Q Family (Children A, B and C)
Local Case Review Briefing
September 2018

This Local Case Review Practitioner Briefing aids to help practitioners and their managers understand the key messages from this review.

Who should read the briefing?

Any practitioner and manager whose work brings them into contact with children, young people and their families. The messages are just as important for those working in adult services (where service users are parents or carers). The term 'children' includes children and young people up to 18 years of age.

Why a Local Case Review

The case was discussed at the Dudley Safeguarding Children Board Serious Case Review (SCR) sub group. As a result it was agreed that although the case did not fulfil the criteria for a SCR in accordance with chapter 4 in Working Together to Safeguard Children 2015 and Regulation 5 of the Local Safeguarding Children Boards Regulations 2006, it was agreed that there was learning for practitioners from the case and a local multi agency case review was agreed. This was endorsed by the National Panel of Experts.

Summary of Case

This case involves 3 children within a family (age 14, 10 and 7). There were issues of chronic neglect (physical and emotional) and emotional abuse leading to a physical assault on Child B resulting in the Police evoking Police Protection Powers and removing the children from their parents following the assault of Child C. The history of the case suggests that the children had suffered significant harm over a protracted period of time.

There were 9 known referrals to Children's Social Care (CSC) since 2014 and a number of domestic abuse notifications leading to the children becoming subject of Child Protection Plans (CPPs) in November 2015. Referrals were centred around domestic abuse (disclosed by mother), non-engagement with health appointments and reports of mother smacking the children and regularly removing them from school. There were four referrals from neighbours reporting the children being hit and screamed at or stating that the children were not having their basic needs met as there were no basic amenities within the home. Each referral resulted in the case being closed with no further role for CSC until November 2015 when the children were made subject of Child Protection Plans (CPPs).

The case was escalated on a number of occasions due to practitioners considering that the CPPs were not effective in safeguarding the children from harm. Core Groups and Child Protection conferences were sometimes cancelled and the CPP not progressed and actions from not always completed. The case was discussed at Legal Gateway Panel (LGP) on several occasions but was not considered to reach the threshold to commence Care Proceedings. This led to a degree of interagency professional disagreement.

There was evidence of non/disguised compliance by the parents and reactivity rather than proactivity (particularly by father) and professionals felt that the issues of mother's perceived poor mental health, long standing poor home conditions and signs of neglect were not addressed in a timely fashion.

Findings

- There was evidence of mental health concerns for both mother and father, neither of which were addressed due to parents, (particularly mother) declining assessment.
- There were several documented injuries to the children and mother was observed over chastising the children on a number of occasions and the children reporting physical assault from mother.
- Home conditions were unacceptable with parents being reactive rather than proactive and always stating once challenged that they would make improvements. The children frequently had

no beds, there were no cooking facilities and no heating in the property over two winters and the children reported that the home was "freezing". Mother was reportedly disconnecting the boiler.

- There was disguised and non-compliance from parents. Mother refused to allow the social worker access to the children and failed to attend Child protection conferences.
- There were a number of cancelled Child protection Conferences and Core Groups which resulted in drift and delay in the progress of the Child Protection Plans.
- There were allegations of domestic abuse from both mother and father and a number of police call outs (including calls from the children). A non-molestation order was granted to father.
- School were reporting that the children were hungry, unkempt at times and losing weight. There was very little food in the house and mother throwing food out.
- The children were not being listened to despite disclosing what was happening at home including reports of physical abuse, maternal alcohol use, and mental health issues.
- There was poor school attendance for all of the children.
- There were a number of discussions at Legal Gateway Panel (to determine if the threshold for care proceedings had been reached). Each time it was felt that the criteria had not been met.
- The eldest child was often acting as "adult" within the home, not only to the younger siblings but also to the parents.
- There was evidence of "start over syndrome" when incidents and episodes of concern were reactively responded to and referrals were closed once the trigger incident had been resolved. Professionals did not appear to consider the cumulative impact of the parental behaviours on the children.
- There was failure on the part of father to protect the children from mother's assault and bizarre behaviour and he did not call the police when she became violent or aggressive. The eldest child called the police on several occasions.
- The escalation process was not effective in improving the outcomes for the children.

Recommendations

- Consideration to be given to the development of multi-agency guidance in cases where parents refuse to engage with mental health services.
- The Resolution and Escalation process to be reviewed to ensure that it incorporates clearer processes and timescales for review and response.
- To consider multi-agency meetings to include the DSCB Independent Chair when escalation has reached level 3B without resolution.
- To consider training for staff around the chairing arrangements to prevent Core Groups being cancelled when the Social Worker cannot attend.
- Local Authority Legal Team to review the case to focus on the decision making process with Legal gateway Panel.
- Consider how referrals into the MASH on open cases are managed.
- To determine if there is any support that can be offered to mother.

What can the DSCB offer to support you in your work?

For both e-learning and face to face training use this link: http://safeguarding.dudley.gov.uk/child/work-with-children-young-people/training/

Visit our website:

http://safeguarding.dudley.gov.uk

for more information and access to the interagency child protection procedures.