur as necessary relating to the support being offered to families and any drift occurring across services. In short, such a process must be expected to improve multi agency working and communication.

5.117 The Author was told this type of partnership supervision is part of the local area's child protection standards pathway, but the criteria currently is when a child's protection plan has been in place for 12 months.

5.118 **Recommendation 6**

The Children's Safeguarding Assurance Partnership should promote the use of the Resolving Professional Disagreements protocol and the role of the child protection conference chair as a point of reference for any professional who is concerned about the progress of a child protection plan.

(vi) De-sensitisation and professional culture

5.119 The existence of neglect within the family and in particular for the children is clear, throughout the entire review timeframe. The local area is known for its deprivation with several families living with poverty[14]. Previous research has identified that some professionals working with families living in areas of high deprivation come to accept lower standards *(Brandon et al, 2014 / Jack and Gill 2003).*

5.120 Professionals become *'*accustomed to working in areas with large numbers of children and high deprivation. As a result, there may be a normalisation and desensitisation to the warning signs of neglect*', Complexity and challenge: a triennial analysis of SCRs 2014-2017, Marian Brandon, Peter Sidebotham et al March 2020*. "Poverty blindness" may occur where professionals are working in these types of areas.

5.121 However, in this case the associated desensitisation to warning signs such as poor hygiene and poor home conditions may have run concurrently with desensitisation to substance misuse and its impact on families, lack of emotional warmth and a general stability for children. Professionals may regularly see families living in these environments and facing similar challenges but that should not become the expectation which then becomes the norm.

5.122 The focus on children and their life experience must remain at the core of all work with families. Professionals should challenge themselves and each other with the question would this be good enough for my own child? Lower standards and aspirations for some children should not be seen as acceptable.

5.123 **Recommendation 7**

The Children's Safeguarding Assurance Partnership must ensure that all multi agency training programmes reference the need for professionals to be alert to desensitisation when working routinely with high levels of need, providing opportunities within training for professionals to focus on desensitisation and the impact this may have on the children and families receiving support.

5.124 The timeframe of this review was a period when considerable pressure existed for the local children's services department in terms of performance which unsurprisingly impacted to some degree across the whole partnership. Whether this had a direct impact on professional culture, and consequentially, services provided to families is not known. The sense of hope and commitment for

[14] Over a quarter of children under 16 were known to be living in poverty in 2016

a joined up professional culture amongst the attendees at the practitioners meeting for the review, and within the Panel was clear. The new model of working fully implemented and embedded across the whole partnership area should encourage a shared professional culture which in turn should be better for children and families needing support.

5.125 *Complexity and challenge, March 2020* states *"*the professional culture within an individual organisation and its wider partnership was repeatedly noted as a significant influence on making a difference and delivering impact from reviews (such as this) and their recommendations".

5.126 Working together in partnership and recognising shared responsibilities will be more effective when there is a shared understanding of roles, professional culture and expectations. The local safeguarding adults board and safeguarding children partnership should continue their endeavours in linking work streams and priorities where possible to encourage a stronger commitment to wider safeguarding.

5.127 Towards the conclusion of the review regarding these four children the local council area received positive findings of a final assessment of children's social care. The judgement should hopefully bring some stability to those working within the department and those working in partnership, which should translate positively into the services delivered to children and families in the area. A focused visit took place in February 2021 with developments continuing to be addressed.

6. Conclusion/ What needs to happen

6.1 Examination of what happened in the lives of the four children and their family has highlighted the environment of significant neglect in which they lived. The brief feedback available from the children, helps to show what life was like for them and that for much of the time they were, as Lucas said *scared and confused*.

6.2 Despite some individual professionals recognising the unacceptable lived experience for the children the multi disciplinary processes which occurred did not routinely help to ensure that the children's situation improved. The children did not always remain the key focus when decisions were being made and when services were delivered. The complex and cumulative nature of neglect for these children was a constant challenge for professionals and organisational circumstances locally at the time meant that some responses were not effective and delays occurred.

6.3 On speaking to the parents, the Author sensed a desire from them both to parent well, but there was a lack of ability to do so due to their own conflicting needs and how they felt about the

support they were offered. The new model of working within the area is based on relational practice which should help to improve how families are supported.

6.4 This review examined key themes and areas of practice impacting on the lives the children based on their experiences during a specific timeframe. Recommendations have been made for the Children's Safeguarding Assurance Partnership to consider as a result of analysis of what happened in the case.

6.5 By trying to keep the children at the centre of the review, child focus and the child's voice was the thread running through all lines of enquiry. However, constant reference to the voice of the children being gathered, has highlighted the question about what difference is made when this happens ("so what?") Even when we listen to children and observe their lived experience it is what professionals do individually and as a collective with the concerns that have been spoken about or observed. If opportunities are not taken to act on what is seen or heard taking note of what is happening in the lives of children will be just that. Extensive records, as in this case, will become larger but proactive responses and positive outcomes must also be the aim.

6.6 The Children's Safeguarding Assurance Partnership must ensure wide circulation of the findings of this review to ensure all professionals and agencies have an opportunity to reflect on the experiences of the children and what needs to change as a result.

7. Recommendations

7.1 The Children's Safeguarding Assurance Partnership should examine the current position relating to neglect in the local area including analysis of data across the continuum of need, examination of audit findings and other relevant performance information to reaffirm the Partnership's responsibility and priority to respond more effectively to children and families believed to be affected by neglect, including specific attention to the position for young carers and the delivery of the early help offer across the local area.

7.2 The Director of Children's Services in the local area should provide assurance to the Children's Safeguarding Assurance Partnership that PLO processes are being conducted in a timely way and any delays and risks are addressed immediately.

7.3 The Children's Safeguarding Assurance Partnership should consider opportunities to ensure a partnership approach is the aspiration in supporting families involved in PLO proceedings and

related matters, including raising the awareness of professionals about the process, timescales and responsibilities.

7.4 The Children's Safeguarding Assurance Partnership should require a multi agency audit to be undertaken of the content and quality of genograms and safety plans for families to ensure relevant information is on record with appropriate assessments completed to inform decisions for emergency short term placements.

7.5 Public Health on considering the findings of the review should revisit the public health substance misuse service commissioning arrangements to re-implement the provision of training by the provider to the multi-agency workforce to ensure a broader confidence and knowledge base exists across the partnership for professionals working with families significantly affected by substance misuse.

7.6 The Children's Safeguarding Assurance Partnership should promote the use of the Resolving Professional Disagreements protocol and the role of the child protection conference chair as a point of reference for any professional who is concerned about the progress of a child protection plan.

7.7 The Children's Safeguarding Assurance Partnership must ensure that all multi agency training programmes reference the need for professionals to be alert to desensitisation when working routinely with high levels of need, providing opportunities within training for professionals to focus on desensitisation and the impact this may have on the children and families receiving support.

8. References

- Working Together to Safeguard Children, July 2018
- The Local Area's Neglect Strategy 2019
- Local Safeguarding Partnership 7 minute briefing - Voice of the Child (2019)
- Complexity and Challenge: a triennial analysis of SCRs 2014-2017, Marian Brandon, Peter Sidebotham et al, March 2020
- Local Serious Case Review- Child CD, February 2021
- Ofsted inspection of the Council area's children's social care services, 2018
- Child Neglect- Identification and assessment, Jan Horwath, 2007
- The Local Area's Neglect Strategy Implementation Plan, 2019
- Local Child Safeguarding Practice Review- Children Ryan, Nathan and Amelia, May 2021
- Best practice guidance: Support for and work with families prior to court proceedings, Public Law Working Group, March 2021
- The Local Area's Social Work and Safeguarding Service Procedures Manual, Chapter 3.4
- Initial Family and Friends Care Assessment: A good practice guide developed by Family Rights Group in partnership with an expert working group, February 2017
- Growing up neglected: a multi-agency response to older children, Ofsted joint targeted area inspection programme July 2018

9. Appendix A

9.1 Purpose of child safeguarding practice reviews, Working Together 2018

9.1.1 The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy makers.

9.1.2 Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose.

9.1.3 Serious child safeguarding cases are those in which:

• abuse or neglect of a child is known or suspected and

• the child has died or been seriously harmed.

9.1.4 Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

9.1.5 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states: Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if – (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

9.1.6 Safeguarding partners must make arrangements to identify serious child safeguarding cases which raise issues of importance in relation to the area and commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

9.1.7 When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review.

9.1.8 The criteria which the local safeguarding partners must take into account include whether the case:

• highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified

• highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children

• highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children

• is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

Safeguarding partners should also have regard to the following circumstances:

• where the safeguarding partners have cause for concern about the actions of a single agency

• where there has been no agency involvement and this gives the safeguarding partners cause for concern

• where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around

• where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

10.0 **Appendix B**

10.1 **Panel Membership**

Head of Cluster (Chair)	National Probation Service
Safeguarding Practitioner	Clinical Commissioning Group
Named GP for Safeguarding	Clinical Commissioning Group
Head of Safeguarding and Principal Social Worker	Local Authority Children's Services
Schools' Safeguarding Advisor	Local Authority
Early Years Service Manager	Local Authority
Review Officer	Police
Deputy Head of Safeguarding	Acute Hospital Trust/ 0 – 19 community health provider
Safeguarding Practitioner	Acute Hospital Trust/ 0 – 19 community health provider
Deputy Director	Community Rehabilitation Company
Safeguarding Manager	Adult substance misuse service provider
Service Manager	NSPCC