Stoke-on-Trent and Staffordshire Safeguarding Children Board

Family F
Serious Case Review

Report Author Joanna Nicolas

20th November 2020

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Acronyms Used

CSC – Children Social Care
SCR – Serious Case Review
SSCB – Staffordshire Safeguarding Children Board
SEND – Special Educational Needs and Disabilities
SALT – Speech and Language Therapy Service
ADHD – Attention Deficit Hyperactive Disorder
DFE – Department for Education

1. Background to the Report

1.1 In February 2019 the then Staffordshire Safeguarding Children Board[1] (SSCB) commissioned a serious case review in respect of four children who died in a house fire on 5th February 2019. Following the children's deaths the parents were arrested on suspicion of gross negligence manslaughter. The circumstances of the case therefore met the statutory criteria for when a Local Safeguarding Children Board/Partnership must commission a serious case review. Following publication of their new arrangements in April 2019 and under the DFE guidance on Transitional Arrangements 2018, the newly formed Stoke-on-Trent and Staffordshire Safeguarding Children Board continued to facilitate this review and track its progress in order to conclude within the required timescales. For the purpose of this review and the reader, the author will continue to refer to SSCB. In August 2020 the Crown Prosecution Service advised that no further action would be taken against the parents.

1.2 It was decided by SSCB that this review should also be a wider, thematic review as many of the factors in this case have been seen in other cases. SSCB wanted to capture the wider learning however it was agreed that this review would only consider practice in Staffordshire not Stoke-on-Trent because in terms of governance Stoke-on-Trent and Staffordshire are completely different apart from the SCR process and therefore one cannot compare like-for-like.

1.3 The initial themes were agreed at the scoping meeting held on 22nd July 2019.

2. About the Author

[1] The Staffordshire Safeguarding Children Board had not yet published its new arrangements and therefore were operating under Working Together 2015 statutory requirements and the published guidance on transitional arrangements 2018.

2.1 I have worked in child protection/safeguarding for 25 years, the last eleven of those as an independent safeguarding consultant, case/practice review author and trainer.

2.2 I am an accredited systems lead reviewer having undertaken the Social Care Institute of Excellence's Learning Together systems methodology training in 2011. I have been leading systems reviews since then.

2.3 For more information please see my website https://joannanicolas.co.uk

3. Methodology

3.1 *Working Together to Safeguard Children, 2015* clearly sets out what is required from a serious case review.

3.2 This is a systems review. I, as the lead reviewer, have worked closely with a review team – a team made up of senior managers from each of the agencies involved. Although the report is published in my name it is the work of the review team as a whole. We as a review team have also worked closely with frontline professionals who worked with the family who are at the centre of this review. This group of professionals is referred to as the case group.

3.3 The process has been interactive throughout and the report and its findings have been constantly tested with the review team and the case group.
3.4 Not each finding has recommendations. It is for the Board to consider the findings and recommendations and respond as they see fit.

Review Team

Interim Board Manager	Staffordshire Safeguarding Children Board (SSCB)
Deputy Head of Safeguarding	Staffordshire Police
Head of Safeguarding Children	Midlands Partnership NHS Foundation Trust
Head of Strategic Safeguarding	Midlands Partnership NHS Foundation Trust
Head of Strategic Safeguarding	Staffordshire County Council
Head of Responsive Services	Staffordshire County Council
Education Safeguarding Lead	Staffordshire County Council
County Manager Educational Psychology Service	Staffordshire County Council
Designated Nurse for Safeguarding Children	South Staffordshire Clinical Commissioning Groups
Named GP	South Staffordshire Clinical Commissioning Groups
Director of Homes	Stafford and Rural Homes
Owner	Nursery

Case Group

Acting Headteacher/Designated Safeguarding Lead	School One
Class Teacher/Special Educational Needs Co-ordinator	School One
Inclusion Officer and Deputy Designated Safeguarding Lead	School One
Class Teacher	School One
Nursery Manager	Nursery
Key Worker	Nursery
GP1	Staffordshire Clinical Commissioning Group
GP2	Staffordshire Clinical Commissioning Group
GP3	Staffordshire Clinical Commissioning Group
Community Paediatrician	Staffordshire Clinical Commissioning Group
Family Support Worker	Children's Social Care
Team Manager	Children's Social Care
Social Worker 1	Children's Social Care
Social Worker 2	Children's Social Care
Health Visitor 1	Midlands Partnership NHS Foundation Trust
Health Visitor 2	Midlands Partnership NHS Foundation Trust
Special Needs School Nurse	Midlands Partnership NHS Foundation Trust
Speech & Language Therapist	Midlands Partnership NHS Foundation Trust
Headteacher/Designated Safeguarding Lead	School Two
Deputy Designated Safeguarding Lead/Special Educational Needs Co-ordinator/Class Teacher	School Two
Educational Psychologist	Education Psychology Service

3.4 Involvement of Family Members

It is a requirement that SCRs involve relevant family members. As part of the review it was agreed we would not approach the father of Child One and Child Two because he had no involvement in their lives. The mother of all the children contributed to the review. The father of Children Three, Four and Five was invited to contribute. He declined to do so but was thought to be present when the report author was speaking to the mother on the telephone. There was nothing he wanted to add to what the mother said.

3.5 Administration of the Review

The smooth running of the review was enabled by the support of SSCB and in particular the Partnership Business Co-ordinator, SSCB

4. Introduction

4.1 Why this case was chosen to be reviewed

4.2 As set out in 1.1 the circumstances of this case met the statutory criteria as set out in *Working Together to Safeguard Children, 2015*

4.3 Succinct summary of case

4.4 The family had been known by a number of agencies, including children's social care for a number of years prior to the death of the children however in the last few years although there were concerns the children were suffering significant harm as a result of neglect there were no concerns about parental mental ill health, substance misuse or domestic abuse – apart from the one alleged incident. It is important to emphasise that although there were grave concerns about the children on the spectrum of neglect cases that all the agencies would deal with, this family would have been considered at the lower end because of the absence of those well-known high risk indicators for children – domestic abuse, unmet mental health needs of parents and/or substance misuse by parents. The family was described by many professionals as "unremarkable" in the context of abuse. They did not stand out in any way.

4.5 Family composition

Family member	**Age at the time of the child's death**
Mother	
Father to Child One and Two	
Father to Children Three -Five	
Child One	Eight
Child Two	Six
Child Three	Four
Child Four	Three
Child Five	Two at the time of the fire. Child Five survived

4.6 Child One and Child Two had no contact with their birth father. They called the father of the other children "Dad" and to all intents and purposes he was their father. Therefore throughout the review I will refer to "the father" but acknowledge that he was not the biological father of Child One or Child Two. The professional who worked with the family were clear the father treated all of the children the same.

4.7 Timeframe

4.8 The timeframe for the SCR was agreed as being from 5 February 2017 to 5th February 2019 the date of the fire. When undertaking a systems review one does not go back years because systems will have changed. There is no value in reviewing systems that are no longer in place. Family history is vital but what matters is that the professionals working on the front line are aware of the family history, not the team reviewing the case.

5. Summary Timeline of Events During the Period Under Review

Date	Event
4.3.17	Police attended home address following 999 call. The mother said her partner had been threatening to take the children away. During an altercation he had pushed her and threatened to stab her. There were no marks or injuries. The father was arrested for domestic assault.
6.3.17	Mother told GP she was getting angry and shouting all the time at her partner for no reason. She told the GP re the incident of 4.3.17 she had accused her partner of things he did not do and he was arrested. She described being of low mood.
14.3.17	Children's social care (CSC) receive a referral from the Police in respect of the domestic incident. CSC undertook an assessment which was concluded on 13.5.17.
2.6.17	Strategy discussion took place due to the incident of domestic abuse, the findings of CSC's single assessment and the family history. Agreed to proceed to initial child protection conference.
9.8.17	Social Worker Two becomes the allocated social worker.
31.8.17	Social Worker Two undertook first home visit – unannounced. Concerns about the state of the home and the children. Child Two had a bruise on his head; the mother said it was Playdough. Child Three had what looked like fingertip bruising to her neck. Social Worker Two described Child Five's expression as "frozen watchfulness and showed no response". A strategy discussion took place due to the injuries to the children and the state of the home. Child Four was not taken to planned developmental assessment. The mother said she had gone to the wrong place.
1.9.17	All children examined by community paediatrician. The mother's explanations for the injuries to Child Two and

	Child Four accepted. Child Four's height was on the 0.4th centile. The community paediatrician wrote to the GP asking them to monitor this. Child Four, aged 22 months noted as non-verbal.
5.10.17	Review Child Protection Conference. Noted that Child Four bites and hurts his siblings. Child Four showing "mild developmental delays". Child Five "significant gross and fine motor developmental delay" which health visitor thought may be due to lack of opportunity to play safely.
10.10.17	Child One reluctant to talk to Social Worker Two "due to being told by his mother that the social worker would take him away".
12.3.18	CSC team manager agrees to fund cognitive assessment of the mother. Child Four seen with two marks on his hips. Father said he bumped into a sofa. CSC informed.
20.3.18	Named nurse for safeguarding escalated concerns to CSC team manager because of lack of progress. She was informed there is to be a cognitive assessment of the mother and a discussion about a Legal Gateway Meeting. This did not happen because CSC were of the view that the parents' engagement started to improve.
21.3.18	Second Review Child Protection Conference took place. Still concerns the mother was not understanding what was being asked of her and the child protection process. Continued to be talk of having a Family Group Conference. This never happened.
8.6.18	Urgent referral made for Child Four to be seen by community paediatrician. Concerns about whether his developmental delay is due to environmental factors or a possible genetic link.
11.9.18	Third Review Child Protection took place. Cognitive and parenting assessments and Family Group Conference remain outstanding. Professionals "unclear how to continue supporting the family going forward".
2.10.18	Child Two diagnosed with ADHD and prescribed medication.
10.12.18	Final supervision notes of Social Worker Two state there are no safeguarding concerns.

6. Findings and Themes

6.1 As stated previously this to be a thematic review. The themes were agreed by the review team. Those themes were:

- Professionals' understanding of the impact of neglect, in particular holistic working, drift and delay, the mental capacity of parents/carers, children with special educational needs and disabilities (SEND), large families, the professionals' acceptance of the parents controlling the terms of engagement with all agencies and the balance between analysis of risk to children and supporting parents
- Children's lived experience
- Professionals' understanding of domestic abuse
- The relevance of family history

6.2 Each of the themes will be addressed in the findings.

6.3 It is also important to consider the national context. Themes from case/practice reviews across the country tend to be very similar. The reason for that is because professionals are working with families often with complex issues. Professionals are working with human beings who are unpredictable and with software systems that do not link up. Professionals cannot remove risk in every case and at a time of increasing poverty, which makes it harder to parent, and austerity which means there is less help available to support families. Risks have to be managed. What professionals have to do is assess risk and act accordingly. What is incumbent on every agency is to ensure their staff understand what the risks are for children and that is where the failings often lie. If the issues were simple it would be easy to find solutions to them and so they would not reoccur. That is not the case.

6.4 Finding One - There Can be a Fundamental Lack of Understanding of the Impact of Neglect on Children in Staffordshire

6.4.1 "Inattentive or unresponsive parenting has been linked to non-organic failure to thrive in babies and young children and to injuries, even fatalities, resulting from lack of supervision"[2]

6.4.2 There is an ever-increasing body of research that sets out very clearly the devastating and potentially life-long impact of neglect as a form of child abuse and yet around half of all children who are on a child protection plan in England are suffering neglect[3]. What that tells us is that although the research is really clear about the devastating impact of neglect as a form of abuse we still leave children in homes where they are suffering abuse that will shape their lives.

6.4.3 In the words of Brandon et al in the Department for Education's analysis of serious case reviews "The need to understand more about neglect, which is present

[2] NSPCC

[3] https://learning.nspcc.org.uk/media/1181/child-protection-register-statistics-england.pdf

in more than 60% of serious case reviews, has been a constant theme across all the serious case reviews studies.

6.4.4 This underlines the importance of neglect as a marker not only for long term damage to a child's development and wellbeing but also as a marker of potential physical danger to the child. This means that neglect should be treated with as much urgency as any other category of maltreatment"[4].

6.4.5 Also in their words "that neglect is not only harmful but can also be fatal should be part of any practitioner's mindset"

6.4.6 What happened in this case?

6.4.7 One of the challenges of neglect is it takes many forms. To consider what happened in this case we will use the different forms of neglect identified by Jan Howarth[5]:

6.4.8 It will never be known what created Child Two's special educational needs. What is known is that children can develop severe learning and physical disabilities as a result of neglect and many children who have a diagnosis of ADHD live in an environment which has contributed to the disorder. The educational psychologist was of the view that he was a reasonably bright child. When she observed him, he demonstrated an awareness of cause and effect, engaged in self-directed tasks for up to 10 minutes (playing with cars in the garage), searched for Easter eggs (two minutes before needing adult support to persist) and showed a good understanding of how to use a keyboard connected to an interactive board. He also showed bursts of fleeting attention when doing whole class action rhymes of usually around 20 seconds but on one occasion this was up to one minute. It was her view that with consistent high-quality long-term support, Child Two could possibly eventually function at the lower end of the average range in attainment assessments. Assessments showed that he was functioning at 50% of his chronological age but as the educational psychologist said that is not surprising if a child is not given stimulation at home and encouraged to learn and progress. She also described elements of hyper-vigilance which is seen in many children with difficult home settings.

6.4.9 Medical Neglect

6.4.10 There was a pattern of the children being discharged from specialist health services because their parents did not take them. This happened with opthalmics, SALT and the hip-screening service.

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[4]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

[5]https://www.actionforchildren.org.uk/media/3368/neglectc_research_evidence_to_inform_practice.pdf

6.4.11 One of the greatest concerns about the children was their lack of speech. Professionals described the home as silent despite there being five children in it. All of the children when they became old enough were referred to the Speech & Language Therapy Service, apart from Child One. Child One grew up in different circumstances; during his early years he lived with his mother and maternal grandparents in the maternal grandparents' home. Children only start talking and develop their speech and language skills with the encouragement of the adults around them and it was well recognised by professionals that the children were not speaking because there was not enough conversation in the home. Child Two and Child Three had both been referred to SALT because of their speech delay and a referral for Child Four was being considered at the time of his death. The speech and language therapist would see the mother after the appointments and give her advice. SALT was also able to advise the school on how to help Child Two but there is no evidence that the input of SALT had any impact on what was happening in the home. That was the crux of the issue and yet that was not resolved. The parents were told they needed to speak to the children, but the evidence showed that that was not happening. Child Two was described as craving attention; he desperately wanted to communicate with professionals but found it hard because he did not have the vocabulary. There was a lot of pointing involved and physical contact with professionals. His speech did improve when he started school but then deteriorated at the same time as his behaviour became more challenging.

6.4.12 Child Two did not always have/wear his glasses. Failure to wear glasses can cause irrevocable damage to eyesight.

6.4.13 Health professionals made many attempts to get the parents to bring their children to developmental reviews. These reviews were often missed or happened very late. They are set at specific stages of development for a reason – so any concerns can be addressed in a timely fashion. The same happened with immunisations. Although childhood immunisations are not a legal requirement they tend not to happen for one of two reasons; either the parents actively choose not to, or appointments are missed along with many other appointments the child has. "Was not bought" i.e. children not being brought to health appointment is now recognised as a risk. It is managed differently by different health providers. Staff should recognise the additional vulnerability when a child is on a child protection plan and respond to that risk.

6.4.14 The parents constantly cancelled and changed appointments with the health visitor.

6.4.15 Child Two was diagnosed with ADHD and prescribed medication in October 2018 but he was not given the medication regularly at home and therefore professionals noted there was no benefit to him despite the fact the mother said he had shown some improvements. The special school also questioned the diagnosis amongst themselves because he did have reasonable control of his behaviour.

6.4.16 Nutritional Neglect

6.4.17 The National Institute for Clinical Excellence gives clear guidance[6] for children's weight and height after the early days of life.

6.4.18 There were no particular issues with the height or weight of Child One or Child Three. Concerns were raised about Child Two's weight because it rose from 9th centile at birth to 50th centile at 6 weeks. By March 2014 (age 1yr 3 m) Child Two's weight was on the 98th centile and height centile was on the 9th centile indicating that Child Two was very overweight. Advice regarding weight (healthy eating and activity) was given by the health visiting team. Child Two's weight was monitored at several successful contacts at home and Child Two referred to a dietician on two occasions, however discharged each time due to non- attendance.

6.4.19 In September 2017 Child Four's weight dropped from the 9th centile he had been at birth to the 2nd centile. The parents' explanation was he had been suffering from sickness and diarrhoea. His weight did return to the ninth centile but in January 2018 his weight had dropped to the 2nd centile again. His height went between the 0.4th centile and the 2nd centile.

6.4.20 When the child protection medical took place in September 2017 Child Four's height was on the 0.4th centile. The Community paediatrician wrote to the GP, who then forwarded the letter on to the health visiting service, asking them to monitor this in three months' time. It would be the role of the health visitor to monitor height and weight. This did not happen because the parents would not attend the appointments.

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6.4.21 At the Review Child Protection Conference in October 2017 the parents were requested to take Child Four to a drop-in clinic to be weighed and height checked but they did not. There were then ineffective home visits in November 2017, February and March 2018. Child Four was next weighed at a home visit on 13/3/18 at 11.26kg, he remained on 9th centile. At the Review Child Protection Conferences in March 2018 and September 2018 the parents were requested to attend clinic with Child Four for growth monitoring. Child Four was never presented to clinic for growth monitoring.

6.4.22 The parents were given information and advice on healthy eating. At different points the mother told professionals the children were eating more fruit and vegetables and having vitamin drops. There is no evidence any professionals sought to corroborate that the children's diet had become healthier, either by observing if there was any fruit and vegetables in the home, or vitamin drops, either in the cooking or by asking the children if their diet had changed.

6.4.23 Emotional Neglect

[6] https://www.nice.org.uk/guidance/ng75/chapter/Recommendations

6.4.24 There is no evidence of emotional neglect in itself of the children although the mother did request that Child One receive counselling at one point because she believed he suffered from low self-esteem. Professionals working with the family commented on the love they saw between the parents and the children however Children's social care knew that the mother did not know how to play with her children and saw no value in play, even though it was impressed upon her by the family support worker.

6.4.25 Educational Neglect

6.4.26 Although not a requirement to go to nursery or any form of group for children who are not stimulated at home this is essential. Child One had gone to nursery. Although always encouraged to by professionals the mother would not let Child Two go to a nursery because she said no nursery would have taken him because of his behavior. No one explored with the parents why they did not want the younger children to attend nursery but through the tenacity of Children's social care Child Three and Child Four did start attending, which was clearly beneficial to them. The plan had been for Child Five to attend nursery but the mother was clear she did not want him to because she wanted to keep him at home as he was the baby.

6.4.27 Child Two only lasted a short time in mainstream education before being placed at a special school. Although children's social care saw it as a good thing when he went to a special school, the educational psychologist felt he could have benefitted from an extended period in mainstream school but with additional support. This is because it is generally better for children in terms of learning language models, behavior models and interacting with a larger number of peers. The question was because Child Two was so young professionals were still trying to pinpoint whether it was a learning need or was that being masked by something else? When a child goes to a special school, they are learning from their peers around them who may be exhibiting behaviour that are not always appropriate. However, the Educational Psychologist saw evidence of social and academic isolation in his mainstream school and after careful consideration concluded that he needed a modified and individualised curriculum with a favorable staff to pupil ratio typically found in a special school environment.

6.4.28 Physical Neglect

6.4.29 The state of the home was a concern at various points and improvements tended to happen at the behest of CSC and often paid by them. At different points there were concerns about Child Two wearing shoes that were too big for him and Child Three wearing pants that were too big for her. A financial assessment had been done and the family was in receipt of carers' allowance and Disability Living Allowance. The family had the money they needed to provide for their children.

6.4.30 There were numerous concerns about the children who were in nappies not having them changed often enough, with the nursery having the view that sometimes they would arrive in nappies they thought had not been changed since

the night before.

6.4.31 The parents were given a lot of advice about weaning Child Four off the bottle. The mother would say she was and give various examples, but he was often seen with a bottle during the day. This was another example of professionals accepting what the mother said when the evidence was clear that nothing was changing. Professionals knew that it was not and spoke to the parents about it again and again; the challenge was what to do about it. A child not being weaned in itself does not cause significant harm; it is the cumulative effect of all the different forms of neglect that cause significant harm to a child.

6.4.32 The greatest concern, in terms of physical neglect, was about the parents smoking in the house and the extent to which they smoked. It was predominantly the mother that smoked. The father did not smoke often. This was addressed with the parents on numerous occasions by some of the professionals and many professionals commented on the powerful smell of cigarette smoke on the children and their belongings. The parents always said they smoked outside the back door. All of the five children presented with respiratory illnesses of some kind at some point or another but just as with the weaning, what needed to happen was all of the concerns be put together to consider the cumulative effect of all the different types of neglect.

6.4.33 Lack of supervision and guidance

6.4.34 There is considerable evidence that the children were not given sufficient stimulation, supervision or guidance. Children only develop with the encouragement of adults around the child. Child Two had special educational needs and an identified chromosomal abnormality but there were no such concerns about Child Three, Child Four or Child Five and yet all suffered developmental delay. There is considerable evidence that that delay for the children, including Child Two was caused by a lack of stimulation. Professionals working with the family noted the silence there was in the home, which is extremely surprising with five children in the home. The children became adept very quickly at using technology. They had televisions and PlayStations in their bedrooms and downstairs, but their speech was significantly delayed.

6.4.35 The words that were used most often to describe the home was “utter chaos”. When professionals visited the children would literally dive on top of them and hang off them and it was very hard to focus on one child or another, or sometimes to focus on anything at all.

6.4.36 There are three aspects to the injuries the children sustained during a seventeen-month period. The first is the sheer number. During that seventeen months in excess of 50 injuries/marks/bruises were seen on all the children apart from Child Five. 16 of those were sustained by Child Three and 26 of them by Child Four. They were aged between two and a half and four and one and a half and three respectively during that period.

6.4.37 The second is the nature of the injuries. Although some were only scratches, seemingly from the cat, a significant number of them were to parts of the body and of a nature that would normally raise concerns of possible physical abuse – such as marks to the bottom when a child is wearing a nappy – two occasions - a black eye, the back and around the eyes and different explanations given for injuries all the children. Apart from on two occasions the injuries were just accepted by professionals even though there were explanations such as Child Four had a mark on each hip and the father said he bumped into the sofa. Child Four was seen with marks to both his forearms; the mother said it happened when he climbed into the pushchair. Child Four had a mark under his eye; the mother said he had been playing with the kitchen drawer.

6.4.38 It was known the Child Two-bit other children; he also bit a member of staff at school. The parents said that the younger children also bit.

6.4.39 All of the children were only examined by a community paediatrician on one occasion because of the state of them and Child Three on two occasions. When all of the children were seen by the paediatrician the mother's explanation for the injuries were accepted, even though the mother told the paediatrician she had lied to Social Worker Two about what one of the marks was – she said it was Play Dough.

6.4.40 When Child Three was examined by the community paediatrician on the second occasion it was because she had nine different injuries in total, including to her inner and outer ear – which the mother told the nursery was eczema, although she did not mention that to the paediatrician. Once again, the mother's explanation for the injuries was accepted, even though the community paediatrician states that in 95% of cases inner ear injuries are non-accidental and that these types of injuries are highly suggestive of physical harm. Following that examination, she was not seen in nursery again for six days – the mother said she had a sore throat initially and the nursery did see she had swollen glands. The day she returned to nursery she was seen with a mark to her back, which the mother said her brother had done trying to bite her "during playful interaction".

6.4.41 The third aspect to the injuries is the neglect element. There was insufficient consideration given to the cause of the injuries and the plausibility of the explanations, particularly as the mother admitted she lied about one. Secondly, even if all of the injuries were accidental, that is not to say that is not causing significant harm. To have a two and three-year-old who are constantly being bitten and sustaining bruises in concerning parts of the body is not ok. Children can be significantly harmed by accidental injuries and if parents have so little authority over their children that they are not protecting two and three-year-olds from this level of injury, that is neglect and neglect causes significant harm.

6.4.42 Some professionals had considerable concerns about the children and the number of injuries they sustained but were told by children's social care not to worry about bites and scratches. This was a large family and a busy household. The community paediatrician also noted the size of the family and how much work it

must be caring for so many children. There is no evidence to show that the larger the family the more likely it is that children will be abused however this was a small house with seven people living in it and adults who are clearly not able to meet the needs of their children. We cannot say there would have been less neglect if there had been less children but undoubtably it puts more pressure on the family the more children there are, the cost, clothing, fitting everyone in the house. We know that Child One also took care of the younger children at times even though he was only eight. These were parents about whom there were more and more concerns the more children there were because they simply could not meet the needs of the children.

6.4.43 Child Five was described by Social Worker Two as having an expression of frozen watchfulness the first time she saw him. He very rarely made any noise or moved which was of great concern to her. Child Four was described similarly. The term "frozen watchfulness" is a term used to describe a child who is unresponsive to its surroundings but is clearly aware of them. Frozen watchfulness is usually a marker of child abuse.

6.4.44 The Multi-Agency Response

6.4.45 There is considerable evidence that the professionals were listening to what the mother said rather than looking at the evidence. The mother would reassure professionals that they were not smoking inside but the children smelt very strongly of cigarette smoke – some described the smell as overpowering, she reassured the paediatrician that Child Four did speak more when she expressed concerns about his lack of speech during an appointment and said Child Four was just shy in front of her but the paediatrician observed he just grunted and pointed at things when he wanted them. On several occasions professional recorded that the mother was motivated to work with all the agencies, was keen to engage with the child protection plan and yet there is little evidence of positive change for the children. Interestingly the mother told the report author that she" laughed in their faces" when professionals mentioned the word neglect. She does not accept to this day that the children were neglected. She told the report author that she had had five children and therefore she knew how to parent. It was more a case of the mother knowing what to say to professionals, rather than accepting there were concerns and wanting to change. No tool was used to gather the evidence in a way that the frontline professionals could see what was actually happening well that might have helped professionals understand the mother did not think there was a problem in the first place. As is a very common feature in serious case reviews nationally it was only upon the frontline professionals seeing the timeline I had collated for this review that they realised the number of injuries and significant events that had taken place during these children's lives. Not a single professional had that level of knowledge while they were working with the family. They were all extremely shocked upon seeing the timeline. There is also no evidence that professionals explored the mother's position with her, even though it was highlighted in September 2017 that the parents did not have a clear understanding as to why the children were on a child protection plan.

6.4.46 When Child Two was assessed by the educational psychologist Child Four was taken along as well. Although the educational psychologist was focussed on the needs of Child Two, she observed that Child Four was unusually passive and her thoughts were “he would be likely to come our way’. The educational psychologist was aware that Child Four had been referred to the Early Years Forum and there were indeed concerns about his lack of speech and a referral to the educational psychologist was being considered. This information would be shared at Child Two’s next review with Early Years Forum.

6.4.47 The educational psychologist was aware that the children were known to social care due to issues of neglect and that the previous educational psychologist had liaised closely with social workers. Due to the limited time scale educational psychologists have to complete statutory advice, she did not access available records or contact the social worker to clarify the status of the child protection plan but was aware that monitoring was ongoing by those who had more frequent contact with the family. This has now been followed up to ensure information shared with the Early Years Forum is fully reflective of child in need or child protection plan information and that all educational psychologists are aware of their responsibility to be aware of any plan that may be in place

6.4.48 There is no evidence that the children being the subject of child protection plans had any significant, positive affect on any of the children’s lives, which is exactly what the mother said to the report author. At the review child protection conference in September 2018 professionals did say they were unclear how to continue to support the family. They did recognise that nothing was changing but then they just agreed to keep the children on a plan until the assessments had been done – the cognitive assessment of the mother and a parenting assessment which were never actioned by children’s social care. What that meant for the children was that they would continue to suffer significant harm as a result of neglect for the next six months at least. There is also no evidence that the professionals and their agencies recognised the severity of the harm being suffered by the children when they clearly acknowledged that no progress was being made. It is important to be clear that the parenting assessment did not happen because that had to await the conclusion of the cognitive assessment, to then decide which form of parenting assessment to use, depending on the mother’s cognitive ability. Children’s social care was clear the main issue was the mother’s dislike of all the agencies and that was the main issue, not her cognitive ability.

6.4.49 Finally there were two incidents that triggered a child protection response; one was the alleged domestic abuse incident the second was injuries to the children. The neglect of the children never did. There were also two child protection medicals that took place. What has come to light undertaking this review is that when community paediatricians are undertaking a child protection medical they do not always have information about the family history, or details of why children are on a plan of any type, if they are. Community paediatricians are also very much focused on whether there has been physical or sexual abuse of a child. They are asked for their professional view as to whether a particular injury could be non-accidental,

rather than considering the impact on the children of sustaining a significant number of injuries through neglect. In this case the community paediatrician was given no information about the history of injuries to the children and says if he had seen a chronology which showed all the injuries and been mindful of the impact of neglect as a form of abuse he would have viewed the case very differently.

Recommendation One

Staffordshire Safeguarding Children Board creates a focus group to examine what works well and what does not work well about child protection medicals, the scope to include the findings from this review i.e. the importance of the child and family history and community paediatricians must consider the impact on the child of any type of abuse, including neglect

6.4.50 In Summary

6.4.51 All of the children, apart from Child One, showed significant signs of neglect. They all suffered from developmental delays including extremely limited speech. The word "feral" was used to describe one of the children when they started at nursery. The mother did not accept, then and now, that the children were neglected.

6.4.52 Apart from with regard to persuading the parents to allow Child Three and Child Four to attend nursery the actions of children's social care, as the lead agency, fell short in this case. The children were on a child protection plan from 13th July 2017 until the time of their death. Core groups did not happen within the required timescales, at times they were poorly chaired and the mother was allowed to dominate and Social Worker Two sometimes did not attend the core groups. It has also come to light through this review that when an invitation to a core group is sent out it does not set out a finish time for the meeting, and different professionals allow different amounts of time. What happened in this case was that professionals sometimes left before the end of the core group because they had only allowed an hour but the meeting carried on. As well as this one of the review child protection conferences did not take place within required statutory timescales and the statutory visits did not take place within required timescales. Visits that did take place were often not written up by Social Worker Two. As well as this the nursery, which children's social care was funding for Child Four was not invited to be part of the child protection process. It was only at the insistence of the nursery manager that this happened. The mother highlighted to the report author that she saw a social worker infrequently, she also commented on the failings of children's social care to fulfil their statutory duties, as set out earlier in this paragraph. This would have exacerbated the problem; how can we expect families to understand the severity of the situation, particularly when the family does not think there is a problem in the first place, if the lead agency does not fulfil its duties? It gives extremely mixed messages to a family. The mother knew that children's social care has a statutory duty to visit every two weeks when a child is on a child protection plan. She said that when she asked why this was not happening and why she had not seen a social worker for weeks, she was

told that they did not have the staff. Despite what was said in child protection conferences and core groups, this gives a clear message that there are other children about whom there are greater concerns, thus reinforcing the mother's view that there was not a problem in the first place.

Recommendation Two

Children's social care to provide assurance to the Board in respect of core groups; specifically the quality and effectiveness of core groups and whether they are operating in line with expected practice as set out in Working Together 2018. Children's social care also to provide assurance to the Board they are monitoring practice on a regular basis and demonstrate how they will inform the Board where issues arise in terms of attendance and quality

Additional Comment
It should be noted that children's social care has asked for the IT system to be changed so that much of this information can be gathered on a number of occasions, but it means a change in the system. A hold was placed on amendments to the IT system used by CSC (a Corporate decision due to upgrades to the system) which caused an unavoidable delay.

6.4.53 When children are on a child protection plan it is the responsibility of the lead professional – the social worker – to lead the work that is being done through the child protection plan. There was no recognition of the lack of progress of the plan or the impact on the children of the ongoing maltreatment, as addressed in **Finding One**. Social Worker Two was also inaccessible to other agencies, which they found very frustrating. The family support worker was more accessible but it is important to be clear that family support workers work under social workers and it is the social worker who tells the family support worker what work needs to be done.

6.4.54 What is particularly concerning is that Social Worker One who worked with family during the period under review had worked with them four years previously. The mother had not wanted children's social care involved then either, even though she agreed to a child in need plan being in place and during that period of time nothing seem to improve for the children either, despite professional involvement. Social Worker One remembered Child Two who would be sat in his pushchair pushed up against the television and that was his only stimulation. The mother had been told then, so four years before the period under review that children needed more stimulation than television.

6.4.55 It should be said there are many examples of the tenacity of the health professionals involved – they chivvied and chased, with varying degrees of success, in order to make the parents take their children to different health appointments. A huge amount of time and effort went into this which is commendable, particularly when all professionals in all statutory services are so stretched.

6.4.56 The number and type of injuries to the children is unacceptable.

6.4.57 The signs of positive changes that were referred to throughout were that the family did make some changes to the property, recommended by professionals, to make the home safer for the children and on one occasion a professional visited and the father had made cakes, apparently with the children. Children's social care did offer to buy new carpets for the stairs and the boys' bedrooms but that required the parents to get quotes, which never happened, despite prompts from the family support worker. None of the fundamentals changed.

6.4.58 There is little evidence, apart from Child Three and Child Four going to nursery at Social Worker Two's insistence, that anything improved significantly for the children during the 19 months they were on a child protection plan and considerable evidence that the continuing maltreatment over that 19 months will have done them considerable harm when one takes into consideration research in this field summed up by District Judge Nicholas Crichton in 2010 "2 months of delay in making decisions in the best interests of the child equates to 1% of childhood that cannot be restored."[7]

6.4.59 A combined chronology would have been extremely helpful in this case because it would have shown professionals exactly what was happening, as well as highlighting the number of injuries the children were sustaining and the fact that there were very few changes.

6.4.60 How likely is it this is a widespread issue in Staffordshire and not unique to this case?

6.4.61 In 2016 Staffordshire Safeguarding Children Board undertook a serious case review in respect of Child E. The concerns in that case were that it was a neglect case and they were concerned about the effectiveness of the core group and frustration about the time it was taking to complete risk and parenting capacity assessment of the mother and her partner. There are many similarities between the findings of that serious case review and this one.

6.4.62 The recommendations included the need for more training on neglect and its impact on children. They also refer to the changing role and landscape of children's social work departments, given the impact of rising demands and reduced resources. There were also recommendations in respect of raising awareness of the escalation procedure, the importance of robust/respectful professional challenge between and within agencies and a recommendation to highlight to agencies the value of using chronologies in supervision, core groups and child protection conferences to monitor progress in cases where neglect is of concern and consider the practicability of establishing combined chronologies for child protection planning purposes. There are many challenges for professionals working with families where there is neglect of children. First of all to identify neglect professionals need a broad view of the family and what is happening and professionals are limited by time and scope and often by

families who are hiding what is actually happening. Also different agencies may have different thresholds and also judgements differ between people, so there needs to be a better understanding of what is neglect and when it is likely to cause significant harm. Another challenge is what should happen when care is not good enough and when does it become bad enough that we should look to remove the child? It would be entirely wrong and also unrealistic to say that all children should be removed from their parents' care if they are suffering significant harm as a result of neglect, particularly in the current climate of poverty making parenting much harder and austerity meaning there is less support for families. This is the conundrum that professionals are dealing with every single day.

6.4.63 Children's social care recognises that the use of chronologies is an area for improvement. There is an expectation that they do their own chronology. As a result of two recent serious case reviews in Staffordshire children's social care now audits when they are using a single agency chronology.

Recommendation Three

Multi-agency chronologies should be used in all cases where more than one agency is working with a child and their family. As an absolute minimum a multi-agency chronology must be started at the point a child is on a child protection plan under the category of neglect and it has reached the second child protection review conference, which means the child has been the subject of a child protection plan for nine months and must be completely up to date by the third child protection review conference

Additional comment

Best practice is clear; chronologies should be used in supervision to inform practice and chronological thinking needs to inform any single agency or multi-agency working. Using multi-agency chronologies in practice is a common recommendation from serious case reviews but it is often not done because of the time involved.

6.4.64 One would have to question the effectiveness of the learning from the Child E serious case review because of the similarities with this case.

6.4.65 In February 2018 OFSTED identified that high caseloads in some teams were impacting upon their ability to record all their work which would extend to their management of administrative tasks such as sharing minutes of core groups. The local authority has responded with a 1.1m investment into social work services and 11 additional social workers have now been successfully recruited to SSU social work teams. In addition to this a significant investment has also been made to introduce an overarching restorative practice model across all early help, youth offending and social work teams.

6.4.66 Whilst there is not statistical evidence to suggest managing neglect cases poorly is a recurring theme there are currently four cases subject to or having been subject to review where the impact of long-term neglect has not been well-managed and decisive intervention has been slow. These cases feature an episodic approach to casework which has undermined effective responses to families. This is recognised as an area for focused learning across the social care teams.

6.4.67 It is important to note that children's social care have identified an interim improvement manager to lead on social care integration with education health and care plans in recognition of the correlation between social care issues and poor educational attendance. This individual has only been in post for six weeks and therefore it is too early to assess the effectiveness of their work and their role.

6.4.68 Children's social care undertook a whole file audit 11 months ago. They found there were elements of drift in 22% of the 180 cases where a plan was in place however this reduced from 32% in the first quarter to 11% in the final quarter. Drift continues to be an area of practice that children's social care considers. Children's social care record statutory visits, the majority of which take place within the required timescales. There is currently an issue with the visits being written up in a timely fashion.

6.4.69 As stated previously, invitations sent out for a core group in Staffordshire do not state what time the meeting will finish and this has led to confusion and professionals leaving before a core group has come to a conclusion because they have only allowed an hour but others have assumed it will be an hour and a half.

Recommendation Four

Staffordshire County Council amends the standard core group invitation letter to state how long to allow for the meeting

6.4.70 Children's social care audits have found that whilst the overall inclusion and assessment of risk and protective factors was felt to be strong the impact of these upon the child and their development was not seen consistently.

6.4.71 There is confusion in Staffordshire as to whether a core group should go ahead if the social worker is not present. Different professionals had different views. The current guidance which is set out in a document entitled "Section 3E Initial and Review Child Protection Conferences" states that the social care team manager should chair the initial meeting of the core group it does not specifically say that core groups have to be chaired by the social worker. There is inconsistency of practice across Staffordshire.

6.4.72 An area for improvement from a number of previous Staffordshire serious case reviews has been that social workers are not routinely sharing plans and other information with other professionals. Social care now monitors that information. In 2017/18 81% of cases audited had evidence of core group minutes being shared. In

2018/19 this had dropped to 50%. It is not clear why that is but the inference is there are more children on child protection plans and more children in care, so greater complexity of work for social workers, leading to more time pressures.

6.4.73 As part of the Improvement Plan children's social care have delivered training workshops to over 500 practitioners and managers in 2019, practice guidance has been developed and audit activity planned to focus on the quality of plans across services and teams for children and young people.

6.4.74 It is a challenge in Staffordshire where there is no particular trigger incident, where long-term neglect is a persistent feature with periods of improvement noted over time followed by periods of deterioration. This issue has been a feature in three recent serious case reviews in Staffordshire. Another area for improvement is senior managers' oversight of children subject to child protection plans for 12+ months requires a more detailed analysis of the impact of the effectiveness of the plan.

6.4.75 Capacity in social work teams is not sufficient to practice in a way that provides long-term, restorative interventions to families where long-term neglect is a feature.

6.4.76 Midlands Partnership Foundation Trust is a 0-19 service that provides public health services to all children and young people in Staffordshire. The 0-19 service has a targeted strengthening families team that work with children and families who are subject to child protection or child in need plans. The team will work with all families where there is an "identified health need". It is this sentence that is open to interpretation because all children have health needs. From Midlands Partnership Foundation Trust's perspective it might be that if another health professional is involved; for example a community paediatrician, physiotherapist or occupational therapist the expectation would be that they attend the child protection meetings and not the health visitor or school nurse. When the new contracts were agreed children' social care and others raised concerns about the gap this would leave because health visitors and school nurses used to be the conduit between all the health agencies and other agencies but that is no longer the case. One could argue though that all children on a child protection plan require monitoring by the health visitor/school nurse due to their vulnerability, particularly where there are concerns about neglect and therefore the health information from their assessments are crucial.

6.4.77 Across health agencies there is no lead professional. It would have been hugely beneficial in this case, as it would with every family, if there had been a health lead professional who had brought together all the information about missed appointments, developmental delay, not wearing glasses etc and the likely impact of all of that on the child's health and development.

6.4.78 There are four current serious case reviews in Staffordshire and all have found the same issues. There is also some evidence that in some cases neglect is clearly understood and professionals work well and children are protected.

Recommendation Five

Staffordshire Safeguarding Children Board creates a focus group to compare cases where neglect of children has been recognised and those children's lives have improved, as a result of effective multi-agency working, with the serious case reviews where neglect has been an issue. This should help the Board understand the difference in practice between the two

Additional comment

It will be important to compare like with like i.e. the circumstances of the children in the neglect serious case reviews – whether they were on a child protection plan, how long for, or any other type of plan, with similar cases where it can be evidenced there have been positive outcomes for children.

6.4.79 Is there any evidence this is a national issue?

6.4.80 In 2014 Ofsted published a report "In the child's time: professional responses to neglect".[8] It found that:

- One third of long-term cases were characterised by drift and delay, resulting in failure to protect children from continued neglect and poor planning in respect of their needs and future care.
- Almost half of assessments seen either did not take sufficient account of the family history or did not sufficiently convey or consider the impact of neglect on the child.
- The practice of engaging parents in child in need and child protection work was found to be a significant challenge to professionals.
- Parents are likely to have multiple and complex needs of their own and may be very demanding of social work time and attention.
- In those cases where children were not making positive progress, a common feature was parental lack of engagement.
- Social work professionals in particular must improve the quality of their engagement with, and assessment of families where children are neglected.
- The cumulative and pervasive impact of neglect on the development of children and their life chances has to be properly addressed if they are to be able to contribute to, and benefit from society as adults and future parents.

6.4.81 In their article published in Child Abuse Review Brandon et al refer to accidents with some elements of forewarning – accidents, both fatal and resulting in serious

[8]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419072/In_the_child_s_time-professional_responses_to_neglect.pdf

harm, in a context of chronic, long-term neglect and an unsafe environment. Their findings stated that “accidents are sudden, unexpected events without forewarning. For these children, there were a range of factors which meant that the incident, although not directly predictable, offered some element of forewarning. The most common accidents concerned fire or drowning, or less frequently accidental poisoning, burns or scalds. Although SCRs often concluded that the death was not predictable, they showed that the risk of accidental harm was high. There was a lack of urgency in the work with families. Thresholds for services were deemed not to be met, or assessments were delayed and poorly completed. Years could pass with children's safety remaining compromised. Moreover, professionals often tacitly accepted domestic conditions and a caregiving environment which were hazardous. Lack of an effective response, particularly where there was a child protection plan, may have increased risks to children, since agencies assumed that their concerns would be dealt with, when in reality there was poor liaison and no clear plan”.

6.4.82 There are a number of hypotheses as to why professionals do not see the urgency of neglect as a form of abuse. One of the reasons may be that neglect is rarely the primary and immediate cause of death, even though it is so prevalent in cases in serious case reviews. Another is the association between poverty and neglect. In 2016 the Joseph Rowntree Foundation published an evidence review into the links between poverty and childhood maltreatment. It concluded “There is a strong association between families’ socio-economic circumstances and the chances that their children will experience maltreatment. There is a gradient in the relationship between family socio-economic circumstances and rates of maltreatment across the whole of society; it is not a straightforward divide between families in poverty and those which are not. This finding mirrors evidence about inequities in child health and education. The greater the economic hardship, the greater the likelihood and severity of maltreatment”.

6.4.83 Evidence shows the people who neglect their children are very often facing adversities of their own. It is a common finding from serious case reviews that professionals have become too focussed on helping and supporting parents and have lost sight of the child and the impact of the maltreatment on the child.

6.4.84 A theory put forward in the Department for Education’s analysis of serious case reviews is one of cultural normalisation and professional desensitisation, which they talk about in the context of “needy families. “The sheer volume of needy families in an area was a frequent feature in reviews. This can mean that there is little to distinguish at-risk families from other families in the area. A danger that can arise in such situations is that of cultural normalisation and professional desensitisation. This may be a very appropriate coping mechanism by professionals overwhelmed by the volume and complexity of their task but can result in vulnerable children being left without adequate assessment of their needs”.

6.4.85 A very high number of serious case reviews feature neglect because it is extremely challenging to work with for all the reasons set out in this review. At what point do professionals in the community say enough is enough and make a referral

to children's social care and at what point does children's social care say enough is enough and go to the court? What is a common feature of families where there is chronic neglect of children is things getting better for a bit and then worse and then better and that is what makes it so hard to reach a cut-off point. Unfortunately, the cut-off point is too often when life-lasting damage has been done to that child through neglect.

6.4.86 A lack of professional curiosity and just accepting what parents say rather than looking at the evidence is a common finding from serious case reviews across the country. Professionals being too optimistic, children being invisible and agencies not working effectively together are also common findings. There are many different hypotheses as to why this is. In my view, having worked in this field for over 20 years and 11 years of doing serious case reviews, the pressure of workloads means that professionals can sometimes just skim the surface and have never really understood what motivates the parents and what is really going on in that family until it is too late and the serious case review is being done. Frontline professionals not only need to be equipped with the skills to understand risks, to assess and analyse risks and strengths in families, they also need to be given the time to work in a meaningful way with that family and with other agencies. Frontline professionals also need to be supervised effectively so that if those working directly with the family are too close to see what is going on the supervisor, with the benefit of distance, should be able to see when little or nothing is actually changing.

6.4.87 It is a common finding from serious case reviews that professionals have underestimated the impact of neglect as a form of abuse. Professionals are much more likely to respond to alleged physical and sexual abuse of children rather than the neglect of children. Findings from serious case reviews show that the perception is the threshold is much higher for neglect, whether that is a referral to children's social care or an application to the court and that one has to wait for something worse to happen before making a referral or submitting an application because only then will it be accepted.

6.4.88 It is a finding from other serious case reviews that professionals can focus too much on whether a parent has a learning difficulty because the changes are not happening, rather than consider what motivates that parent to behave as they do. There is often considerable evidence that the parent is able to function perfectly well in other areas of their life, thus highlighting that the issue is not some form of learning difficulty that renders them unable to make the changes required but that thas not been recognised and understood by professionals. The issue is the parents' motivation, or lack of motivation, but again, that has not been understood by professionals.

6.4.89 It is also a common finding that other agencies can struggle in their relationship with children's social care - the high turnover of staff, not being told what is happening, not being able to get hold of them and not receiving minutes of meetings. Whilst all of these things are very common it is important to be clear the finding is usually about the unrealistic demands put on social workers.

6.4.90 It is a common finding from serious case reviews that there can be numerous health professionals involved with one family, but no one is overseeing and coordinating that work. It is often a recommendation made to Local Safeguarding Children Boards that such an individual should be in place. The challenge is who that individual should be. The logical answer is the GP but the response from GPs is always that they cannot physically do this as well as everything else that they have to do and so nothing changes, and it continues to be a finding in serious case reviews across the country.

6.4.91 It is a common finding across the country that as public health has had to reorganise and restructure to cope with increasing demands alongside funding cuts this has had a significant impact on their working practice and in turn that is concerning for those working in child protection because of the pivotal role health visitors, in particular, used to play in terms of having eyes on the child and their level of knowledge and expertise. The importance of multi-agency working is recognised as being essential in terms of effective child protection practice and when any key agency is not able to be part of that because of increasing pressures that is a concern.

6.4.92 What would need to be done differently to prevent harm

6.4.93 Fundamentally professionals need to understand that neglect is as damaging, if not more damaging than other types of abuse and that injuries that come from accidents or lack of supervision can be just as damaging to children as non-accidental injuries.

6.4.94 Professionals also need to really understand the parents' position. When agencies talk about the parents' "capacity to change" what they usually mean by that is the mental capacity, but capacity is made up of two components, the mental capacity and the motivation. Motivation needs to be explored and understood equally.

6.4.95 Professionals need to keep focused on the children and whether their situation is improving and constantly question the effectiveness of any plan.

6.4.96 Notwithstanding some individual excellent relationships between social workers and other professionals if we are to improve the overall relationship between children's social care and other agencies and reduce the hostilities and frustration felt by other agencies then the system will have to change and social workers will have to be given the time to work more collaboratively with other agencies, to be more accessible to them, to be given time to write up minutes and circulate them and to generally be more available to other agencies. In my experience social workers want to work more collaboratively with other agencies and wish they were given the time to do so.

6.4.97 My view would be that if all professionals whatever their discipline started every single review meeting about a child with the questions 1. What has got better

for the child since we last met? 2. What has got worse for the child? 3. What has stayed the same for the child and is that good or bad? That would keep us focused on the child and whether they continue to be maltreated.

6.5 Finding Two – There can be a lack of understanding of the child's lived experience in Staffordshire

6.5.1 What happened in this case

6.5.2 The fundamental issue in this case was that although there was considerable evidence that the father provided most of the care in the home to the children professionals focused almost exclusively on the mother who was the more visible and louder parent; it was she who took the children to most of the appointments they did attend and always took the children to school/nursery, sometimes with the father too and she who did most of the talking to professionals. What also influenced the professionals was that the mother had parental responsibility for all of the children whereas the father only had it for Child Three, Child Four and Child Five and therefore professionals also tended to focus on the mother for that very reason.

6.5.3 It was the father who showed more understanding of star charts and their value and also one of the children commented how much they loved his cooking. It was the father who went into the school when Child Two was struggling and sat with him. The staff commented how good he was with Child Two and how he calmed and helped him. The father also calmed the mother down when she became heated. The child protection plan did not reflect the positive role the father played and the strength of that.

6.5.4 On one occasion the mother took her fifth child to the GP. He was dirty and sore around his groin. The mother told the GP she does not change nappies and had no nappies or cream with her. No one involved in this review has ever heard a mother say that, and indeed, she told the report author that both parents changed nappies. The mother had been seen by other professionals changing the children's nappies so it is unclear why she would say that.

6.5.5 Although during the serious case review process some of the frontline professionals did say the father had been the primary carer during the period they worked with the family no professional challenged other professionals about their erroneous focus on the mother. The issue for the professionals was that the mother was very domineering and even when they spoke to both parents the mother would always jump in and answer and the mother was always the one in control. If one was to reverse this – a domineering father who was not the primary carer in the home - professionals would have grave concerns.

6.5.6 The language of all the professionals was entirely mother-focused; always a variation of – "Mum didn't turn up for an assessment but sent Dad instead".

6.5.7 The words frontline professionals used to describe the mother were feisty, harsh, volatile and forthright, someone who could be frightening "when she got a look in her eye and could give you a real mouthful" whereas the father was described as gentle, mild-mannered, quiet and shy, who some professionals described as being overwhelmed by the mother. The mother attended all the meetings and often professionals were told that the father was not at the meetings because he was caring for the children. It was also the mother who took the children to all the health appointments they did attend, apart from one which they both attended. If this had been the other way round and the mother was seen to be gentle, shy and quiet and was clearly the primary carer of the children and the father was feisty and frightening and went to all the meetings and said the mother could not go because she was caring for the children that would never been accepted by professionals and it would have been seen as an abusive relationship with the man controlling the woman.

6.5.8 The mother made it very clear she did not like the health visitor or Social Worker Two – both of whom were expressing concerns about the children, although, interestingly, she told the report author that she did not like the health visitor, because the health visitor was saying the children were neglected, but she did like Social Worker Two when she recommended the children should no longer be on a child protection plan. It was with these professionals specifically that she more frequently cancelled or rearranged appointments. Again, the appointments were made with her and not with the father, who at the very least cared equally for the children. The focus was on the mother, rather than the children. She was controlling everything.

6.5.9 The focus of the professionals was very much on whether the mother had some sort of learning difficulty that was impeding her ability to make the changes required as part of the child protection plan. Children's social care had even agreed to fund a cognitive assessment, which is unusual in itself outside of legal proceedings because of the cost and unheard of in respect of funding a cognitive assessment of a parent who is not the primary carer. Yet because professionals were unable to imagine that the father was the primary carer this remained a constant of the child protection plan. As part of this review the educational psychologist explained that she was not in a position to accurately judge the mother's intellectual functioning based upon one meeting. However, in her opinion the mother presented as reasonably articulate with an adequate range of vocabulary to express her needs and views. She described her as appearing fatigued by her life and to show limited aspirations for her child. Other professionals described the father as having much better social skills and knowing social boundaries better than the mother. There is no evidence that there is any form of learning difficulty that would impede on a parent's ability to be a good enough parenting and if that is the case then a cognitive assessment is not relevant, unless there is a concern of a learning disability, which there definitely was not in this case. It is much more likely that because the mother did not accept her children were being neglected, she was not going to change how she parented them. She knew how to appease professionals, by saying the right things, but from her conversation with the report author, she would not have changed the way she parented her children because there was no problem with her she did it, in the first place.

6.5.10 To some extent the frontline professionals did have an understanding of the children's lived experience but one of the problems was they mistook love for nurture. A number of the professionals working with the family commented on the love they saw between the parents and their children but one mentioned that the mother had no affinity with the children. The relevance is not that a parent loves their child the relevance is what does that love look like, how does it manifest itself and is the parent willing or able to meet the child's needs?

6.5.11 When the police were called to the domestic incident on 4.3.17 the mother said the father had been threatening to take the children away. She said that during an altercation he had pushed her and threatened to stab her. There were no marks or injuries. The father was arrested. This led to a referral to children's social care and then a strategy discussion and the children becoming subject to child protection plans under the category of neglect.

6.5.12 None of the professionals who knew the family thought for a moment that the father might be a perpetrator of domestic abuse and some said that if either partner had been abusive it would have been much more likely to have been the mother not the father. None of the professionals picked up on the fact that the mother told the police the father had been threatening to take the children away and in fact this might have been because of the mother's behavior and he was being a protective parent. There is no doubt from talking to the professionals who knew the family well that it was the mother who was the controlling, feisty one although there is no suggestion, she was a perpetrator of domestic abuse. The mother also told the GP two days after the alleged incident that she was getting angry and shouting all the time at her partner for no reason. She told the GP re the incident of 4.3.17 she had accused her partner of things he did not do, and he had been arrested. This information was never shared with children's social care.

6.5.13 Just as a father being the more protective and nurturing parent when the mother is present, it seems the professionals were unable to conceive that maybe the father allegedly saying he was going to take the children away from their mother was him being protective. It was set in stone that he was a perpetrator of domestic abuse. One agency described as they handed over from one professional to another "a history of domestic abuse".

6.5.14 Another reason the professionals were challenged when considering the children's lived experience was because the mother was controlling the relationships that the entire family had with agencies. Child One was the only child whose speech was developed enough to have proper conversation with. During the period under review he was only seen once by the allocated social worker, which is concerning in itself. On that occasion he told her that his mother had told him that she, the social worker, would take him away from his family. He also said that he cared for his younger siblings and played on PlayStation games that were for adults. Later the parents said they did not let him play on his games anymore and again, that was just accepted without anyone testing out with Child One.

6.5.15 The professionals' focus was very much on the parents, and in particular the mother, rather than on the rights, wishes and feelings of the children. As has been stated elsewhere there is little evidence that anything got better for the children despite input by a considerable number of agencies, apart from the two children attending nursery.

6.5.16 The mother was constantly cancelling or changing appointments. On one occasion Child Four was not taken to his developmental assessment. The mother said she had gone to the wrong place but in fact it was on the day that Social Worker Two had arranged for child protection medicals for all of the children because of her concerns following an unannounced visit.

6.5.17 As stated in **Finding One** the mother's word for everything seems to have just be accepted and so how could the children's lived experience ever be understood if everything professionals were told was just accepted? Each of the mother's explanations for the numerous injuries were accepted even though on one occasion the mother admitted lying to Social Worker Two about the cause of one of the bruises. There should have been endless questions from professionals. Another example was the mother saying she did not change nappies, when she had five children under the age of eight, that should have been discussed with children's social care.

6.5.18 How likely is it this is a widespread issue in Staffordshire and not unique to this case?

6.5.19 The controlling nature of adults has been a theme of three current serious case reviews. This controlling behavior combined with an episodic approach to practice with the longer-term neglect cases can seriously undermine the voracity and rigour of social work interventions.

6.5.20 Staffordshire children's social care's new restorative practice model should support practitioners in working more effectively to affect positive change for children. Social care recognises the importance of any risk assessment and making sure that plans are focused, timely and impactful but this is very challenging work and they recognise there is lots of work to do.

6.5.21 Some professionals can allow the families to manipulate multi agency meetings, be that with passive or aggressive behavior, resulting in losing the focus of the child and the plan itself. That happened in this case and has been a feature in other families as well.

6.5.22 Staffordshire is currently rolling out the restorative model of social work. Part of this is to consider how social workers can use the time they have more effectively. The reality is they cannot create more time to work individually with children and so it has to be about using the time they have more creatively and focusing more on children.

6.5.23 Is there any evidence this is a national issue?

6.5.24 It is still very unusual for the primary care of children to be the father if the mother is equally present in the home and that probably explains why the professionals was so focused on the mother.

6.5.25 It is a common finding from serious case reviews nationally that professionals ignore fathers and do not make enough effort to work with fathers; the focus is almost always on the mother.

6.5.26 It is a common finding from serious case reviews that the child is invisible, that professionals focus on parents and lose sight of the child. Sometimes this is because of the issues the parents are dealing with themselves and sometimes it is because the parents are manipulative and controlling. This results in professionals being too focused on supporting parents rather than the analysis of risk to children.

6.5.27 It is a common feature of serious case reviews that parents have controlled events and the focus has been on the parents. It is drummed into professionals quite rightly that they should help and support parents but sometimes they go too far down that path and lose sight of the child.

6.5.28 The Department for Education's analysis of serious case reviews found that inadequate supervision is a common feature in serious case reviews and supervision has not always been effective and played the part it should, as part of the checks and balances that should protect children. If the frontline professional does not have the knowledge or experience to understand risks and protective factors it is for the supervisor to recognise that and take the appropriate action.

6.5.29 It is very common, and very understandable, that families being supported in the child protection arena prefer professionals who they perceive to be "on their side", who do not challenge their parenting.

6.5.30 What would need to be done differently to prevent harm

6.5.31 If children's social care is to change the way they work and focus much more on children than adults they need to be given the time and capacity to do that. Parents need to be seen too and building relationships with children takes time and social workers do not have time.

6.5.32 It will continue to be a feature of serious case reviews that the child was invisible, the focus was entirely on the parents, until social workers are given the time to spend with individual children. The more children there are in the family the less realistic it is to expect social workers to spend any time at all with individual children. This will not change until the systems change.

6.6 Finding Three – There can be a lack of understanding of the

importance of family history in Staffordshire

6.6.1 What happened in this case?

6.6.2 Professionals did not know much about the father's childhood, although the family support worker tried very hard to engage with him. He said he was brought up by his grandparents but never really spoke of his family. His mother, apparently, was a foster carer. No efforts were made to find out more about his childhood.

6.6.3 A number of professionals involved with the family knew the mother's extended family well, particularly the maternal grandmother and maternal aunt. Some had been involved with the family previously when Child One was little and he and his mother were living with the maternal grandmother and aunt. The family was very well known in the area and it was recognised that the mother's childhood had been neglectful in some ways; she said she had never been played with as a child. The mother and the aunt had not been stimulated or encouraged to thrive.

6.6.4 The mother would talk about her upbringing. She did not know how to play with her children. She would not go to mother and toddler groups because she thought people were judging her which is how she said the maternal aunt and the maternal grandmother felt too. The mother did not speak to her children and did not play with them and neither did the father.

6.6.5 Although it was recognised that the mother was repeating the childhood she herself had experienced that did not inform practice as it should have done and particularly because the family history was one of the reasons for the strategy discussion in June 2017.

6.6.6 How likely is it this is a widespread issue in Staffordshire and not unique to this case?

6.6.7 It has been a finding in a number of local serious case reviews that frontline professionals have not taken family history into consideration and professionals in Staffordshire have been unaware of the importance of family history and how it should inform practice.

6.6.8 For children's social care training in relation to chronologies, genograms and family history has been an integral part of the training syllabus for many years. This shows the importance that is placed on this as a foundation for assessments and on-going work with families. A recent review of 22 children becoming Looked After provided evidence that social workers and managers were taking patterns of behaviour from previous involvements into account in decision making.

6.6.9 For the educational psychology service advice for an Education, Health and Care Needs Assessment should include an analysis of information about relevant family history. This is a key component of initial training for teachers and educational psychologists. However, Staffordshire County Council has recently introduced an

electronic platform for the gathering and collation for professional advice from all partners, including educational psychology and social care. There is evidence that the format of the report required does not facilitate analysis or sharing of information on family history.

Recommendation Six

Staffordshire Safeguarding Children Board to write to the Child Safeguarding Practice Review Panel to propose the format of the statutory Education, Health and Care Needs Assessment is amended to include a section on family history

Recommendation Seven

Staffordshire Safeguarding Children Board to undertake an audit to assess whether all agencies include the importance of family history in single and multi-agency training and that family history is mentioned in all relevant templates and is discussed in supervision. Once the findings come back Staffordshire Safeguarding Children Board creates a focus group to consider the findings, what the stumbling blocks are and how practice can be improved

6.6.10 Is there any evidence this is a national issue?

6.6.11 It is a common finding from serious case reviews nationally that family history is overlooked. There are a number of reasons for this. First of all because of a lack of understanding of the cycle of abuse, the impact of adverse childhood experiences in the parents' own childhood or curiosity about how parents cope with adversity and the challenges of life. Secondly computer systems change and then fewer and fewer people in the organization can access the previous system, and even less the system before that. That combined with a high turnover of staff, particularly in children's social care, means that vital history can be lost.

6.6.12 As stated previously, in 2014 Ofsted found "Almost half of assessments seen either did not take sufficient account of the family history or did not sufficiently convey or consider the impact of neglect on the child".

6.6.13 **What would need to be done differently to prevent harm**

6.6.14 In order for all professionals to understand the importance of family history it should be highlighted in all training for all professionals working with children that family history is vital and should be part of any assessment. It should also be in all templates so that professionals are reminded of its importance. It should also be mentioned in supervision sessions, to remind professionals of the importance, if it is missing and should be one of the constants that professionals know is essential to consider.