Independent Overview Report of the Serious Case Review Concerning

Family Blue

February 2021

Contents

Serious Case Review

1 Introduction

1.1. In July 2018 the Surrey Safeguarding Children Board (SSCB) decided to undertake a Serious Case Review in respect of a 19-month-old child who will be known as (Sibling 3). It was agreed that the criteria for carrying out a Serious Case Review as defined by Working Together to Safeguard Children 2015[1] had been met.

1.2. Sibling 3 was admitted to hospital in December 2017 suffering from severe malnutrition and starvation. Given the indication of neglect all four children in the Family (referred to as the Blue Family in this review) were taken into police protection. Father was arrested on charges of neglect and at the time of writing the police investigation was ongoing.

2 Methodology

2.1 This review has followed the Government guidance outlined in Working Together 2015 which states that SCRs should be conducted in a way that;

- Recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform the findings[2].

2.2 The purpose of this review was to identify whether improvements were needed in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice. Lessons learned both within and between agencies have been clearly identified and informed a programme of action for improvement which is sustainable and explicit about what is expected to change and within what timescale (Appendix i).

2.3 It was agreed that the review would consider the professional involvement with the family from August 2015 when Mother booked for antenatal care for Sibling 3, until December 2017 when all four children in the Blue Family were made subject to an Emergency Protection Order and accommodated in foster care.

2.4 Information provided to the review included single and interagency chronologies. Key practitioners, managers and agency safeguarding leads were invited to a Learning Event to explore issues relating to multi-agency practice during the timeline considered by this review. Participants involved in the initial Learning Event were invited to a Recall Event to study and debate the initial findings and lessons learned. The SCR Steering Group contributed to the findings and recommendations to ensure that actions resulting from this review complemented the improvement activities of the SSCB and Partner Agencies and avoided duplication. The contribution of all those involved enabled a greater

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[1]Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children, HM Government 2015

[2]Working Together to Safeguard Children was updated and published in July 2018. Arrangements for reviews following the death of a child have now changed;
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722305/Working_Together_to_Safeguard_Children_-_Guide.pdf

understanding of the context in which practitioners and managers worked and maximized opportunities for organizational learning.

2.5 Relevant information prior to these dates was also considered and included professional concerns about the possible neglect of Sibling 1 and faltering growth[3] of Sibling 2.

2.6 The detailed Terms of Reference considered throughout this Review are included at Appendix ii. In summary, the review focussed on two overarching questions which broadened the opportunity for learning whilst retaining focus on the presenting issues;

- What can we learn from this case about the effectiveness of practice in Surrey to identify the neglect and abuse of children?
- What can we learn about the assessment of risks and vulnerabilities (known at the time) and how these influenced decision making and intervention?

2.7 Children's Services remain involved with the family and it was decided not to involve the children directly in the review process. On balance it was thought that participating in the review would risk further trauma at what was known to be a difficult time. SSCB advised Mother and Father by letter that the review was taking place, invited them to participate and provided contact details for further information. There was no response to this letter and unfortunately the views of Mother and Father have not been included in this review.

3 ANALYSIS

3.1 The following definition of neglect from UK statutory guidance[4] was used throughout the review process to guide discussion and analysis;

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

a. provide adequate food, clothing and shelter (including exclusion from home or abandonment)
b. protect a child from physical and emotional harm or danger
c. ensure adequate supervision (including the use of inadequate care-givers)
d. ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Evidence of each of these indicators was provided during this review.

3.2 Guided by the Terms of Reference for this Review specific themes emerged following a systematic analysis of all the available information and discussion with practitioners at the learning and recall events and the SCR steering group. Exploration of each theme enabled rigorous examination of practice and identification of opportunities to improve the systems to safeguard children in Surrey.

3.3 It is important to note that each theme impacted on the others in a systematic and dynamic way. Professional recognition of neglect influenced the effectiveness of assessment and

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[3] This term is used in relation to infants and young children whose weight gain occurs more slowly than expected for their age and sex. In the past this was often described as a 'failure to thrive' but this is no longer the preferred term. nice.org.uk/guidance/ng76 p 44

[4] Department for Education (DfE) (2015) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (PDF) London: HM Government. Page 93

adequacy of information sharing within and between agencies which in turn informed the understanding that professionals had about the lived experience of the children.

3.4 The themes identified were:

- Monitoring and review of faltering weight in an infant
- Recognition of neglect and effectiveness of assessment
- Professional understanding of the children's lived experience
- Parental engagement and professional challenge
- Professional supervision and managerial oversight
- Communication – inter and intra agency

Monitoring and review of faltering weight in an infant

3.5 Lack of a consistent electronic system to enable the systematic recording and monitoring of the weight of Sibling 3 emerged as a significant issue for professionals during this review. Not all areas were able to access an electronic centile chart[5] and when an electronic chart was available this was not consistently used to record the weight of Sibling 3. Some information was scanned to the GP records in June 2016 however the main system used to record weight was the Personal Child Health Record (PCHR) book, often referred to as The Red Book, which was kept with the child. Reliance upon parental hand held records to record the weight of Sibling 3 contributed to the lack of robust monitoring to ensure appropriate weight gain and adequate growth.

3.6 Absence of a shared system for health professionals to record the weight of Sibling 3 increased the likelihood of practitioners viewing the weights in isolation rather than observing the pattern of growth and weight gain over a period of weeks and months. This may have resulted in professionals being falsely reassured following a slight change, as illustrated by a record in the PCHR for Sibling 3 in September 2016 which stated; *great weight gain, no parental concerns.* It was noted in the electronic records that Sibling 3 was *following the centile line,* however there was no explanation of which centile line or whether that was appropriate.

3.7 At the Learning Event it was acknowledged by Practitioners that there appeared to be a general acceptance that Sibling 3 was just a small baby and explanations provided by mother were accepted without question. There was no evidence that available tools to assess neglect had been used and concerns about weight were viewed separately to the presentation of parents and home conditions. The Clinical Lead recorded that a HV would be allocated if there were further concerns however as Sibling 3 was not monitored additional concerns were not identified in a systemic way that resulted in action.

3.8 The NICE Guideline 75[6] on the *Organisation of Care* for infants with faltering weight states:
Ensure there is a pathway of care for infants and children where there are concerns about faltering growth or weight loss in the early days of life that:

- *clearly sets out the roles of healthcare professionals in primary and secondary care settings*
- *establishes and makes clear the process for referral to and coordination of specialist care in the pathway*

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[5] Mid-Surrey RIO system does not have an electronic centile chart available

[6] https://www.nice.org.uk/guidance/ng75/chapter/Recommendations#weight-loss-in-the-early-days-of-life

3.9 Information submitted to this review did not evidence that a feeding plan was in place, or that professionals had monitored Parents feeding Sibling 3 prior to hospitalisation in November 2017. These measures should form part of a basic assessment when trying to determine the underlying cause for why a baby is not growing. There was no evidence that consideration had been given to the impact of faltering weight on the general development of Sibling 3.

3.10 This Review has identified complex systemic factors which impacted on the ability of practitioners to effectively monitor and review the slow weight gain of Sibling 3. In summary these include; insufficient exploration to clarify the cause of faltering weight, lack of robust systems to monitor weight gain, ineffective communication between practitioners and agencies and uncritical acceptance of information provided by parents. All of these factors influenced practice and contributed to the missed opportunities to prevent the critical deterioration of the health and wellbeing of Sibling 3 during the first 18 months of life.

Effectiveness of assessment and recognition of neglect

3.11 Practitioners involved with Sibling 3 had responded to presenting concerns in isolation prior to the referrals to Surrey Children's Services. A Child and Family Assessment was in the very early stages when the children were made subject to police protection and subsequently taken into care. There was no evidence within the first 18 months of Sibling 3's life that slow weight gain had been considered as a risk factor for neglect. Additional concerns about home conditions and lack of stimulation for the children lacked urgency and were not considered as potential indicators of neglect.

3.12 Omission to consistently record observations of the home environment and parenting capacity impacted on the ability of practitioners to gain a holistic overview of concerns. The importance of undertaking an early help assessment was not recognised. In addition there was lack of consistent observation and monitoring during the early days of Sibling 3's life. The new birth visit for Sibling 3 was completed by a bank Health Visitor and Mother reported that she was breast feeding and the HV observed good interaction between Mother and both children however observations of the home environment were not recorded.

3.13 It would have been appropriate (and in line with the Threshold Document in use at the time) for practitioners to have completed an Early Help Assessment shortly after the birth of Sibling 3 in response to concerns about faltering weight and observation of home conditions. In setting out the principles of an effective child protection system, Professor Munro highlighted that *preventative services can do more to reduce abuse and neglect than reactive services*[7]. Whilst it is not possible to state with certainty what the outcome would have been had Sibling 3 and the family been subject to an Early Help Assessment, it is reasonable to conclude however that it is likely that Sibling 3 would have been assessed much earlier to be a Child in Need (Children Act 1989)[8]. Provision of appropriate

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[7] Professor Eileen Munro, Munro review of child protection: final report – a child-centred system, Department for Education, 2011; www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system.

[8] "Section 17(10) For the purposes of this Part a child shall be taken to be in need if—
(a)he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;
(b)his health **or** development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or

services and support may have prevented the significant deterioration in health and wellbeing experienced by Sibling 3.

3.14 During the time of relevance for this Review there were significant challenges in the delivery of Early Help services in Surrey which have been well recorded (Ofsted 2015, 2018)[9]. Working Together to Safeguard Children[10] guidance highlights the important role of effective early help and places a duty on LSCB's to ensure that an agreed threshold document is in place so that professionals are clear when it is their responsibility to help children and families as difficulties emerge.

3.15 There was little evidence that professionals considered the need to deliver early help support prior to the referral to Children's Social Care. This was identified as a systemic concern in the Ofsted 2018 inspection report which recommended that;

> *Leaders should urgently renew efforts to engage universal partner services, such as schools and health, to undertake lead professional roles and to form teams around children and families when difficulties emerge p8.*

This review has highlighted the serious consequences that children can experience when vulnerabilities and risks are not assessed and early support and intervention are not provided.

3.16 There is significant evidence to demonstrate that neglect has the potential to compromise progress across the seven dimensions of development identified in the Assessment Framework: health, education, identity, emotional and behavioural development, family and social relationships, social presentation and self-care skills[11].

Professionals working in universal services have a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and provide children and young people with the help that they need[12].

3.17 Sibling 3 experienced many of the following known consequences of neglect in 0-5 yr olds;

- *Failure to thrive; stunting, poor height and weight gain*
- *Developmental delay; not meeting milestones e.g. not sitting, crawling,*
- *Pale skin, poor hair and skin condition*
- *Under stimulation; head banging, rocking*
- *Language delay*
- *Emotional, social and behavioural difficulties e.g. frequent tantrums; persistent attention seeking or demanding; impulsivity or watchful and withdrawn*[13]

3.18 Practitioners at the Learning Event acknowledged that there had been over reliance on information provided by Mother who stated that both older children had a milk intolerance

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(c) he is disabled, and "family", in relation to such a child, includes any person who has parental responsibility for the child and any other person with whom he has been living."

9 Review of the effectiveness of the Local Safeguarding Children Board (August 2015) https://files.api.ofsted.gov.uk/v1/file/50004302 Re-Inspection of services for children in need of help and protection, children looked after and care leavers (May 2018) https://files.api.ofsted.gov.uk/v1/file/50004443

10 Department for Education (2015) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (PDF) London: HM Government p15

11 Pathways to harm, pathways to protection: A triennial analysis of serious case reviews, 2011 -2014. Sidebotham P et al. DH 2016 P8

12 Department for Education (2015) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (PDF) London: HM Government p13

13 Neglect Matters. NSPCC 2013 p10

which caused them to lose weight. This acceptance by Practitioners contributed to the absence of critical questioning and reflection about possible alternative causes for the slow weight gain of Sibling 3 and delayed implementation of robust monitoring and assessment.

3.19 Brandon et al. (2014) acknowledged that health and education professionals and social workers often find it difficult to identify indicators of neglect or recognise their severity. The following characteristics of neglect may make it harder for professionals to recognise that a threshold for action has been reached:

- *First, given the chronic nature of this form of maltreatment professionals can become habituated to how a child is presenting and fail to question a lack of progress;*
- *Second, unlike physical abuse for example, the experience of neglect rarely produces a crisis that demands immediate proactive, authoritative action;*
- *Third, neglect can in some cases be challenging to identify because of the need to look beyond individual parenting episodes and consider the persistence, frequency, enormity and pervasiveness of parenting behaviour which may make them harmful and abusive*[14].

3.20 Each of the characteristics detailed above were present during this review;

- Practitioners became accustomed to Sibling 3 being small and explanations provided by Mother were considered plausible.
- Slow weight gain was not considered when Sibling 3 was reviewed in hospital. There was a lack of urgency when monitoring Sibling 3 and professionals were reassured that the centile line was being followed although there was lack of clarity about which centile line and whether growth was adequate.
- Mother was described as a plausible and confident parent by practitioners. Father became increasingly abusive and aggressive however the impact of this on the children was not considered.

3.21 It is likely that these factors provided reassurance to professionals and influenced decision making. No practitioner had a full overview of Sibling 3 and the family dynamics. Had information sharing been more effective this may have resulted in a decision to undertake an assessment at an earlier stage in the life of Sibling 3. There was limited evidence within agency records that the observations of practitioners were considered as possible indicators of neglect. Professional understanding of neglect as a chronic and cumulative condition appeared to be limited. This was a significant factor which contributed to the lack of assessment by practitioners and impacted on the effectiveness of decision making.

3.22 There was no reflection between the MASH Officer and the HV about whether the family required additional support and no evidence of communication with the Midwifery Service. There was sufficient information to trigger an Early Help Assessment at this time however Practitioners did not appear to have a clear understanding about the Early Help offer. The early observations of this HV were significant and concerns well founded. It became evident during this Review that these issues of concern had escalated significantly following the birth of Siblings 2, 3 and 4.

3.23 The extent and significance of neglect in children's lives has been a key and recurrent theme within Serious Case Reviews. A recent analysis found that neglect was apparent in the lives of nearly two thirds (62%) of the children who suffered non-fatal harm, and in the lives of over half (52%) of the children who died[15]. Two recent SCR's in Surrey also focussed on neglect and it was acknowledged that without clear monitoring and

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[14] Missed opportunities: indicators of neglect – what is ignored, why and what can be done? Brandon M, Ward H et.al. Research Report DH Nov 2014 p 7

[15] Pathways to harm, pathways to protection: A triennial analysis of serious case reviews, 2011 -2014. Sidebotham P et al. DH 2016 (p43)

assessment it can be very difficult to evidence persistent neglect and the serious consequences for children may not be immediately apparent. Neglect was one of the four key priorities for Surrey Safeguarding Children Board (SSCB) in 2016/17. A Neglect Audit conducted during the timeline of this review noted that;

> *.....There is a gap in neglect data reporting and the current reporting system needs to be developed further to understand the prevalence of neglect in Surrey as well as to measure the impact of some of the work that is being carried out*[16]*.*

3.24 During the period considered by this review tools available to assess neglect were not utilised. This is significant as the Graded Care Profile is due to be introduced in Surrey. It is important that consideration is given to awareness rising and training for practitioners to ensure that implementation of the GCP is effective and enables earlier recognition of indicators of neglect by practitioners working in partnership with parents. A study to test the efficacy of the GCP concluded; *GCP2 has been found to be reliable and valid. It can be used in the knowledge that it has sound psychometric properties, and is a reliable and valid assessment tool in aiding practitioners in the assessment of child neglect*[17]*.*

3.25 Earlier recognition of neglect should result in the timely provision of support and intervention to improve the wellbeing of children and young people and reduce harm due to long term experience of persistent neglect.

Professional understanding of the children's lived experience

3.26 There was little evidence that practitioners fully considered the implications of their observations from the perspective of the children. Completion of an Early Help Assessment would have been an appropriate and proportionate response and may have prompted practitioners to reflect and have a greater understanding of the lived experience of the children.

3.27 Omission to undertake an Early Help Assessment of the family contributed to the issues listed below being viewed separately. Professionals were reassured by and accepted explanations provided by Mother and Father. Indicators of neglect were not recognised there was limited critical reflection and the experience of the children was not explored or understood.

3.28 Statutory guidance emphasises the importance of remaining child focussed and ensuring that the child is at the centre of all decisions which impact on their lives[18]. There is extensive evidence which highlights the importance of professionals with responsibility for safeguarding children having an understanding of their lived experience. In addition there have been many examples from serious case reviews of the serious and potentially fatal consequences when professionals lose sight of the children whom they have a responsibility to protect[19]. Understanding the lived experience of the child is a complex process and the importance of professionals having a child centred approach is well recognised.

3.29 Practitioners at the Learning Event were shocked at the extent of Sibling 3's physical deterioration prior to hospitalisation at 18 months old. Subsequent medical tests have identified that there was an organic cause that may have contributed to the developmental

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16 SSCB Multi Agency Neglect Audit Children's Case File Audit: November 2016. Report Produced: February 2017

17 Testing the Reliability and Validity of the Graded Care Profile Version 2. Johnson R. Smith E. Fisher H. NSPCC 2015 p27

18 Working together to safeguard children. DfE, 2015 and 2018

19 In the child's time: professional responses to neglect. Ofsted 2014

delay. It is clear however that failure to thrive could and should have been addressed prior to Sibling 3 experiencing extensive weight loss and developing a pressure sore due to being immobile in a car seat for long periods. It is highly unusual for an infant to develop a pressure sore and this illustrates the importance of Practitioners going beyond observing presentations of a child i.e. in a car seat to asking themselves what the experience is like for the child and how may they be feeling?

3.30 It is important to note that in response to findings and recommendations by Ofsted much work has been undertaken by Surrey Safeguarding Children Board (SSCB) and partner agencies to improve how the Childs voice is heard in practice and influences decision making processes. Priority 1 in the current action plan of SSCB is;

Ensure that the child's voice and lived experience is integral to all the work that the SSCB and its partners undertake and that partner agencies proactively respond to direct feedback from children to improve their experiences.

Parental engagement and professional challenge

3.31 This review highlighted a pattern of aggression by Father which increased as professional concern about the wellbeing of the children increased. At the Learning Event Father was described as having a very quick temper but was said to calm down when challenged. Father informed the Head Teacher that his outbursts resulted from his own upbringing.

3.32 There were few examples of professional challenge to Father within the information provided during this review. The Head Teacher of the school attended by Sibling 1 had at least two robust conversations with Father when he was said to be angry and abusive during a telephone conversation. Similarly, the Health Visitor was persistent and persuasive during the clinic visit which resulted in the referral of Sibling 3 and Sibling 4 to the GP. However, there was lack of consistent challenge to Father by Professionals.

3.33 Practitioners at the learning event spoke about their extensive efforts to establish and maintain a relationship with parents. Professionals, particularly teachers and health practitioners spoke about their training and organisational culture which stressed the importance of relationships and did not easily lend itself to automatically question and challenge the views of adults. It is possible for respectful child focussed practitioners to offer high challenge to parents and carers whilst maintaining positive relationships. Statutory guidance is clear that; *a desire to think the best of adults and to hope they can overcome their difficulties should not subvert the need to protect children from chaotic, abusive and neglectful homes*[20].

3.34 The explanations and reassurance provided by Mother were not always accurate and served to mask the true condition of Sibling 3. In addition, there was no recorded challenge to parents when some decisions and actions did not appear to be in the best interests of the children.

3.35 Practitioners stated that they accepted information provided by Mother as they had no reason to think it was incorrect. Practitioners described different presentations of Mother who was said to appear confident and competent at times whilst totally downtrodden at others. When Sibling 3 and 4 were in hospital Mother denied that she experienced any form of abuse from Father. It is not known if Mother would have responded differently had professionals been consistent with such enquiries when concerns initially emerged. Professional readiness to accept parental explanations without showing any curiosity

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[20] Department for Education (DfE) (2018) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (PDF) London: HM Government p28

about whether the explanations are correct has been a consistent finding within Serious Case Reviews[21].

Professional supervision and managerial oversight

3.36 There were times during the period considered by this review when supervision was not provided to or sought by practitioners. In addition, there were occasions when managerial support and oversight was not evident. Had there been managerial oversight during the period NN1 conducted weekly home visits it is possible that there would have been an opportunity for critical reflection and further exploration to understand the reasons for the slow weight gain of Sibling 3 during the first weeks of life.

3.37 Practitioners who attended the learning event were of the view that even if they had received regular safeguarding supervision it was unlikely that Sibling 3 or the family would have been discussed as they were in receipt of universal services and safeguarding concerns and indicators of neglect had not been identified.

3.38 There was no information available about the decision making process at the MASH which resulted in the allocation of a SW and start of a Child and Family Assessment. There was consensus among the steering group for this review that given the seriousness of the concerns shared by colleagues in Health it would have been appropriate to arrange a multi agency strategy meeting to consider whether a S47 assessment[22] was necessary. This view was supported by analysis within the multi agency chronology which noted that *the next steps agreed by the manager do not fully address the concerns regarding the children or the appearance and presentation of Sibling 3.* Given that Sibling 3 was admitted to hospital within the next 18 days due to being significantly underweight and was said to be in a state of cachexia (starvation) it was evident that the response by the MASH was inadequate, lacked urgency and did not protect Sibling 3 from further harm.

3.39 It was evident from medical records that the Named Nurse challenged the decision made by SCS that the children should return home. The Named Nurse advised that it was possible for the children to remain in hospital for a second night. Concerns were shared about the mental health of father and the difficulty Mother may have in obtaining help as the family lived in an isolated area and Mother was unable to drive and had no credit on her mobile phone. SCS advised that despite the concerns of medical colleagues there was no evidence that the parents posed an immediate risk to the children and it was not possible to consider accommodating the children at this time.

3.40 At the learning event practitioners said that there had been lengthy discussions between the SW and ward manager who both expressed significant concerns about the children returning home. It was the view of professionals within SCS that there was insufficient

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[21] Pathways to harm, pathways to protection: A triennial analysis of serious case reviews, 2011 -2014. Sidebotham P et.al. DH 2016

[22] Section 47 Local authority's duty to investigate.
(1)Where a local authority—
(a)are informed that a child who lives, or is found, in their area—
(i)is the subject of an emergency protection order; or
(ii)is in police protection;
(b)have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm,
the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare

evidence to suggest that the children would be at risk of significant harm and it was not possible to prevent Mother from returning home with the children. The decision-making process and rationale for the children and their mother to return home in light of the concerns raised was not clear within SCS records.

3.41 Practitioners from SCS reported that at the time it appeared that the main concern was with regard to possible domestic abuse although this was not substantiated. It is unclear how this was communicated or whether there had been any assessment of risk should Mother return home with the children. Once Mother had been informed that she could go home by the SW it was not possible for Health professionals to dissuade her. At the time of the decision the details of the written referral from Health was not known to the SW at SCS. When the detail did become clear the Strategy meeting was prioritised and moved forwards by 2 days.

3.42 It is likely that, had information contained in the referral from Health been available to the MASH, managerial oversight would have resulted in a strategy meeting prior to the children returning home and may have prevented further exposure to possible harm.

Communication – inter and intra agency

3.43 Various challenges to effective communication were identified during this review; some were caused by difficulties with electronic recording systems. The impact of health practitioners having different systems to record the weight of babies has been discussed. There were also delays in acting on information received which practitioners advised was due to information not being pulled through to a child's ICS records when the case was opened.

4 Good Practice

4.1 It is important to note the good practice which took place during the period considered by this review which included;

- Home visits during the early weeks of Sibling 3's life were carried out by the same Nursery Nurse which provided continuity.
- Extended support was offered by the Community Midwife following the birth of Sibling 4 due to concerns regarding slow weight gain and the involvement of SCS.
- Following the admission of Sibling 4 to hospital at 7 days, medical staff made an immediate referral to SCS to report concerns about lack of parental responsiveness to all the children and the developmental delay of Sibling 3.
- Following a clinic appointment in November 2017 there was good communication between the Health Visitor and GP practice with regard to Sibling 3 and the urgency for medical treatment. Information about the aggression of Father was also shared.
- Sibling 3 and 4 were seen by a GP on the same day the Health Visitor expressed the need for a hospital admission.
- The GP informed the consultant paediatrician about the serious condition of Sibling 3 and advised about the urgent need for medical intervention and assessment.
- Two days following the admission of Sibling 3 to hospital medical staff requested that a strategy meeting was convened which resulted in immediate action to safeguard all the children.
- Health professionals challenged father when he left the children at the hospital.
- Health professionals explored the impact of Father's behaviour on the children and Mother in discussions with Mother.

5 Organisational Context

5.1 During the time frame considered by this review the Health Visiting Service was under considerable strain due to low staffing levels. Health Visitors carried very high case loads which were reported to be unmanageable and resulted in low morale across the service. At the learning event practitioners stated that this situation is ongoing and the challenge to recruit Health Visitors is a national issue and not specific to Surrey.

5.2 Surrey Children's Services was reported as inadequate by Ofsted in 2015 and 2018 and there was rapid turnover of staff, low morale and considerable organisational change during the time frame considered by this review. Whilst this remains a time of uncertainty for many staff at SCS and organisational restructure is ongoing it is important to acknowledge that significant changes have been made to practice which impact on the findings made during this review. Following a second monitoring visit by Ofsted in January 2019 it was reported that;

> *The local authority has a more realistic and informed understanding of its performance and progress through a comprehensive, closely monitored improvement plan and improved quality assurance and auditing programmes. A learning culture is emerging across the county, alongside explicit requirements for social workers and their supervisors to meet improved practice standards.*

5.3 In addition Surrey Children's Services Academy was launched in January 2019 and will support the County Council's drive to support children and families as early as possible to prevent problems escalating. Staff from all partner agencies working with children and families will be able to access the academy.

6 Conclusion

6.1 From information shared with this review it was evident that more assertive action should have been taken to monitor and understand why Sibling 3 had slow weight gain and whether this impacted on general development. A combination of factors influenced the actions of practitioners as discussed within the analysis and can be summarised as;

- Lack of recognition amongst practitioners that slow weight gain could be a contributory factor for neglect
- Omission to use available tools to assess neglect
- The complexity of Health IT systems across Surrey and lack of electronic growth charts
- Unquestioning acceptance of accounts provided by parents which provided false reassurance to practitioners
- Lack of robust supervision and managerial oversight
- Lack of consideration about the impact on the children of home conditions, lack of stimulation and aggression by father
- Missed opportunities to escalate concerns to SCS
- Limitations in information sharing, written, verbal and electronic
- Lack of consistent challenge to the unacceptable and abusive presentation of Father

6.2 This review has benefited from the generous participation and reflection of practitioners and managers at the Learning and Recall Events. Whilst practitioners worked to support Sibling 3 within their respective agencies there were systemic issues which had a significant impact on the practice of all. These included communication, multi-agency working, and limited recognition of risk factors for child neglect.

6.3 It was evident during this review that the behaviour of Father would have had a significant influence on Mother and an impact on her ability to care for the children. Mother would have known that information provided to professionals was not accurate and it is unclear why she consistently supported the explanations provided by Father. Professionals visited the family home in pairs and Father's aggression increased as Professionals became more concerned yet there was very limited exploration of whether Mother and the children were subjected to coercive control by Father. Had practice been sensitive to the needs of Mother and focussed on the behaviour of Father, Mother may have been empowered to recognise abuse, work towards change and better protect the children[23].

6.4 Lack of professional curiosity and challenge has been a significant feature throughout this review and contributed to the many missed opportunities to safeguard the children of the Blue family. All Professionals who participated in this review were shocked and found it difficult to understand how Sibling 3 had been overlooked until becoming critically ill and not expected to survive. It is too simplistic to state that practice may have been different if practitioners had exercised professional curiosity. Whilst true to a point, it is important to note that organisational factors impacted on the way in which individuals had the capacity to exercise professional curiosity. High case loads, organisational pressures and culture, focus on procedures, limitations of practitioner knowledge, lack of managerial oversight and limited opportunity to reflect all impacted on practice considered during this review. These themes are explored further by Burton and Revell (2018)[24] who state; *professional curiosity is enabled within organisations which promote reflective practice and external scrutiny of practice via supervisory processes and training to engender rigorous practice.*

6.5 It is a significant concern that Practitioners and managers who participated in this review stated that it is possible a similar oversight could occur again as Health Visitors continue to carry very high caseloads. In addition, the requirement for children to have a check at one year of age has been removed and many health clinics provide an option for parents to self weigh babies who may not be seen by a practitioner and early issues of concern may not be identified.

6.6 The overarching questions considered within this review were;

- What can we learn from this case about the effectiveness of practice in Surrey to identify the neglect and abuse of children?
- What can we learn about the assessment of risks and vulnerabilities (known at the time) and how these influenced decision making and intervention?

There was agreement within the steering group for this review that the learning identified illustrated the need for improvements to practice, systems and processes in order to

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[23] *Watson D, Domestic abuse and child protection: women's experience of social work intervention*. March 17 Insight 36 IRISS (The Institute for Research and Innovation in Social Services). https://www.iriss.org.uk/resources/insights/domestic-abuse-and-child-protection-womens-experience-social-work intervention?gclid=CjwKCAjwnMTqBRAzEiwAEF3ndpO8urVdbPZKgCGQpD8l5GZ8uG22RmJxFa4-XVuCJ42Sxhu6-noCNRoCJMsQAvD_BwE

[24] Burton V, Revell L, Professional Curiosity in Child Protection: Thinking the Unthinkable in a Neo-Liberal World. *The British Journal of Social Work*, Volume 48, Issue 6, September 2018, Pages 1508–1523

effectively identify the neglect and abuse of children and to assess risks and vulnerabilities in a timely way.

6.7 It is recognised that there have been significant historical challenges to improve children's services in Surrey specifically with regard to the implementation of an effective system of Early Help Provision. Some of the issues identified in this serious case review have been highlighted in previous reviews e.g. ineffective communication between Health Visitors and GP's. It is critical that the lived experience of Sibling 3 detailed in this review influences change to systems and practice. Learning and recommendations detailed below focus on;

- Improving the recognition and response to child neglect
- Improving the recognition and response to coercive control
- Development of an effective multi agency response to address risk factors for neglect when they first emerge
- Development of multi agency support and intervention to children and families in need
- Improving the skills, confidence and support of practitioners to address neglect and reduce the risk of children experiencing significant harm.
- Improving systems and processes identified during this review[25] to support effective practice to safeguard children in Surrey

7 **Learning and Recommendations (**to include single agency recommendations submitted to the review as an appendix)

As previously acknowledged, implementation of an extensive improvement action plan regarding the work of SSCB and all partner agencies is in progress following the Ofsted inspection in 2018. Throughout this Review every effort has been made to ensure that learning builds on what is already known about practice to safeguard children in Surrey and recommendations complement the current action plans and avoid duplication.

Learning point 1

Appropriate investigations and assessments must be conducted when babies and infants have faltering weight. Findings will clarify the causal factors and inform the provision of support in order to improve weight gain and promote the wellbeing of babies and infants.

Recommendation 1

SSCB to seek reassurance that the policies and procedures of partner agencies regarding the faltering weight of babies and infants are robust and barriers to effective implementation are addressed.

Learning point 2

Without effective systems and processes to enable clear communication between Practitioners in Universal Health Services significant concerns may be overlooked and vulnerable babies may not receive the support and intervention that they require.

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[25] Specifically with regard to recording and sharing of information and communication within and between agencies

Recommendation 2

Surrey Safeguarding Children Board to request Surrey Health Subgroup to review, improve and monitor systems which impact on communication and information sharing between practitioners in Universal Health Services. With a specific focus on;

- Communication between GP's and Health Visitors
- Monitoring of babies with faltering weight
- Access to electronic growth charts on community IT systems

Learning point 3

Without an Early Help Assessment factors which impact on the health and development of babies and infants may be viewed in isolation and opportunities to provide multi-agency support and intervention may be missed.

Recommendation 3

SSCB to seek assurance from Partners that improvement to the Early Help offer will;

- facilitate effective support and monitoring of babies with faltering weight
- support practitioners to consider if factors which impact on the health and development of babies and infants are potential indicators of neglect

Recommendation 4

SSCB to satisfy itself that learning from this Review influences the development and provision of Early Help Support in Surrey.

Learning point 4

When information provided by parents is accepted without question it may be difficult for practitioners to fully appreciate and understand the lived experience of the child and (in this family) Mother. It is important that practitioners have the skills and confidence to speak directly with children about their wishes and feelings and challenge parental accounts when necessary.

Recommendation 5

SSCB to satisfy itself that that learning from this Review informs and influences activity to; *ensure that the child's voice and lived experience is integral to all the work that the SSCB and its partners undertake (Priority 1 SSCB business plan 2018/19)*

Recommendation 6

SSCB to satisfy itself that that learning from this Review improves the understanding of coercive control and the provision of effective support/intervention for Mothers[26].

Recommendation 7

SSCB to seek reassurance from Partners that systems of supervision and managerial oversight encourage and support critical reflection whilst remaining child focussed.

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[26] And any parental figure thought to experience coercive control

Recommendation 8

SSCB to audit and monitor the implementation and impact of recommendations 5 and 6

Learning point 5

If cumulative long term coercive control is not recognised or addressed babies, infants, children and Mother's can experience significant harm.

Recommendation 9

SSCB seeks assurance from the neglect sub group that implementation of the Graded Care Profile is monitored effectively and includes feedback from service users and practitioners to highlight outcomes and support ongoing activity to embed the GCP across the County.

Recommendation 10

The SSCB to satisfy itself that learning from this review is communicated to relevant practitioners and partners to improve and promote;

- recognition of neglect/coercive control
- understanding of risk factors that constitute neglect/coercive control
- monitoring of the cumulative impact of neglect/coercive control

Recommendation 11

SSCB to request that Surrey Social Work Academy provides opportunities to share learning from this review to;

- improve interagency communication when sharing concerns about children.
- improve the confidence and competence of practitioners to identify neglect/coercive control

Questions for the Board

1. How can the Local Safeguarding Children Board satisfy itself that the provision of Early Help for children and families is coordinated, effective and recognised as the responsibility of all agencies?
2. How can the Board satisfy itself that actions to address the four priorities identified in the SSCB Action Plan April – September 2019[27] are informed by the learning from this review?

An action plan with named person/agency responsible for the implementation of the recommendations and timescales to be developed

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[27] 1) Ensure that the child's voice and lived experience is integral to all the work that the SSCB and its partners undertake....; 2) Hold partners to account for the development of an Early Help system....; 3) Reduce harm to children and young people in vulnerable groups...; 4) Ensure that all partners working with Children and Young People in Surrey recognise and respond to the needs of children and young people living with domestic abuse, substance misuse, neglect and mental health concerns to improve their outcomes and keep themÂ"4JO e