

**Buckinghamshire**

**Safeguarding Children Partnership**

**Independent Overview Report of the Serious Case Review Concerning**

**Child V**

January 2020

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# Introduction

# In January 2019 Buckinghamshire Safeguarding Children Board decided to undertake a Serious Case Review in respect of a child aged 2 years 7 months who will be known as Child V. It was agreed that the criteria for carrying out a Serious Case Review had been met[[1]](#footnote-1).

# Child V was found unresponsive during a visit to see her Mother, half siblings and maternal grandparents. Child V died the following day due to a cardiac arrest likely to be caused by a natural but undetermined cause[[2]](#footnote-2). Child V and her older sibling were subject to Child Protection Plans at the time.

# Methodology

# 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 identify good practice. Lessons learned have been clearly identified and contributed to an existing improvement plan which is sustainable and explicit about what is expected to change and within what timescale. Progress against the improvement plan is reported to each Improvement Board meeting, which is chaired by the Commissioner, and is reviewed at each of the monitoring visits that Ofsted undertake.

# It was agreed that the review would consider the professional involvement with the family from November 2015 when Mother booked for antenatal care for Child V until the death of Child V in December 2018. Relevant information prior to these dates was also considered and included agency involvement due to concerns about the neglect of Sibling 1 and Sibling 2 between 2012 and 2014.

# Information provided to the review included a multi-agency chronology, and other relevant documents[[3]](#footnote-3). Professionals met to explore issues relating to multi-agency practice and opportunities for learning. The SCR Steering Group[[4]](#footnote-4) contributed to the learning and recommendations to ensure that actions resulting from this review complement the improvement activities of the Buckinghamshire Safeguarding Partnership and avoid duplication. The contribution of all those involved enabled a greater understanding of the context in which practitioners and managers worked at the time and maximized opportunities for systemic learning.

# 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 Buckinghamshire 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?*

# 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. Mother, Father and maternal grandmother were informed by letter that the review was taking place[[5]](#footnote-5)*.* The independent author met with maternal grandmother, Father and paternal grandmother[[6]](#footnote-6) and their views are reflected in this report which will be shared with the family prior to publication.

# The Family

# Mother had four children, Child V was the youngest. A was the father of Sibling 1 and Sibling 2 and S was the Father of Child V and Sibling 3 and will be referred to as Father in this review. At the start of this Review Child V was unborn and Sibling 1 was 10 years old.

# Other family members mentioned in this review are the maternal and paternal grandmother of Child V who will be referred to as MGM and PGM respectively.

# Background Information

# In 2010 Sibling 1 and Sibling 2 (aged 2 and 4 years at the time) were found wandering in the park by police officers who returned them home. No referral was made to Children’s Social Care.

# In 2012 Sibling 1 and Sibling 2 were subject to a Child Protection Plan (CPP) under the category of Neglect and this was stepped down to a Child in Need (CiN) Plan in 2013. Mother was pregnant with Sibling 3 at this time. It was recorded that Schools did not agree with the decision to end the CPP.

# In 2014 the Police received a complaint from a neighbour who stated that Sibling 1 and Sibling 2 were playing with knives in the road[[7]](#footnote-7) and this information was shared with Children’s Social Care.

# Agency involvement between November 2015 and December 2018

5.1 The agencies involved with the family during this time period included;

# Buckinghamshire Children’s Social Care (CSC)

# Buckinghamshire Healthcare Trust (BHT)

# CCG/GP

# Children’s Centre

# Thames Valley Police (TVP)

# One Recovery Bucks (ORB)

# Primary School 1

# Nursery School 1

# A summary of agency involvement of direct relevance to this review is included in the table below and reflects information within agency records.

|  |  |  |
| --- | --- | --- |
| DATE | ACTIVITY | AGENCY |
| November 2015 | Antenatal booking, Referral to consultant due to Mother’s mental health history and safeguarding midwife as Mother informed the older children had been subject to CP Plans. | BHT maternity |
| December2015 | Child and family (C&F) assessment requested by practice improvement manager[[8]](#footnote-8).  | CSC |
| February2016 | C&F assessment completed. Child in Need Plan recommended.  | CSC |
| May 2016 | Growth scans due to static foetal growth (under 5th centile).Child in Need Review meeting* Professionals expressed concern that risks may change following the birth of unborn baby and discussed whether the Child in Need plan could remain in place.

CSC Management decision to close the case and a referral was made to the Family Resilience Service (FRS).Child V born  | BHT maternityCSCBHT maternity |
| December 2016 | Disclosure at school by a third child of alleged sexual behaviour by Sibling 1 towards her and Sibling 2. Information shared with CSC. Strategy meeting and single agency Section 47 inquiry.The S47 inquiry concluded that there was no evidence of sexually harmful behaviour and highlighted concerns regarding neglect and poor home conditions, ICPC recommended. | SchoolCSC |
| January 2017 |  It was decided at the ICPC that the threshold for child protection was not met and the children to be supported by a Child in Need Plan. | CSC |
| February 2017 | Vulnerable Families Meeting - Health Visitor (HV) concerned that Child V may be showing some signs of developmental delay.  | GP |
| March 2017 | Child in Need review meeting* Family Assessment team to support with parenting work
* Family Support Worker to focus on boundary setting and praising the children – 6 sessions
 | CSC |
| April 2017 | Referral made by a member of the public. Sibling 3 was seen running into the road wearing only a nappy, this was alleged to have happened on two previous occasions. Additional concerns were about the care of Child V, older children receiving little attention from parents, out late at night in bedclothes and no shoes and domestic abuse. Strategy meeting and Section 47 inquiry.  | Anonymous referral to police |
| May 2017 | S 47 outcome - Managers decision, CiN to continue.  | CSC  |
| June 2017 | Vulnerable Families Meeting. Child in Need Review**:*** HV concerned that with so much for the family to do they are not able to prioritise the developmental needs of Child V.
 | GP |
| July 2017 | Child in Need Review:* Mother acknowledged little progress with the CIN plan due to family illness.
 | CSC |
| August 2017 | HV development review found Child V’s development was delayed and noted there was lack of stimulation to support normal development. Level of support increased to Partnership Plus. | Children’s Centre |
| September 2017 | Child in Need Review Child V needs to develop: problem solving, fine motor skills, communication and speech* FAST team have closed their involvement with the family because the family did not engage.

Bailiffs attended the family home due to historical debts, repayment plan agreed. | CSC |
| October 2017 | Anonymous referral: Sibling 3 found wandering in the park and taken home, Child V reported to be covered in faeces and house smelt of cannabis.Strategy meeting, S 47 inquiry – ICPC to be requestedFSW home visit – Mother confirmed separation from Father. Mother disclosed domestic abuse and was advised to contact Women’s Aid.ICPC – children made subject to a Child Protection plan under the category of neglect. | CSCPoliceCSC |
| December 2017 | Sibling 1 told teachers that he had not eaten dinner, breakfast or lunch. SW informed and safeguarding concern form submitted by school. | School |
| January 2018 | Core group. Parental issues dominated discussion.* Sibling 1 and Sibling 2 often unkempt and dirty
* Sibling 2 has persistent head lice

First Child Protection Review;* SW not available and a representative attended who did not know the case and had not read the social work report.
* No significant change and there remain areas where the children are at risk of harm if parents continue to not to make the changes needed.
* Child V needs more encouragement to have opportunities to develop.
 | CSCCSC |
| February 2018 | Core group no record on CSC case notes.* Parents to undergo parenting assessments
 | CSC |
| March 2018 | Mother became unable to cope with the care of the children.Sibling 1 and Sibling 2 become looked after and were placed with Maternal grandparents. Sibling 3 and Child V placed with Father and PGMCore group* Arguments between mother and Father due to Father telling other parents that the children have been removed.

School safeguarding concern – Sibling 1 used inappropriate sexualised language in school. Strategy Discussion. Police record; Sibling 3 disclosed to Father sibling 2 had engaged in a sexual act with him. CSC looking to delay return of children to Mother due to negative parenting assessment. Father still awaiting his assessment.Core GroupMother has supervised contact with the children each Saturday. Parenting assessment of Mother was negative.New SW allocated. | CSCSchoolPoliceCSC |
| April 2018 | Health Visitor report following home visit to Father and PGM:* Child V continues to appear delayed with her development and this may be due to the neglectful parenting she has had with lack of opportunities.
* Father has requested information and advice, due to his own needs he will require a lot of practical support with parenting Child V to ensure that her physical and emotional needs are met. HV is unsure how this will be achieved.
* Child V observed to be very miserable and clingy, this is likely to be caused by being more unsettled since she has not had contact with her mother.
 | BHT Health Visitor |
| May 2018 | Core group * Child V observed to be clingy and grizzly and will continue to live under a voluntary arrangement with her Father and PGM in LA2.
 | CSC |
| June 2018 | GP liaison meeting – Child V discussedCore group, no record on CSC case notes.HV record;* Child V continues to live with Father and PGM however both have negative parenting assessments.
* Local authority is seeking care orders for Sibling 3 and Child V.
* MGM passed viability assessment and Sibling 1 and Sibling 2 are to remain in her care.
 | GPChildren’s Centre /CSC |
| July 2018 | Second CP Review  | CSC |
| August 2018 | Unannounced home visit by HV to Father and PGM PGM wishes to change health visitors, social worker and GP PGM reported that the contacts with Mother upset Child V.  | BHT Health Visitor |
| September 2018 | Core Group meeting:* Sibling 3 is now attending Primary School in LA 2. SW and head teacher very concerned that this is not in the best interests of Sibling 3.

LA application for Interim Care Orders for Child V and Sibling 3 was not granted due to insufficient evidence to support removal of the children. Court directed that:* Both parents are to have a psychological assessment. Father is to have a cognitive assessment of his learning needs.
* School to organise full cognitive assessment for Sibling 1 to identify specific learning difficulties.

Child V and Sibling 3 to remain living with father in LA 2 until the completion of court proceedings. | CSC |
| October 2018 | Core group;* Ongoing issues between the children’s parents.
* Concerns about the sexualised behaviour of Sibling 3.
 | CSC |
| November 2018 | Sibling 1 cognitive assessment completed and concluded very low cognitive ability.  | School |
| December 2018 | Father contacted GP concerned that Child V had been coughing for a few days. Unable to bring her to the surgery that day, no concerning features, to see the following morning. GP appointment regarding cough advice given TRIGGER INCIDENTReport of 2 year old in cardiac arrest at house of MGM whilst visiting half siblings and Mother. Taken to hospital by ambulance and Child V died the following day.  | GP |

# 6 Analysis

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

# 6.2 The themes identified were;

# Quality and effectiveness of assessments and decision making

# Professional understanding of parental mental health, domestic abuse and substance misuse and the potential impact of these factors on Child V and siblings

# Parenting Capacity

# Recognition of and response to neglect

# Professional understanding of the lived experience of the children

# Multi-agency cooperation and information sharing and escalation

# It is important to note that each theme impacted on the others in a systematic and dynamic way. The effectiveness of assessment and decision making influenced the ability of professionals to recognise and address long term neglect. In addition the voice of the child was not prioritised and this impacted on professional understanding about the lived experience of the children.

# Each theme will be discussed separately within the analysis.

# *Quality and effectiveness of assessments and decision making*

* 1. During the period considered by this review one Child and Family Assessment and three Section 47 inquiry reports were completed before Child V and siblings were made subject to a child protection plan. It was noted within the multi-agency chronology that the assessments were incomplete and had significant limitations. Professionals at the learning event and the SCR review panel acknowledged that the assessments did not contain sufficient information to adequately inform decision making regarding the support and intervention required to effectively safeguard Child V and siblings. A combination of factors contributed to the poor quality of assessments which included: high turnover of social workers, poor record keeping, lack of information about historical events and inconsistent multi-agency cooperation.
	2. It was known that Mother had mental health difficulties and agency recordscontained frequent references to parental substance misuse. In addition, professionals involved with the family expressed concerns about the ability of Mother and Father to meet the needs of Child V. The potential impact of parental mental health and substance misuse on children is well recognised and the provision of support to parents when there are concerns about parental capacity is expected practice. It was a significant omission that these factors were not explored within the assessments and this will be addressed as a specific theme within the analysis.
	3. The initial Child and Family assessment recommended that a Child in Need (CiN) Plan would provide an appropriate level of support to the family, however information contained within the assessment was limited. Father of unborn Child V and Sibling 3 was not consulted and the level of support that he could offer to Mother was unknown. Father of Child V and Sibling 3 informed the independent reviewer that he could not recall having an input to any assessment and stated that he received little support from any professional during the period considered by this review. The birth father of Sibling 1 and Sibling 2 was not considered as part of the assessment and the relationship between the children and their Father was not known.
	4. Omission to assess the contribution that Fathers can make to safeguard children has been a consistent finding within Serious Case Reviews nationally[[9]](#footnote-9). Lack of information about Fathers within assessments has been a recurrent theme in serious case reviews within Buckinghamshire. A Thematic Review of serious case review reports published by BSCB between 2009 and 2019 found lack of information about Fathers to be a factor in half of the reviews. It is important that consideration is given to why this continues to be a practice issue and why previous actions to improve the involvement of fathers in assessments have had limited impact.
	5. The assessment also contained information which appeared to be inaccurate and inconsistent. It was recorded that Mother had reported feeling lonely and isolated as she had moved away from her family[[10]](#footnote-10). The assessment concluded however that Mother had settled into the local area, had some supportive friends and was engaging with the Local Authority. There was no evidence that Mother had any supportive friends and whilst she had agreed to the Child and Family assessment, engagement with the Local Authority had been inconsistent. Previous engagement was not considered when making referrals to services which required parental commitment.
	6. The Child and Family Assessment noted that concerns of neglect were ongoing. It was acknowledged that Mother was 20 weeks pregnant and predominantly a single parent to three children, one of whom had significant additional learning needs (Sibling 1). The CiN Plan focussed on support for Mother to manage the behaviour of Sibling 1, Sibling 2 was referred to young carers. Professionals were not aware if Father was involved in the parenting of Sibling 3. Father informed the review that at this time he was living with Mother and the children and worked long hours. Father said that the relationship with Mother was abusive and he was unable to tell anyone.
	7. At the second CiN Review meeting the SW informed colleagues that they were leaving the authority and it was appropriate for the CiN plan to close and a referral made to the Family Resilience Service (FRS)[[11]](#footnote-11). It was recorded that professionals from health and education expressed concerns that the risks may change after the birth of Unborn Child V and that Mother may feel overwhelmed which could impact on her mental health and ability to care for the children. Professionals asked if CSC would consider keeping the case open until after the birth of Child V. There was no exploration of the different views between professionals. It was decided[[12]](#footnote-12) to close the case and the multi-agency chronology noted that the rationale for this decision was unclear. This practice did not follow local guidance about the contribution of all professionals when making a decision to close a CiN plan[[13]](#footnote-13).
	8. There was a lack of understanding amongst professionals regarding the decision making process to close a CiN plan which should be a multi-agency decision. At the learning event it was noted that a TAC meeting should take place when stepping down from CiN. There was a view that no agency or practitioner takes responsibility for these meetings and they are not coordinated. Whilst a TAC meeting did take place it was ineffective and not sustained.
	9. There was no evidence that the vulnerability of Unborn Child V was considered in the decision to close the case to CSC. The impact of a new born on Mother who was already struggling to meet the needs of her children does not appear to have been recognised or addressed. The FRS was a consent based service and Mother’s previous lack of engagement with services was not considered. It was not known whether Mother would be willing or able to engage with the service.
	10. Practitioners at the Learning Event stated that the case should have stayed open as there had been limited change following a previous CiN plan for neglect. It was evident from records that Mother was struggling to care for three children one of whom had additional needs and there were concerns at the time about Mother’s ability to cope with a fourth child.
	11. The SCR Steering Group noted that there was no requirement at the time for practitioners to undertake a specific Unborn Baby Assessment and it would have been expected that the needs of an unborn baby would be included within an updated C&F assessment. Practice has since changed and an UBB assessment would now be completed if a Mother caring for children with known vulnerabilities and involved with CSC becomes pregnant.
	12. During the timeline for this review there were three strategy meetings within ten months in response to referrals about the welfare of the children[[14]](#footnote-14). A decision to undertake a Section 47 inquiry was made following each strategy discussion. Poor assessment, flawed decision making and ineffective practice to safeguard Child V and siblings contributed to the escalation of concerns as discussed below.
	13. The first referral was made by school six months after closure of the CiN Plan. The referral detailed a disclosure from another child about the sexualised behaviour of Sibling 1 towards herself and Sibling 2. In the absence of disclosures from Sibling 1 and Sibling 2 and denial by Mother and MGM that the alleged incident could have taken place, the possibility of Sibling 1 presenting with sexually harmful behaviour was not explored further. The Section 47 inquiry found ongoing evidence that Mother was struggling to meet the needs of the children[[15]](#footnote-15) and concerns were expressed by school regarding the presentation of the children who were reported to smell and have dirty uniforms. An Initial Child Protection Conference (ICPC) was recommended. At the ICPC it was decided that the threshold for Child Protection had not been met and that the family would be supported under a Child in Need Plan.
	14. It was agreed by the steering group for this review that the assessment, decisions made and intervention agreed were not adequate to address the level of historical and persistent concerns including the emergence of sexually harmful behaviour. There was no evidence that previous history of social care intervention, lack of engagement by Mother and ongoing exposure of the children to long term neglect was considered. Child V was new born at this time and there was no effective consideration by professionals of the risk and impact of neglect on a vulnerable baby. Professionals involved with the review stated that there was an over optimistic view of parental ability to change and no evidence of parental motivation to change or understanding of whether Mother and Father had the capacity to adequately safeguard the children. MGM stated that SW’s were constantly changing and only visited for five minutes to check there was food in the cupboards and then left. Mother usually knew when the visits were taking place and tidied the house in advance.
	15. A second Section 47 inquiry took place four months later following two further referrals from the public one of which was made via the NSPCC. The referrals included concerns about lack of supervision, domestic violence and cleanliness of Child V. It was decided by a CSC manager that the children should remain supported by a CiN plan. The rationale for this decision was that the Family Action Support Team had only recently become involved with the family and a period of time was required to understand the effectiveness of this intervention.
	16. This decision was not adequate to protect and safeguard the children. The Health Visitor had noted concerns at this time about the delayed development of Child V and more urgent and proportionate action was required. Each event appears to have been viewed in isolation and there was no evidence that consideration was given to previous history and the limited impact of previous intervention was not reviewed. Following an anonymous referral five months later the children were made subject to a Child Protection (CP) Plan under the category of neglect. Sibling 3 had been found in the park alone and taken home, Child V was reported to be covered in faeces and there was a smell of cannabis in the house.
	17. It was acknowledged at the practitioner’s event that the family were in crisis and safeguarding concerns had escalated. Whilst there were strategy meetings and assessment in response to separate incidents, there was a missed opportunity to complete a holistic assessment to clarify the risks and vulnerabilities that Child V and siblings experienced. The children were exposed to long term neglect and there was evidence that this had impacted on the development of Child V and the wellbeing of Siblings 1, 2 and 3. The pace of change was insufficient to safeguard the children.
	18. Research has shown that taking a systematic approach to enquiries using a conceptual model is the best way to deliver a comprehensive assessment for all children. Buckinghamshire County Council Local Assessment Protocol (2017)[[16]](#footnote-16) noted that: all assessments in Buckinghamshire should be undertaken using the framework for assessment within national guidance[[17]](#footnote-17). The assessment framework contains three domains:
* The child’s developmental needs, including whether they are suffering or likely to suffer significant harm
* The capacity of parents or carers (resident and non-resident) and any other adults living in the household to respond to those needs
* The impact and influence of wider family and any other adults living in the household as well as community and environmental circumstances

The domains were not fully understood and information was presented as descriptive within assessments with little analysis.

* 1. Lack of a thorough Child and Family Assessment had a significant impact on decisions made to safeguard Child V and siblings. Whilst the records of practitioners (specifically health and education) contained detailed information about concerns and risks these were not included within a wider assessment. There was a lack of understanding about the impact of risk factors and vulnerabilities and no effective plan to manage these.

6.23 When Mother was unable to care for the children Child V and Sibling 3 were placed with Father and PGM in LA 2. There were significant concerns at this time about the ability of Father to keep the children safe and provide adequate care. Father had parental responsibility and PGM was considered to be a protective factor however during court proceedings the assessments of Father and PGM as potential future carers of Child V and Sibling 3 were negative. Had assessments been more thorough with meaningful involvement of multi-agency partners it is possible that Sibling 3 and Child V would not have been placed with Father without a robust support plan to ensure that the needs of the children would be met. Father and PGM stated that they were involved with professionals (school, GP and Health Visitor) in LA2 and the wellbeing of Child V and Sibling 3 improved whilst in their care. Communication between professionals in LA1 and LA2 was limited and this had an impact on the support provided which lacked coordination and focus.

* 1. This discussion has demonstrated that without a holistic and thorough assessment, decisions to safeguard children and young people may be limited and inadequate. Shortcomings within the assessment process impacted on other themes within this review, specifically the identification of and response to neglect as discussed below.

***Learning Point 1***

*When the siblings of an unborn baby (UBB) are subject to a Child in Need Plan it is**important that there is an opportunity within the multi-agency CiN meetings to:*

* *Discuss the impact of a new baby on the family circumstances*
* *Include the UBB on the Plan with specific reference to risks and vulnerabilities*
* *Ensure there is multi-agency agreement prior to closure of the Plan.*

***Learning Point 2***

*It is important that Child and Family Assessments include relevant historical information and contributions from partner agencies, children, parents and carers to inform understanding of and response to safeguarding concerns. In the absence of a comprehensive assessment decision making may be flawed and children exposed to unnecessary risks.*

#  *Professional understanding of parental mental health, domestic abuse, substance misuse and the potential impact of these factors on Child V and siblings*

* 1. Concerns about parental mental health, domestic abuse and substance misuse were recorded by practitioners, however there was no effective analysis of these issues within assessments and there was little consideration given to the impact on Child V and siblings.

***Parental mental health***

* 1. Information about Mother’s mental health was known to agencies and recorded by practitioners. Maternity notes from the antenatal booking for Child V stated that Mother was to be referred to a consultant due to her mental health history. The author of the CSC chronology noted that adult mental health services had not been contacted during the Child and Family Assessment despite mother’s significant history of mental health issues.
	2. It was acknowledged within agency records and by practitioners at the learning event that excessive demands were placed on Mother within the CiN and CP processes. It was known that Mother was involved with multiple professionals and there was a sense that Mother was unable to address all the required actions. Limitation in assessments and poor decision making contributed to the lack of a coherent multiagency plan to support Mother and Father to meet the needs of the children. It is of significance that six months into the CP Plan Mother became overwhelmed, unable to meet the demands of the plan and said that she was unable to care for the children
	3. There is extensive research evidence that demonstrates the impact of parental mental health problems on children. Advice provided by the NSPCC states that parental mental health problems can affect a parent’s ability to provide the care that children need. Parents or carers may:
* Have mood swings
* Find it difficult to recognise their children’s needs
* Or struggle with keeping to routines such as mealtimes, bedtimes and taking their children to school[[18]](#footnote-18).

There was evidence of all these issues within the multi-agency chronology. Record of a Health Visitor at the time Mother said that she was unable to cope with the children stated:

*Mother presented as tearful and lacking in energy and interest. She is reported to have been very low and unwell and for the past few weeks this has been reflected in the children appearing neglected and unkempt when arriving at school.*

* 1. There were regular references within the multi-agency chronology to Mother struggling to meet the needs of the children and specifically the developmental needs of Child V. Whilst parental support was provided via the Family Resilience Service and Family Support Services Mother did not engage consistently and frequently cancelled or was not at home for pre-arranged visits. It was unclear whether support, specifically the Family Resilience Service was experienced by Mother as an additional pressure. It is possible that Mother cancelled visits due to stress and anxiety however there was no evidence that this was explored with her.
	2. Parental mental health problems were identified as a factor in over half of a sample of 33 serious case reviews in England from 2009-2010 (Brandon, 2011)[[19]](#footnote-19). Learning from published case reviews has shown that professionals sometimes lack awareness of the extent that a mental health problem may impact on parenting capacity. This may result in a failure to identify potential safeguarding issues.
	3. A guide to parental mental health and child welfare (SCIE, 2011)[[20]](#footnote-20) highlights key recommendations for practice which include: effective screening tools to identify adults with mental health problems who are parents, assessment of the whole family and effective planning to meet the individual needs of each family member. There was evidence that Mother’s mental health had deteriorated however it was not until the children were no longer living with her that Mother was advised to return to the GP and it was agreed that a referral to the adult mental health team should be made[[21]](#footnote-21).

***Parental substance misuse and domestic abuse***

* 1. During the child protection process additional concerns emerged regarding the substance misuse of Mother and Father and allegations of domestic abuse by each parent against the other. The relationship between the parents became increasingly acrimonious. It was necessary to have separate core groups as it was not possible for parents to prioritise the needs of the children over their own disagreements.
	2. It was acknowledged at the practitioner’s event that the needs of Child V and siblings were not always prioritised due to conflict between the adults. At times professionals focussed on supporting the adults with their issues rather than the needs of the children. MGM said that she told Mother and Father that their constant arguing would have a negative impact on the children.
	3. Concerns about domestic abuse and substance misuse were known at the time of the S47 inquiry which resulted in the children remaining subject to a CiN plan. The decision to give a longer period of time for family support services to have an impact was not sufficient to safeguard Child V and siblings, given the information that was available to agencies at the time. It was acknowledged by the author of the CSC chronology that there had been an over optimistic view of the parents ability to change. Had there been a thorough exploration of domestic abuse allegations and substance misuse concerns, it is likely that a more proportionate decision to safeguard Child V and siblings would have been made.
	4. Father said that he had been unable to tell anyone about the abuse he was experiencing and when he tried to leave the relationship Mother told the children that he didn’t love them. Father acknowledged that both he and Mother had misused substances and said that he accessed support to address substance misuse when he left the family home. Whilst it is unclear if Father would have spoken to professionals about his experience of substance misuse and domestic abuse at this time, he did not have the opportunity due to lack of involvement in assessments and limited engagement with practitioners.
	5. A comprehensive assessment and in depth professional understanding about how risk factors (mental health, substance misuse and domestic abuse) interact, is essential to ensure that interventions are effective and to promote the safety and wellbeing of all members of a household. At the learning event practitioners expressed the view that whilst concerns were recorded there was a lack of multi-agency coordination to address issues as they emerged. There was also little consideration given to the support required to reduce the impact of parental substance misuse and domestic abuse on Child V and siblings.

***Learning Point 3***

*When there are concerns about parental mental health, substance misuse and/or domestic abuse it is important that practitioners understand how these difficulties interact within the family and this information informs assessments and decisions to safeguard and reduce the impact on the children.*

#  *Parenting Capacity*

* 1. Assessment of parental capacity is a significant domain within the assessment framework and includes: basic care, ensuring safety, emotional warmth, stimulation, guidance and boundaries and stability. Agency records during the timeline for this review include frequent reference to the concerns of practitioners that parents were unable to meet the needs of Child V and siblings in any of these areas. There was limited consideration given to whether Mother and Father required additional support to enable them to parent effectively and this was a significant omission. It was the view of the SCR steering group that a cognitive assessment should have been completed for Mother and Father.
	2. Practitioners stated that Mother had a poor ability to retain information, and although she could appear to want support she actively avoided some situations. It was not possible to be confident whether this was deliberate avoidance or a processing or memory problem. It was known that Mother had attended a special school however there were no discussions with her about what would help her to work effectively with professionals to meet the needs of Child V and siblings. Plans to safeguard the children (CiN and CP) placed considerable demands on Mother and there was little consideration given to whether she needed support to make the required changes.
	3. MGM said if someone had explained to Mother what may happen if things didn’t improve she may have understood why it was important to change. MGM said that Mother never thought that she would lose the children. It is likely that Mother was advised at various times by different practitioners about the possible consequences should the care of Child V and siblings not improve. It is not possible however, to have confidence that Mother fully understood what she was told or that she was able to retain the information provided by professionals.
	4. It was known that Father could not read or write and school provided some support to develop these skills. Father told the Health Visitor that due to his own learning difficulties he sometimes found it hard to follow what was being said, or understand the language/jargon often used in meetings. The Child and Family Assessment made reference to Father having learning difficulties and queried how much support he was able to provide Mother. Other than observe and record there was no understanding of how the additional needs of Father impacted on his capacity to parent Child V and Sibling 3. At the learning event practitioners said that Father often repeated what had been said to him and it was possible that some practitioners mistakenly accepted this as Father understanding what had been said.
	5. Father said that he had asked professionals to write things down for him and recalled the actions of one social worker who had been particularly supportive in doing this. Father said that not all professionals were as supportive and stated that: ‘*I was not listened to, judged and bullied by some’.* Father said that he was unable to get his voice heard in meetings even when he had an advocate and that he was unable to challenge minutes which were often inaccurate.
	6. Practitioners spoke about the challenge to support Mother and Father to improve their care of the children. Intervention and support was provided without a clear understanding of parenting capacity and had limited impact, lacked focus and did not improve the outcomes for Child V and Siblings. It is important to note that Practitioners from different agencies, specifically health and school worked hard to provide support and improve outcomes for the children and there was some good practice. However, as noted throughout this review, intervention provided without a thorough assessment and coordinated multi-agency plan may not be adequate or appropriate to effectively safeguard vulnerable babies and children. MGM said that nothing was done to help Mother and Father become better parents and she was unsure who to speak to about her concerns. PGM said that from her experience the paternal family was not given sufficient support by CSC.
	7. Mother and Father had cognitive assessments during court proceedings, which were outside the timescale considered for this review. Father subsequently received a diagnosis of learning disability which provided clarification about the support required to assist him to parent effectively and placed a duty on the local authority to ensure that Father’s needs were met in this regard. Parents with learning disabilities must be given every opportunity to show that they can parent safely and be good enough parents, with appropriate support[[22]](#footnote-22). Working with parental learning difficulties has emerged as a theme in previous Buckinghamshire SCR’s[[23]](#footnote-23). It is important that lessons are learned to reduce the risk of further repetition and that there are robust systems and processes to facilitate the assessment of parents when there are concerns about their capacity and ability to meet the social, emotional and developmental needs of children. Members of the SCR steering group were clear that the learning from this review provides an opportunity to clarify and strengthen cooperation and pathways between adult and children’s services to support the provision of appropriate and proportionate assessments of parental capacity when there are safeguarding concerns regarding children.
	8. At the practitioners event it was noted that it was a challenge for safeguarding professionals from Schools to question parents or to freely express their views in CP meetings due to concerns about damaging the relationship with the family. Practitioners stressed the importance of maintaining a positive relationship with parents to be able to work with them. This approach is problematic and it is important that practitioners across agencies are consistent in their communication with parents and work collectively to put the needs of the children at the centre of all work. Practitioners highlighted the need for training for professionals[[24]](#footnote-24) to become more confident in having challenging conversations with parents and carers about safeguarding concerns for babies and children. Practitioners at the learning event said that confident and experienced practitioners may be able to actively challenge parents and carers, however, practice was described as inconsistent.
	9. Disguised compliance was reflected in some agency records to describe the presentation of Mother and Father. Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement[[25]](#footnote-25). Given the lack of understanding about parental capacity it is not possible to have confidence that the presentation of Mother and Father was one of disguised compliance. Both parents experienced significant challenges which impacted on their ability to parent. When parental engagement is framed as disguised compliance without a comprehensive assessment with clear evidence and analysis, there is a risk that the underlying support needs of parents may be overlooked.

***Learning Point 4***

*In the absence of a parenting assessment it is a challenge for Practitioners to have clarity about the capacity of parents to understand safeguarding concerns and confidence in the ability of parents to protect children. This may result in practitioners having unrealistic expectations of parents and the vulnerability of children could increase.*

# *Recognition of and response to neglect*

* 1. 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[[26]](#footnote-26). Brandon et al[[27]](#footnote-27) acknowledged that health and education professionals and social workers often find it difficult to identify indicators of neglect or recognise their severity. Unlike physical abuse the experience of neglect rarely produces a crisis that demands immediate attention.
	2. Neglect has serious consequences for children and young people of all ages however there is evidence to suggest that it has a particularly adverse impact on the development of very young children[[28]](#footnote-28). Babies and young children are inherently vulnerable and low birth weight babies are especially fragile and at higher risk of abuse and neglect[[29]](#footnote-29). Child V weighed 1.98kg at birth which was induced at 36 weeks gestation due to foetal growth restriction. Siblings 1, 2 and 3 were under 10 years of age during the period considered by this review.
	3. Whilst there were strategy meetings in response to individual incidents, historical information was not considered and the cumulative impact and risk of long-term neglect was not recognised. The author of the CSC chronology prepared for this review noted that the social work assessments did not reflect the impact on the children of ongoing neglect.
	4. Child V was 18 months old when the ICPC took place and it was recorded that the children had been subject to long term chronic neglect. It was evident from the multi-agency chronology that the HV, FSW, school and nursery provided substantial support to the family however the impact of this was limited due to many missed appointments, failed home visits and inconsistent engagement by both Mother and Father.
	5. Sibling 3 was accepted into the Nursery full time without payment as professionals recognised that Mother was not coping with the children and Practitioners thought that Sibling 3 would be safer at the nursery than at home. It was reported that the behaviour of Sibling 3 had regressed[[30]](#footnote-30). School and Nursery supported Mother to provide uniforms, shoes, and at times, food for the children. MGM said that she always checked each day to make sure that the children had sufficient food. It is possible that this additional support masked the reality that Mother and Father were unable to provide for the children’s basic needs and unable to cope with the behaviour of the children. Whilst the assistance provide by School and Nursery was necessary to meet the basic needs of the children this was insufficient to reduce the impact of long-term neglect which they experienced.
	6. Decisive action to safeguard the children from further neglect was only taken when the concerns were undeniably serious, difficult to dispute and highlighted by a member of the public. Sibling 3 had been taken home by a member of the public when wandering in the park unsupervised. An anonymous referral was made to CSC and reported that the children were very dirty and hungry, Child V was covered in faeces and the flat was described as dirty and smelling strongly of cannabis.
	7. Even when subject to a CP plan the pace of change for the children was very slow and there was persistent evidence of neglect. School recorded that Sibling 1 and 2 were often unkempt and dirty. Sibling 1 told teachers that he sleeps in his clothes and Sibling 2 regularly had head lice. The HV recorded that *Child V continues to appear delayed with her development and this may be due to the neglectful parenting she has had with lack of opportunities.* The serious impact of neglect on the growth and development of the children was recorded, however, a multi-agency response with a coordinated plan to address presenting concerns was lacking. It was noted at the learning event and within discussions of the SCR Panel that practice could be described as ‘*watch and wait*’ and action to address neglect during the course of this review *‘inadequate’*. It would have been appropriate to refer Child V for a paediatric assessment to clarify if there were medical reasons underpinning the delayed development and this has been addressed as single agency action.
	8. Practitioners at the learning event spoke about the immediate transformation when Sibling 1 and Sibling 2 moved to live with MGM. The following day Sibling 1 and Sibling 2 attended school in a clean uniform and their physical hygiene had improved. There were ongoing concerns when Child V and Sibling 3 went to live with Father and PGM and additional risks emerged as noted within the HV records: *soiling issue for Sibling 3 may take a long time to address and I continue to be worried about the child being caught in the middle of adult difficulties.*
	9. The HV completed the year 2 developmental check for Child V during a home visit whilst living with Father and PGM. It was recorded that: *Father will continue to need a lot of input, support and reinforcement of parenting techniques in order to continue to keep her safe and meet her needs. There is a challenge around this due to his illiteracy and possible cognitive difficulties.*
	10. Father and PGM said that they worked hard to establish a routine and it was very difficult as they lived in a different area and they did not receive enough support. It was known that Father would require additional support to parent Child V and Sibling 3, however, there was lack of consideration given to his needs and limited support was provided. PGM was perceived by professionals to be a significant protective factor. Father stated: ‘*I asked for help and was told I couldn’t do it. I felt that I was never going to keep the children as CSC did not want that’.* Child V and Sibling 3 had unmet needs due to persistent neglect and there was lack of coordinated multi-agency support to address these.
	11. During the timeline of this review neglect was one of the priorities for the Buckinghamshire Children’s Safeguarding Board. Buckinghamshire multi-agency neglect strategy was revised in September 2017 and noted:

*Neglect represents a key issue for the BSCB and now fits within the Early Help, Thresholds and Neglect priority. This reflects the fact that we recognise all our partners play a key role in picking up the signs of neglect, particularly the early signs (p4).*

Key aims of the neglect strategy are:

*To improve the identification and assessment of children and young people, including unborn children, living in neglectful situations before statutory intervention is required, including the use of appropriate assessment tools.*

***To developing and sustain a clear Multi-Agency response to neglect***

* 1. The Graded Care Profile is an evidence based assessment tool endorsed by safeguarding partners in Buckinghamshire for use when working with families where neglect is a concern. The tool helps identify support needs, build relationships and improve the identification and recording of neglect Extensive training on the implementation of the GCP has been delivered to practitioners and guidance about when to complete the GCP is contained in policy and procedures.
	2. The steering group for this review noted that a GCP should have been completed for Child V and siblings at the time Child V was born if not earlier. Limited use of the GCP within Buckinghamshire has been known for some time and was highlighted during this review, to be an ongoing and significant issue of concern, particularly when there are long term concerns regarding neglect.
	3. At the learning event practitioners expressed mixed views about the usefulness of the GCP and stated that: *‘it takes too long to complete’, ‘it is only offered when families are at child protection level’* and *‘it should be completed much earlier’.* Without a tool to measure neglect concerns may be viewed in isolation, the long term cumulative impact on children may not be recognised or monitored, and children will remain subject to neglect without appropriate support and intervention as experienced by Child V and siblings.
	4. Given the concerns and information known at the time about the neglect of Child V and siblings it should have been standard practice to complete a GCP when the family were in receipt of early help support and intervention. This would have enabled professionals working with the family to be explicit about concerns, agree the change required with Mother and Father and evidence the capacity of the parents to implement change. Omission to use the required tool to identify neglect contributed to Child V and siblings experiencing long term neglect for a considerable period.
	5. There was consistent reference to the delayed development of Child V during this review. Whilst it was not possible to totally discount a medical cause, agency records indicated that practitioners believed neglectful parenting and lack of stimulation to be significant contributory factor for the developmental delay experienced by Child V. It was clear that Child V was not provided with opportunities to thrive and develop. Child V did not experience good enough care and support during her life and this will have had a significant and negative impact on her lived experience. Provision of a limited response to concerns regarding neglect emerged within this review as a systemic issue, of relevance to all agencies.

 ***Learning Point 5***

 *When processes and tools to identify, assess and respond to neglect are not used, children may be exposed to long term risk and harm without adequate support or intervention.*

# *Professional understanding of the lived experience of the children*

* 1. Whilst professionals had significant contact with Child V and siblings, work was not conducted in a way that was consistently child focussed. Understanding the lived experience of the child is a complex process and the importance of professionals having a child centred approach is well recognised. Listening to the voice of the child has emerged as key learning in SCR’s[[31]](#footnote-31).
	2. There was little evidence that practitioners had considered the lived experience of the children in a way that influenced change and improved their wellbeing. Within this review much emphasis was placed on providing opportunities for the children to talk[[32]](#footnote-32) and less time considering what they may have said about their home situation if they had spoken. It was acknowledged by practitioners that there was too much reliance on the child speaking. There was limited evidence that consideration had been given to using age appropriate approaches to understand the lived experience of Child V.
	3. Agency reports reflected some observations of Child V and siblings and recorded some comments that Sibling 1, 2 and 3 made to professionals. These will be discussed under the headings, behaviour and voice of the child.

***Behaviour***

* 1. The behaviour of children can be a clear indicator of their emotional state and on occasions Sibling 1 presented as very needy at School however the behaviour was labelled challenging. Learning points from previous SCRs have highlighted the importance of recognising behaviour as a means of communication and the implications of doing so for practice (Ofsted 2011 p 18[[33]](#footnote-33), Sidebotham P. Brandon M. 2016 p118)[[34]](#footnote-34).
	2. There was little consideration given to understanding what the children may have been attempting to communicate by their behaviour or the potential cause of their behaviour. Agency records contain examples of behaviour which could have been an attempt by Child V or a sibling to communicate their distress which included:
* *Child V was observed by the HV during a home visit to bite Mothers arm and head-but her as she sat on her knee. Child V ignored Mother when she said no and Mother asked the HV how to manage this behaviour.*
* *School informed the SW about concerns regarding what were described as aggressive outbursts by Sibling 1.*
* *Child V was seen pressing herself against the glass door with her back turned to adults during a core group[[35]](#footnote-35).*
* *Sibling 3’s behaviour has regressed recently, he has become destructive, breaks and throws toys. There is no discipline and parents are unable to cope with his behaviours*.
	1. There were some examples of reflection by the HV within agency records which included;
* *Child V was observed to be very miserable and clingy; this is likely to be caused by being more unsettled since she has not had contact with her mother.*
* *Due to many distractions and difficult relationships between adults, Child V’s developmental and emotional needs may not be met. At each HV contact she appears to be left to her own devices with no adult being proactive in finding her something to do.*
* *It has become apparent over the last two (core group) meetings that Child V will have been exposed to drug abuse and domestic violence. The parents will not have been able to put her needs first while in these situations. This will have been impacting on Child V’s feeling of security and parental responsiveness to her physical and emotional needs is in question.*
	1. There was an allegation of sexually harmful behaviour involving Sibling 1 during the timeline for this review. A third party child disclosed sexual activity towards herself and Sibling 2. The initial disclosures were investigated by the police and there was no further action following denials by parents that the behaviour could have taken place and no further disclosures from the children involved. It was recorded by CSC that there was no evidence to substantiate the concerns.
	2. There was no evidence from agency records that the BSCB Harmful Sexual Behaviour: Procedure and Guidance was followed[[36]](#footnote-36). The S47 inquiry noted that: *Sibling 1 does not present with sexualised behaviour and there was no evidence to substantiate the concerns raised*. Information from children and adults appears to have been accepted without further assessment. Inappropriate sexualised behaviour is often an expression of a range of problems or underlying vulnerabilities and it was a missed opportunity to explore the disclosure further within a multi-agency assessment. A safeguarding concern regarding Sibling 1 using inappropriate sexualised language at school was recorded some months later and there was no further assessment or exploration of possible causes, this was a significant omission and ongoing issues relating to sexually harmful behaviour were overlooked.

***Voice of the child***

* 1. Examples of what the children said were recorded by different agencies. Whilst the information did provide some insight into the well-being of the children and details were shared with the social worker this had limited impact on the support provided. Examples included;
		+ Sibling 1 told staff at school that *I am rubbish I am going to fail*. School offered support with self esteem
		+ Sibling 1 said that he had not eaten dinner, breakfast or lunch. The SW was informed.
		+ Whilst at school doling an activity to learn about weight, sugar was placed in to small bags to demonstrate to the children. Sibling 3 stated *we have white bags at home of stuff like that.* The school reported to Social Care and the local TVP contact.
		+ Sibling 3 said *daddy hurt me* when explaining a scratch to his face, and *mummy smacked me* when explaining light bruising.
		+ Sibling 1 told school that Sibling 3 dropped Child V and he was scared.
		+ Sibling 3 disclosed to Father that a paternal half sibling had engaged in a sexual act with him.
	2. There was little evidence that the children’s voice was responded to in a meaningful way during the timeline for this review. Practitioners reported that the children will have been impacted by their experience of neglect, domestic abuse and the substance misuse of parents. However, the support and intervention provided did not lead to a significant change in their lived experience.
	3. At the practitioners event it was stated that practice has changed with the Strengthening Families approach and the child’s voice is increasingly being heard. The challenge will be to move beyond listening and recording, to reflect on the child’s experience in a way that has a positive influence on the support provided. Buckingham Safeguarding partnership recently hosted a ‘Voice of the Child’ partnership event and there is a strategic drive to develop practice in a way that is clearly child focussed.

***Learning point 6***

# *It is not sufficient to record observations of children and/or what children say. If the voices and lived experiences of children do not inform assessments and interventions, it is likely that they will not feel listened to, intervention may not be appropriate and concerns could escalate.*

# *Learning point 7*

# *In the absence of a multi-agency assessment following a disclosure of sexually harmful behaviour, underlying problems and difficulties may be overlooked.*

# *Multi-agency cooperation and escalation*

* 1. Practitioners involved in the review described practice as reactive rather than pro-active. Agencies worked individually to monitor progress rather than responding with partners to emerging concerns and engaging with the family in a meaningful way that had a positive impact on the children.
	2. Partner agencies were aware that CSC was acutely understaffed during the time considered by this review and some practitioners went beyond their role to support the family. For example, the HV made additional visits due to concerns about the family and knowledge that there was at times no allocated social worker. In addition, health and education records of core groups and CiN meetings were very detailed, in contrast to those of CSC. At this time it was decided by senior CSC managers that minutes of core groups did not need to be recorded to alleviate some pressure on the service. However, this decision caused additional challenges as there was limited information on the system to assist new social workers to understand the issues of concern.
	3. At the learning event practitioners spoke about significant inconsistencies in child protection practice and said that much was dependant on the skills and experience of the social worker. Core groups were described by Practitioners as listening events rather than meetings to actively review the progression of a plan. Practitioners spoke about pushing for action at the core groups and not always feeling respected or listened to.
	4. Strategy meetings were of variable quality and the correct practitioners did not always attend. Contributions from professionals in health and education was often missing and resulted in limited information sharing which impacted on subsequent decisions and actions. There was a view at the learning event that strategy meetings are now more effective and the quality of discussions is monitored by strategic safeguarding leads.
	5. There were challenges with information sharing throughout the timeline for this review. Practitioners described difficulties in contacting social workers and spoke about frustrations when some workers left at short notice without a replacement being allocated. Each new SW effectively had to start again, information on the ICS system was out of date and it was problematic for new SW’s to understand the issues facing children and families. Due to high caseloads there was no time to read large files before meeting with the family and starting work. High turnover of social workers and limitations in staffing had a significant impact on this case.
	6. There was a significant disconnect in this review between CSC and education. Designated Safeguarding Leads (DSL) from school described raising safeguarding alerts on many occasions and there were clear records of the concerns raised by school with CSC. There was a high level of frustration about the number of times school had been advised to address issues directly with parents. It was evident that school and nursery knew the children and family well and offered a significant amount of help and support. School provided food and clothing at times and cleaned the children when they arrived at school dirty. This was not enough however to safeguard the children and the family should have been open to CSC much earlier supported by a multi-agency plan with clear manageable targets and tangible outcomes.
	7. There were many occasions during the period considered by this review that professionals could and should have used the escalation policy. The escalation process was not used effectively by any agency although all had serious and significant concerns about the wellbeing of the children. There appears to have been an acceptance amongst partners that escalation would not make any difference to the children. BSCB have delivered extensive training on the escalation policy however, it is unclear how this training has impacted on practice. It was acknowledged by the steering group that some escalation is currently taking place however the procedure is not routinely followed and concerns are raised directly with strategic safeguarding leads. It is important that partner agencies are able to challenge each other when there are concerns that practice is not in the best interests of babies and young people.
	8. There was very little multi-agency cooperation evident during the timeline considered by this review. Practitioners agreed that improving multi-agency cooperation and practice is the responsibility of all partners. Positive professional relationships based on trust and mutual respect should have an impact on the outcomes for babies and children. Practitioners spoke about the importance of having opportunities to develop and nurture multi-agency co-operation.

***Learning Point 8***

*When practitioners have concerns about practice to safeguard children it is important that these are escalated using the correct procedure. Omission to do so may result in drift and delay in the provision of appropriate support and intervention to safeguard children.*

***Learning Point 9***

 *When professional relationships between partner agencies become strained and challenged this can impact on the effectiveness of multi-agency cooperation and the quality of practice to safeguard children and young people*.

1. **Good Practice**

7.1 Partner agencies were aware of the challenges experienced by CSC at the time considered by the review. There were some examples of professionals undertaking work that was over and above their responsibility in response to the needs of the Child V and family. Good practice included:

* School provided support to Father with reading and writing
* Health Visitor made additional visits to support the family
* School supported Mother to provide clothing and shoes
* Nursery offered a place to Sibling 3 at no charge
1. **Context**
	1. During the period considered by this review Children’s Social Care in Buckinghamshire County Council experienced a period of turmoil. Two consecutive Ofsted inspections (2014 and 2018) concluded that children’s services were inadequate and there was a change in leadership at a strategic and practice level. In addition, many social workers left and whilst there have been significant efforts to recruit, social worker vacancies remain.
	2. Findings of a recent monitoring visit which focussed on services for children in care noted that there have been limited improvements[[37]](#footnote-37). Ongoing concerns mirror the findings of this review; children continue to experience a frequent change in social worker, quality of practice is variable and assessments not regularly updated which makes it difficult to understand children’s lived experience and current needs.
	3. At the learning event practitioners said that practice at the time was process driven, non-compliance by SW’s was an issue and practice standards were not always met. A comprehensive improvement plan is currently being implemented by CSC, the learning and recommendations from this review aim to strengthen and complement the improvement journey.
2. **Conclusion**
	1. This review was triggered by the death of Child V from cardiac arrest determined by the Coroner as likely to be caused by a natural but undetermined cause. During the 2 years 7 months of her life Child V experienced neglect and delayed development. Information provided to the review evidence that the social, emotional and developmental needs of Child V and Siblings 1, 2, and 3 were not met.
	2. It is important that consideration is given to how the learning and recommendations identified in this review will be shared with all partners working together to safeguard children in Buckinghamshire County Council. The main purpose of a review is to prevent similar practice shortcomings affecting the lives of vulnerable babies and children who are powerless to care for themselves.
	3. It is a concern that practice issues identified in earlier BSCB reviews have been repeated within this review for Child V. It is important that partners understand why previous actions to improve practice have had limited impact and this understanding informs the implementation of recommendations from this review.
	4. The review was guided by two overarching questions;
* *What can we learn from this case about the effectiveness of practice in Buckinghamshire 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?*
	1. Child V and siblings 1, 2, and 3 were known to be experiencing long term neglect however, the response of agencies was fragmented and there was a lack of effective multi-agency assessment. Plans were overwhelming for parents, lacked child focus and did not have clear outcomes. The capacity of parents to effectively safeguard Child V and siblings were not understood or assessed. The impact of long term neglect on Child V and siblings was not adequately recognised and intervention to improve their life experience had limited impact.
	2. The influence of poor assessment on practice was evident throughout this review. Decisions about intervention and the provision of support were not proportionate or robust as the available evidence about the lived experience of Child V and Siblings 1, 2 and 3 was not assessed systematically. It was evident that practitioners cared about Child V and Siblings and wanted their lives to improve. School and health worked particularly hard to ensure that records were kept and the children seen as often as possible. Without a clear multi-agency plan to respond to emerging concerns any change was not sustained.
	3. The views of Father and PGM have been reflected throughout this review and informed the learning and recommendations. Father and PGM provided robust feedback to this review, particularly with regard to their experience of not being listened to by professionals. It is not possible to change the events detailed in this review, or remove the distress experienced by Father and PGM. However, it is important to note that implementation of the recommendations from this review should have an immediate impact on the ongoing work to support Father.
	4. It was evident from this review that multi-agency relationships have been significantly tested, due in part to the period of turmoil experienced by CSC. Agencies were working in isolation and there was limited evidence of a coordinated multi-agency approach to address the needs of Child V and family. It is important that opportunities are provided to develop and sustain constructive relationships between practitioners in partner agencies. Improved professional relationships will contribute to practice improvement and better outcomes for children and families.

**Learning and Recommendations**

 ***Learning Point 1***

When the siblings of an unborn baby (UBB) are subject to a Child in Need Plan it isimportant that there is an opportunity within the multi-agency CiN meetings to;

* discuss the impact of a new baby on the family circumstances
* include the UBB on the Plan with specific reference to risks and vulnerabilities
* ensure there is multi-agency agreement prior to closure of the Plan.

**Recommendation 1**

**The Safeguarding Partnership to seek assurance that learning from this review is addressed in the new practice standards regarding unborn babies**

**Recommendation 2**

**All partner agencies are reminded about the decision making process prior to closure of a CiN or CP plan.**

***Learning Point 2***

It is important that Child and Family Assessments include relevant historical information and contributions from partner agencies, children, parents and carers to inform understanding of and response to safeguarding concerns. In the absence of a comprehensive assessment decision making may be flawed and children exposed to unnecessary risk.

**Recommendation 3**

**The Safeguarding Partnership to seek assurance that:**

* **learning from this review is addressed in the new practice standards and procedures regarding assessment**
* **multi-agency contribution to assessment at all levels is facilitated and supported by effective processes**

***Learning Point 3***

When there are concerns about parental mental health, substance misuse and /or domestic abuse it is important that practitioners understand how these difficulties interact within the family and this information informs assessments and decisions to safeguard and reduce the negative impact on the children.

**See Recommendation 3**

***Learning Point 4***

In the absence of a parenting assessment it is a challenge for Practitioners to have clarity about the capacity of parents to understand safeguarding concerns and confidence in the ability of parents to protect children. This may result in practitioners having unrealistic expectations of parents and the vulnerability of children could increase.

**Recommendation 4**

**The Safeguarding Partnership considers the development of pathways with adult services to assist with the assessment of parents and carers when there are concerns about their cognitive ability.**

***Learning Point 5***

 When processes and tools to identify, assess and respond to neglect are not used, children may be exposed to long term risk and harm without adequate support or intervention.

**Recommendation 5**

**Buckinghamshire Safeguarding Partnership with partner agencies identifies the barriers to the effective use of tools to support the early identification, assessment and analysis of neglect, specifically, Graded Care Profile 2.**

**Recommendation 6**

**Buckingham Safeguarding Partnership to seek assurance that arrangements to improve the early identification of and response to neglect are included and monitored within the current improvement plan.**

***Learning point 6***

# It is not sufficient to record observations of children and/or what children say. If the voices and lived experiences of children do not inform assessments and interventions, it is likely that they will not feel listened to, intervention may not be appropriate and concerns could escalate.

# Recommendation 7

# The Safeguarding Partnership to seek assurance that learning from this review is addressed within process and procedures regarding voice of the child and there is robust monitoring to evidence the impact of the voice of the child in practice.

# *Learning point 7*

# In the absence of a multi-agency assessment following a disclosure of sexually harmful behaviour, underlying problems and difficulties may be overlooked

# See Recommendation 3

***Learning Point 8***

When practitioners have concerns that the risks children are exposed to and the vulnerabilities experienced are not effectively addressed it is important to escalate concerns using the correct procedure. Omission to do so may result in drift and delay in the provision of intervention and support to safeguard children.

# Recommendation 8

**Buckinghamshire Safeguarding Partnership with partner agencies to identify and address the barriers to the effective use of the escalation policy.**

***Learning Point 9***

When professional relationships between partner agencies become strained and challenged this can impact on the effectiveness of multi-agency cooperation and the quality of practice to safeguard children and young people.

**Recommendation 9**

**Buckinghamshire Safeguarding Partnership together with partner agencies, identify and develop opportunities to improve multi-agency cooperation and professional relationships. This should include the development of effective professional relationships when children live in another Local Authority.**

**Recommendation 10**

**Buckinghamshire Safeguarding Partnership shares the learning from this review with partner agencies and practitioners.**

1. SCR’s have been replaced by child safeguarding practice reviews which should be considered for serious child safeguarding cases where: abuse or neglect of a child is known or suspected and a child has died or been seriously harmed. <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2> [↑](#footnote-ref-1)
2. Ruling by the Coroner, December 19 [↑](#footnote-ref-2)
3. Minutes of meetings, reports, policies and procedures in place at the time etc. [↑](#footnote-ref-3)
4. Managers and safeguarding leads [↑](#footnote-ref-4)
5. The letter was shared with parents by a relevant professional who was able to support them to understand the contents [↑](#footnote-ref-5)
6. The views of Father and paternal grandmother were obtained during a virtual meeting with the independent author and a representative from the safeguarding partnership [↑](#footnote-ref-6)
7. Said to have been taken from the kitchen without parents knowing, Father informed the review that he was in work at the time [↑](#footnote-ref-7)
8. To clarify if there was ongoing neglect [↑](#footnote-ref-8)
9. Hidden Men: Learning from Serious Case reviews. NSPCC, 2015 [↑](#footnote-ref-9)
10. whilst pregnant with Child V [↑](#footnote-ref-10)
11. Following reorganisation and service development the FRS is now known as the Family Support Service <https://www.bucksfamilyinfo.org/kb5/buckinghamshire/fsd/advice.page?id=GmFSf5vKl3s&=> [↑](#footnote-ref-11)
12. By a manager at CSC [↑](#footnote-ref-12)
13. <https://www.proceduresonline.com/buckinghamshire/chservices/p_cin_plans_rev.html?zoom_highlight=child+in+need#3.-reviews-of-child-in-need-plans> [↑](#footnote-ref-13)
14. Two anonymous referrals from the public and a further referral from school following a disclosure by a third party child regarding sexually harmful behaviour of Sibling 1 [↑](#footnote-ref-14)
15. During a home visit by the SW there was no bedding on the beds, the children had nits and the presentation of sibling 1 and 2 at school and Sibling 3 at nursery was a concern (said to be dirty with a bad odour and frequently hungry) [↑](#footnote-ref-15)
16. <https://bscb.procedures.org.uk/assets/clients/5/6b_BCC%20Local%20Assessment%20Protocol%20FINAL.pdf> [↑](#footnote-ref-16)
17. Working Together 2015 [↑](#footnote-ref-17)
18. <https://www.nspcc.org.uk/keeping-children-safe/support-for-parents/mental-health-parenting/> [↑](#footnote-ref-18)
19. Brandon, M. et al. (2011) A study of recommendations arising from serious case reviews 2009-2010 (PDF). [London]: Department for Education [↑](#footnote-ref-19)
20. Think child, think parent, think family: a guide to parental mental health and child welfare (SCIE 2011p6) [↑](#footnote-ref-20)
21. Health Visitor records of core group [↑](#footnote-ref-21)
22. Good practice guidance on working with parents with a learning disability (2007). University of Bristol , Esmee Fairboune Foundation [↑](#footnote-ref-22)
23. Baby/Child E, M and Q [↑](#footnote-ref-23)
24. Specifically designated safeguarding leads in schools [↑](#footnote-ref-24)
25. Reder, P.Duncan, S. and Gray, M. (1993) Beyond Blame: child abuse tragedies revisited. London: Routledge [↑](#footnote-ref-25)
26. Pathways to harm, pathways to protection: A triennial analysis of serious case reviews, 2011 -2014. Sidebotham P et al. DH 2016 p8 [↑](#footnote-ref-26)
27. Brandon M, Ward H et al., DH Nov 2014Missed opportunities: indicators of neglect – what is ignored, why and what can be done? P7 [↑](#footnote-ref-27)
28. 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 [↑](#footnote-ref-28)
29. Sidebotham P et al. DH 2016 p13 [↑](#footnote-ref-29)
30. Sibling 3 had been observed breaking toys, kicking, pushing and putting hands around the necks of other children [↑](#footnote-ref-30)
31. The voice of the child: learning lessons from serious case reviews. Ofsted 2010 [↑](#footnote-ref-31)
32. School nurses saw Sibling 2 for 8 weeks however she didn’t want to speak [↑](#footnote-ref-32)
33. The voice of the child: learning lessons from serious case reviews Ofsted 2011 [↑](#footnote-ref-33)
34. Sidebotham

P. Brandon M. et al Pathways to harm, pathways to protection: a triennial analysis of

serious case reviews 2011- 2014 DfE 2016 [↑](#footnote-ref-34)
35. When a disagreement between parents quickly escalated into a loud argument [↑](#footnote-ref-35)
36. <http://bscb.procedures.org.uk/qkqsp/children-in-specific-circumstances/harmful-sexual-behaviour-procedure-and-guidance> [↑](#footnote-ref-36)
37. <https://files.ofsted.gov.uk/v1/file/50134640> [↑](#footnote-ref-37)