# West Sussex
# Safeguarding Children Partnership
# Serious Case Review in respect of
# Family W

## Executive Summary
## FINAL
## CONFIDENTIAL

**20th January 2020**

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**Director**

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## 1. Background to this Serious Case Review

1.1 This Serious Case Review concerns two children who experienced life-long difficulties due to the care given to them by their family and the lack of effective intervention by professionals.

1.2 Both children had been the subject of child in need plans since October 2016 and child protection plans under the category of neglect since June 2017, the latter covering the 14-month period prior to the incident that led to this review.

1.3 On 15th April 2019, following a Rapid Review, Lesley Walker, the Independent Chair of the then West Sussex Safeguarding Children Board, from September 2019, the West Sussex Safeguarding Partnership, decided the criteria for a Serious Case Review were met and commissioned a multi-agency review.

## 2. The views of the family

2.1 West Sussex Safeguarding Partnership is grateful to the family members who accepted an invitation to share their views and experiences with the Independent Reviewer.

2.2 In summary their concerns were;

- that they were given insufficient early help to support their parenting of their children;
- they found the information, reports and plans that were shared with them at meetings and in writing were not in a language or format they could read and understand;
- the frequent changes of social worker were particularly unhelpful in establishing trusting relationships; and
- they felt they had been given the impression that the plan was for the children to remain in their care.

**Information on the Serious Case Review Process is attached at Appendix 1.**

## 3. Good Practice

3.1 In seeking to support the needs of the children and improve their care, professionals worked hard to explore the capacity and commitment of the carers and provide agency support and resources, there were examples of good practice:

- When the children were subject to child in need planning, timely cognitive assessments of the parents resulted in an agreed PAMs assessment.
- The Children's Social Care practice manager recognised that the allocated worker was not managing the case appropriately and took remedial action by allocating an advanced practitioner to support the existing more inexperienced worker.
- The advanced practitioner sought advice from one of the children's schools about how best to communicate with the child and liaised with Lifelong Services, although at the time, the family did not meet the criteria for a referral to the team, a support worker was allocated to support the child and her family.
- The recognition that one of the children's decayed teeth and bleeding gums were indicative of neglect, the observations that the adults attending the dental surgery were carrying or had consumed alcohol, together with their lack of supervision of the child whilst in the surgery, led to the dentist making a safeguarding referral, this was very good practice.
- Referrals were made for one of the parents to have advocacy support and support from the Learning Disability Team which was provided through an adult's social worker. The advocate was a good source of support, both to aide her understanding and to assist professionals in providing information in a more accessible format.
- One of the children was sometimes seen alone, and their wishes and feelings explored with some good direct work, although this was not consistent. The school nurse was clearly able to engage the child and did some very good direct work, as evidenced in her reports to child protection conferences.
- The work completed by the Child and Family Intervention service included direct contact with the children and the workers' case recordings gave a good picture of the children's experiences. Whenever the worker encountered concerns, the allocated social worker was notified.
- The Child and Family Intervention service accessed advice from a psychologist to meet one of the family members to offer advice on how best to work with them and supported intervention, undertaking visits outside of office hours and completing the comprehensive assessment.
- A nurse provided easy read documents to the family to ensure they understood how to care for one of the children.
- Although outside the scope of this review the support given by one of the children's schools to support the child's move to foster care was exceptional and made it much easier for them.

## 4. Conclusion

4.1 Despite the fact that the family loved the children very much the children in this case they suffered significant physical and emotional neglect for all of their lives, one of the children was often dirty and unkempt, lacked stimulation and proper medical care and did not make the physical and developmental progress that could have been made, they suffered distressing physical condition and discomfort which was not relieved.

4.2 One of the children was able to talk about what life was like, but professionals did not always pick up on the messages and use their professional curiosity to explore them and

sometimes his wishes were overlooked. For a long time, the child suffered pain and discomfort in relation to a problem which took too long to address. The child was at times fearful and anxious but despite this was mature, loyal, protective and supportive to their family

4.3 The impact of this neglect has far reaching consequences for both the children.

4.4 These children were not “invisible” to services; they and the adults in their lives were well known to universal services including mental health, some of them to the police and probation and the children went to nursery and then to school; the involvement of early help when the children were very young would have been particularly helpful and may have led to an earlier recognition of the difficulties.

4.5 The issue of alcohol use and abuse runs through this family but was never identified as a risk factor and addressed.

4.6 Cases of neglect are recognised as particularly challenging for professionals, despite the obvious manifestations of neglect in this family there were no clear incidents of physical harm, the adult carers loved the children very much and the children always appeared to professionals to be happy, some professionals described similar situations differently, reaching a shared view as to whether the care given was good enough was difficult.

4.7 Working with neglect can be frustrating for professionals, progress can be slow with no quick solutions and often differences of opinion as to whether the care provided is good enough. Neglectful families can be chaotic and difficult to access, especially if there is resistance to professional scrutiny, as in this case.

4.8 In this case agencies were very mindful of the needs and difficulties of the adult carers and wanted to give them the best opportunity to look after the children, especially as they were very vocal in their love and determination to raise them but reaching a conclusion as to whether the adults had the capacity to care for the children was never properly assessed.

4.9 At times the focus was on the adults rather than the lived experiences of the children which were often omitted from assessments and analysis and did not contribute to safeguarding plans. Assessments, though often delayed, were undertaken but plans were not closely monitored which led to significant drift and delay in improvements.

4.10 Staffing difficulties and a lack of experience in Children’s Social Care contributed to the lack of progress which improved markedly when an experienced worker was appointed, and the social work input was increased.

4.11 The sharing of information within and between agencies, especially those not directly involved in the child protection work was not always consistent and although concerns about the children were regularly shared with social workers, concerns about the lack of progress were not formally escalated. There is a sense that assumptions were made that someone else would be doing what needed to be done, without good supervision and closely monitored plans and a culture of respectful professional challenge, drift and delay set in.

4.12 There was over-optimism about the likelihood of the adult carers improving their care of the children and perhaps a lack of understanding as to what the impact of their intellectual capacity was in practice. The challenges in the relationships between the family and professionals made it difficult to engage them effectively and evaluate progress.

4.13 The cumulative harm they experienced was not sufficiently considered in the planning and there was a lack of urgency in responding to risks. Managers, including the child

protection adviser, were aware of the concerns, lack of progress made by the family and the impact on the children, but adequate protective measures were not employed while assessments were undertaken. The level of the risks to the children was underplayed.

4.14 The child protection process was helpful in terms of bringing agencies together to review information and risks but the planning to address the concerns was not adequate and the plans were not progressed in a timely way. The mapping documents were lengthy, were not always updated and therefore contained some outdated information. The mapping document did not capture the discussions held in the core group meetings and thus, important information was not recorded.

4.15 There was a lack of challenge to adult family members which led to gaps in information, some family members were intimidating to professionals and were not always open and honest with them.

4.16 As the report mentions, the Graded Care Profile was not adequately used in this case, whilst not the only tool which is recognised as useful in neglect, agreeing and sharing the profile can provide a shared understanding of what life is like for the children, what needs to be addressed, and whether progress is being made.

4.17 There appears to have been little use of chronologies to reflect on patterns of care and intervention and reach a shared view about the care being good enough or not.

4.18 The review has highlighted more areas for improvement than contained in this overview report, individual agencies have been reflective about their contribution and practice and made recommendations to address improvements in the practice of their individual agencies.

4.19 West Sussex has been the subject of recent external scrutiny and improvements in Children's Social Care are currently being overseen by a Commissioner, appointed by the Department for Education. This review agrees with the findings of the external scrutineers-Ofsted and the Commissioner; it identifies the same systemic failures that were created by the difficulties described in their published reports. The proposed new arrangements for Children's Social Care will take time to implement and embed, the West Sussex Safeguarding Partnership has a critical role in contributing to improvements in practice across agencies and monitoring risks to children.

**5 Recommendations - learning outcomes**

5.1 This report recognises that there are comprehensive improvement plans to: review the Safeguarding Partnership; refresh and relaunch the Neglect Strategy which includes a new multi-agency toolkit and tools to assist social worker's in assessing neglect and a framework that will measure the impact of the work on children and their families. There are also robust action plans for individual agencies, but these are yet to be fully implemented and their impact assessed.

5.2 This section does not provided recommendations for specific actions as these are already covered by existing plans but it highlights the improved outcomes that have been identified specifically from this review and should be addressed by the WSSCP, which may decide they will be achieved by current improvement plans or that plans need to be enhanced to capture them. In addition, two specific issues for consideration are included.

5.3 West Sussex Safeguarding Partnership should ensure that the following learning from this review is addressed by assuring itself or including actions in improvement plans to ensure that:

a) Multi-agency partners can evidence a shared responsibility for the safeguarding and protection of children.
b) Multi-agency professionals are skilled and confident in carrying out child centred multi-agency assessments and safety planning to ensure children's safety and the best outcomes for them.
c) Multi-agency assessments, risk assessments and effective safety plans are secured and monitored within the child protection conference process, to ensure the best outcomes for children.
d) The use of the West Sussex Safeguarding Partnership Escalation policy and procedure is used effectively to address and resolve professional disagreements and add to the learning of the Partnership.

5.4 In addition, the West Sussex Safeguarding Partnership should consider specifically:

e) amending the pathway for capacity assessments of carers with learning difficulties so that they can be undertaken at an earlier stage, currently they are not undertaken unless the situation reaches the threshold for level 4 intervention by Children's Social Care.

**Glenys Johnston OBE**

**Director of Octavia Associates Ltd**

**Date:20th January 2020**

## Appendix 1: The Review Process

### Recent developments

Although Working Together 2018 included new guidance in relation to Serious Case Reviews, this review was commissioned before it was statutory and has been undertaken in accordance with Working Together 2015.

However, in accordance with the DfE Transition Guidance for 2015-2018 a Rapid Review was first undertaken to determine whether a Serious Case Review would be recommended to the West Sussex Safeguarding Children Board, Independent Chair.

On 21st May 2019, the Child Practice Review Panel supported the Independent Chair's decision to commission a Serious Case Review under the Working Together 2015 criteria.

### The Serious Case Review process

'Working Together 2015' states:

'Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt, and services improved to reduce the risk of future harm to children'

When a child dies or is seriously harmed, and abuse or neglect are suspected to be a factor, or there are concerns about how organisations or professionals worked together to safeguard the child the West Sussex Safeguarding Children Board has always conducted a review to:

- Establish whether there are lessons to be learned from the case about the way professionals and agencies work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.
- Improve inter-agency working to better safeguard and promote the welfare of children.

A Serious Case Review enables all the information known to agencies to be seen in one place. This is beneficial to learning but the Serious Case Review Panel recognises that this information may not have been available to individual practitioners during their work. Reviews should avoid hindsight bias and can only evaluate compliance with extant practice.

### Independent Reviewer

West Sussex Safeguarding Children Partnership commissioned an independent social work consultant Glenys Johnston OBE to lead the review and produce this independent overview report. Mrs Johnston is independent of agencies represented on the West Sussex Safeguarding Children Partnership and has extensive experience of chairing safeguarding boards, child protection inspection, audit and Serious Case Reviews.

### Scope, methodology and key questions

The Serious Case Review Panel agreed the following scope, methodology and key questions to be addressed;

**Scope**: The period covered by the review was April 2015-October 2018 with any relevant information outside the time frame, being included in the chronology.

**Methodology**

The methodology used for this Serious Case Review combined narrative reports, Individual Management Reviews and a chronology from each agency with a learning event for practitioners and managers involved in the case.

Participating agencies were encouraged to apply a systems approach to the review i.e. explore all contributory factors in order to identify changes needed at an organisational level as well as at individual practice level.

**The key questions to be addressed:**

- The lived experience and views of the children
- What was known about the children's voices and lived experiences during this period? What consideration was given to any specific communication needs of the children in hearing their voices?
- When and how were their wishes and feelings obtained and considered when making decisions about the provision of services? If not, why was this?
- What was known about, and what consideration was given to the impact on the children of other adult family members living in the family home and the grandmothers.
- The potential for assumptions to be made about adults in and visiting the two households? Was there significant challenge - both interagency and agency to caregivers - regarding this?
- The learning difficulties/disabilities (including their literacy and ability to understand what was said and written by professionals); substance or alcohol use; domestic abuse or criminal record of caregivers and the impact this may have on their caring and protective capability?
- Were the communication needs of the family understood and assisted and was this information shared with partner agencies who were also working with the family? If not, why was this?
- Why were the child protection plans put in place not taken forward?
- How was the Graded Care Profile used to track progress in addressing the neglect of the children?
- Did the staff implementing the child protection plan have appropriate levels of knowledge, experience and training?
- How effective was management oversight and support via supervision?
- Were there frequent changes of staff and were caseloads manageable?
- During the period covered by the review how effectively did agencies work with other agencies during this period.

**Participating Agencies and their roles in the review.**

| Agency | Panel Member | Report author |
|---|---|---|
| Chair | Head of Safeguarding, West Sussex County Council | NA |
| Sussex Police | Detective Sergeant – Safeguarding Review Team | Crime Review Officer |
| West Sussex County Council Early Help | Hub System Leader | Team Manager-Process |
| West Sussex County Council Education Department | Safeguarding in Education Manager | Safeguarding in Education Manager |
| Sussex Community NHS Foundation Trust | N/A | Named Nurse Safeguarding Children |
| Sussex Partnership NHS Foundation Trust | N/A | Lead Nurse Safeguarding Children |
| West Sussex County Council Children's Social Care | Deputy Head of Children's Social Care | Interim Auditor – Quality Assurance and Practice Improvement |
| Sussex Clinical Commissioning Groups (CCGs) | Designated Nurse for Safeguarding Children - Sussex and East Surrey CCGs | NA |
| Western Sussex Hospitals NHS Foundation Trust | N/A | Named Nurse Safeguarding Children |
| The representation and work of Primary Care were covered by the Panel member from the CCG | | Paediatric Practice Nurse |

## Appendix 2: Bibliography

'In the child's time - professional responses to neglect'. Ofsted survey report - March 2014.

Department for Education research report 'Missed opportunities: indicators of neglect – what is ignored, why, and what can be done'? - November 2014.

'Growing up neglected a multi-agency response to older children' Ofsted : Joint Targeted Area Inspection Report - July 2018.

'The Child's World, Third Edition: The Essential Guide to Assessing Vulnerable Children, Young People and their Families': Jan Horwath (Editor), Dendy Platt (Editor), Danielle Turney (Contributor). - December 2018.

'The relationship between poverty, child abuse and neglect: an evidence review' Paul Bywaters, Lisa Bunting, Gavin Davidson, Jennifer Hanratty, Will Mason, Claire McCartan and Nicole Steils. The Joseph Rowntree Foundation- March 2016