Lambeth Safeguarding Children Board

Serious Case Review

Child I

Agreed by the Lambeth Safeguarding Children Board
October 2014

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It was not possible to publish the report before April 2015,
until the conclusion of Police and Crown Prosecution enquiries.

1. Introduction

Why this case was chosen to be reviewed

Child I died on 23rd July 2013. The circumstances of his death were considered at a meeting of the Lambeth Serious Case Review Subcommittee where it was agreed that the criteria, outlined in statutory guidance[1] for undertaking a serious case review, had been met.

Lambeth Safeguarding Children Board decided to review this case using The Social Care Institute for Excellence, Learning Together Case Review methodology.

Methodology and Process of Review

This case has been reviewed using a systems approach, the focus of this approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

The data is gathered from a variety of sources, including review of existing documentation alongside data provided by front line practitioners and their managers, who had involvement in the case during the time line under review. Within this report, these professionals are referred to as '*The Case Group'*.

The review is completed by a team of senior managers, who did not have line management responsibility for the case, led by two independent lead reviewers[2]. Together, they make up *The Review Team.*

The data, gathered during the course of this review, the analysis and findings, are the subject of scrutiny by the Review Team. Recurrent cycles of feedback and amendment, by the Case Group and Review Team, are inherent features of case reviews, using this methodology.

A critical aspect of a review, using this methodology, is the perspective of family members. The perspectives of both mother and father are reflected within this report.

Details of the **methodology, data sources** and **structure of the review process,** are outlined in **Appendix 1.**

[1] Working Together to Safeguard Children : HMG 2013

[2] Accredited as Lead Reviewers by the Social Care Institute of Excellence (SCIE)

Succinct summary of the case[3]

Child I was born in November 2011 to white British parents living in Lambeth. Child I had two older sisters, a younger brother and a large maternal family, all of whom lived in Lambeth. His childhood was spent living at home with his mother and father and his siblings; he was described as a "happy bonnie" child.

Both parents had been known to professionals, from various services, since their childhood. In his teenage years, father had been assessed as having a learning disability. Mother was also thought to have learning difficulties, she had been the subject of a statement of special educational needs (SEN), as a child.

Child I, was the 3rd of their 4 children. He was aged 1 year and 8 months when he died. At the time of his death, both parents were in their mid-twenties, his eldest sister was 6, his second sister was 3, and his younger brother was 9 months old.

Prior to the birth of the second child in the family (Sibling 2), in April 2010, an assessment using the Common Assessment Framework (CAF) was completed. This led to the allocation of an early intervention social worker. The family were assessed as being vulnerable and isolated and there were concerns about parenting capacity, and domestic violence/anger management. There was regular input from the Early Intervention Multi-Agency Team (MAT) and a number of services were provided to the family during this time.

In August 2011, Sibling 1 was found to have an injury to her eye and was referred to Children's Social Care. A child protection investigation commenced. In November 2011, Child I was born. The child protection investigation, into the injury to Sibling 1, resulted in an initial child protection conference, on 18 November 2011 all three children were made the subject of child protection plans, under the category of neglect. They remained the subject of child protection plans, until July 2013, when I died. A wide variety of services were provided. These services supported the parents in their care of their children.

The birth of the fourth child, the youngest child in the family, in September 2012, was a challenging time for the family.

On the morning of 23 July 2013, mother left the house to take their eldest child to school. On her return, she found Child I in the bath face down. Attempts made to resuscitate Child I, were not successful. He was pronounced dead on arrival at hospital. Although the exact circumstances of Child I's death were not clear, and were subject to on-going police investigations, the pathologist concluded that Child I's death was consistent with drowning. Mother reported that she placed Child I in the bath that morning, advising father that she had done so, before leaving the house to take the eldest child to school.

The three remaining siblings were removed using police protection powers, and were placed in foster care.

[3] Some of this information precedes the start of the time line for this review, but the Review Team felt it important background information to include in order to assist the reader in giving an understanding of the broader context, and in shedding light on practice within the timeline of this review.

Family Composition

Family member	**Age in July 2013**
Father	24
Mother	26
Sibling 1	6
Sibling 2	3
Child I	Aged 1 year 8 months at time of death.
Sibling 3	9 months
Ethnic Identity	White British

Local Context

Child I and his family were receiving services from across a wide range of agencies and services in Lambeth, including services provided by the Community and Voluntary Sector. A conservative estimate, of the professionals, staff members and their managers involved, numbered over 40 individuals.

During the time line under review, Lambeth was experiencing a significant increase in the demand for services. In April 2010, Lambeth had 210 children with child protection plans. By April 2013, this had risen to 320. A Public Health-commissioned report looked at reasons for the rise and could draw no firm conclusions, but audits showed that these extra children definitely needed statutory protection.

This significant increase, in numbers of children requiring statutory protection, had clear resource implications for all services in Lambeth. The increase in numbers of children subject to child protection plans, placed a number of additional pressures on all services and agencies .This included additional demands placed on the administration requirements, inherent within agency systems regarding children who are the subject of child protection plans, and on the increased demands placed on professionals in their day to day work.

In terms of the Children and Young Peoples Service, additional capacity was put in place to ensure that caseloads remained appropriate and management was strengthened. However, earlier in 2013, staffing fell away considerably within the Social Work Team providing services to Child I. These issues are discussed in the latter part of this report.

2. The Findings

What light has this case review shed on the reliability of our systems to keep children safe?

A case review plays an important part in efforts to achieve a safer child protection system. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies in the child protection system. Using the Social Care Institute for Excellence (SCIE) Learning Together methodology, the particular case acts as a 'window on the system'[4].

For this to happen, the outcome of the review has to say more than what happened in this particular case and needs to provide messages to the Local Safeguarding Children Board (LSCB) about usual practice and normal patterns of working. These messages are presented as 'findings', and provide the LSCB with an insight into the underlying patterns that influence professional practice, and outcomes for children.

By responding positively to the findings, the LSCB has the opportunity to change how the child protection system operates, and to make it safer. It makes sense, therefore, to prioritise the findings to identify those that need to be tackled most urgently, for the benefit of children and families, even though these may not be the issues that appeared most critical in the context of this particular case. In order to help with the identification and prioritisation of findings, the systems model that SCIE has developed includes six broad categories of these underlying patterns. The ordering of these is not fixed and will change according to which issues are felt to be most fundamental for systemic change.

The categorisation of findings is as follows:

- Tools
- Family-professional interactions
- Management systems
- Patterns of multi-agency working in response to incidents/crises
- Patterns of multi-agency working in longer-term work
- Innate human biases (cognitive and emotional biases)

The findings from each category convey a message to the LSCB about how that element of the child protection system was working, at the time of Child I's death. They state succinctly what is, or was problematic, about the system, and are therefore helpful to the reader. It is not uncommon for there to be overlap between the categories of findings.

[4] C. Vincent : Analysis of clinical incidents: a window on the system not a search for root causes 2004

In what way does this case provide a useful window into our systems?

At the start of this Serious Case Review (SCR), Lambeth Safeguarding Children Board (LSCB) identified that this tragic case held the potential to shed light on particular areas of practice, and asked the Review Team to examine the following issues, within the course of the review:

- How effectively do local agencies work with families where the parents have learning difficulties and there is evidence of neglectful parenting?
- How do we equip practitioners to work with neglectful parents?
- How can we effectively monitor children subject to a CP plan for neglect?
- How can we link safeguarding risks to children from neglect to key stages in their development?
- How can we effectively support parents with young children where there is evidence of neglect?
- What is the availability of specialist workers/advisers? If available, are they well used?
- How is professional challenge raised and resolved?
- How are written agreements used to protect children?
- How were the needs of the children individually assessed, and their voices reflected?
- What was the nature of the neglect? Was it neglect by omission or commission?

We have aimed to address these issues in the remainder of this report. A definitive answer to the final question is not provided, as this remained the subject of criminal investigation throughout the review. The result of those enquiries, which have now concluded, is that no one has been charged with any offence as a result of I's death.

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Taken as a whole, this case illustrates the complexities that professionals face in their efforts to safeguard children in situations where the parents of young children have learning difficulties, and there is evidence of neglectful parenting. Many of the issues highlighted here, in relation to neglect, are not new. There is a significant body of research[5] about the difficulties faced by professionals in supporting families and safeguarding children in cases of neglect, where change is not easily achievable, and support needs to continue over a prolonged period. However, as identified by Gardner[6], integration of this literature, and research findings, into front line services remains patchy.

[5] Brandon et al : Neglect and Serious Case Reviews 2013

[6] Ruth Gardner et al : Developing an effective response to neglect and emotional harm to children 2008

This case also has the potential to highlight the effectiveness of the local response to parents with learning difficulties, which can present additional challenges to the multi-agency group. Evidence of these challenges can also be found in the research literature. For example, Cleaver and Nicholson note:

> *"While there is no association between learning difficulties and willful neglect there is considerable evidence to suggest children suffer neglect by omission as a result of a lack of parental education combined with the unavailability of supportive services*".
>
> Children's needs: parenting capacity: Cleaver & Nicholson et al 2011

Specifically, this case involves a number of challenges which safeguarding agencies, working in Lambeth and nationally, encounter regularly, in the following common areas of practice:

- Assessing and intervening in cases of neglect
- Working with parents who have learning difficulties
- Multi-agency safeguarding work when children are the subject of a child protection plan
- Multi-agency ownership, accountability, debate and challenge, and the pivotal roles of supervision and management oversight
- Working with families where care givers are openly hostile and intimidating towards profession

Appraisal of professional practice in this case – a synopsis

This appraisal of practice sets out the view of the Review Team about how timely and effective the interventions with Child I and his family were, including where practice fell below expected standards. Where possible, it provides explanations for this practice, or indicates where this will be discussed more fully in the findings.

Overview

The parents in this family had been known to services since childhood. This appraisal of practice is focused on the period under review (May 2010 - July 2013).

In a number of ways, this case illustrates the impressive range of services that are available to children and families in Lambeth. Practitioners made use of the resources available, and a number of services provided were of a good quality. Many practitioners, across these services, demonstrated a heartfelt desire to improve the outcomes for the children in this family, and provided services where tangible improvements for each child was evidenced. Practitioners also clearly cared for, and wanted to support, two young vulnerable parents.

There were also a number of instances of good practice in this case that were identified during the course of this review. Examples included:

- Good initial core assessment and child protection medicals.
- Persistent attempts to appreciate the emotional needs of the parents.
- Valiant efforts by practitioners to communicate with family members, who were at times hostile and aggressive.
- High levels of intervention by agencies/service providers to respond to, and manage, the high levels of need in the family.
- Commitment to engage the parents, with particular reference to the work of a youth worker in providing advocacy at the point early intervention services were involved.

However, when taken as a whole, it can be seen that practitioners were, at times, working in isolation- working hard to improve outcomes for each separate part of the family system. Practitioners struggled to balance their support for the parents, with a focus on the needs of the children. Over the period under review, there were few changes in the parenting received by the children, or the neglect they suffered.

The remainder of this section explores in detail the response of professionals to the family, falling into a number of distinct areas of practice over a total period of three years and three months.

Phase 1 – Early intervention: May 2010-November 2011.

Prior to the birth of Sibling 1 in 2007, services were provided to mother and father, including services provided by the CYPS Leaving Care Team and services provided by Youth Support Services. Following Sibling 1's birth a number of multi-agency services were involved with the family. In May 2010,after a decision was made that the family required services at a higher threshold if intervention, additional services were provided through the Multi-Agency Team (MAT)[7].These services were aimed at addressing parental isolation, assisting with parenting, providing assistance with daily living tasks/household management and managing paternal anger. Both parents were recognised as having learning difficulties. Father was known to have experienced a troubled childhood, characterised by loss, separation, abuse, and a troubled life in the care of the Local Authority. The behaviour of both mother and father frequently evidenced their feelings of anger and hostility. In this early period, whilst there were early signs of co-operation from mother, father was openly hostile and resistant to interventions.

[7] MAT meetings previously known as Team Around the Child Meetings are the main vehicle in the Early intervention phase for a range of professionals working with the family to come together to share information in the CAF and in other assessments, assess risks, identify interventions to support the family and draw together an action plan.

This period of early intervention provided a pivotal opportunity to understand parenting capacity, and to make a judgement of future capacity. The Common Assessment Framework (CAF) was used as the main assessment tool, and as the referral tool to the Multi-Agency Early Intervention Team (MAT), to access 'family support' services. An early intervention social worker was appropriately allocated to the family. A number of services were provided and meetings were held. However, these meetings were inconsistent and did not include all the services working with the family. This inhibited both information sharing, and discussion of risk. An emphasis on unmet needs, rather than risks, in these interventions and meetings, resulted in assessments characterised by narrative accounts of family functioning, and meetings that focussed on the provision of more services, not on the risks posed to the children. The reason for this focus was not entirely clear, although from data gathered it appeared these services fulfilled what they regarded to be their remit: of identifying unmet needs, and providing services to meet these needs. Their role in relation to the assessment of risk, was less clear.

The childhood history of the parents, and their resulting unmet emotional needs, the lack of sustained change in the parenting of the children, and the evidence of risks to the children, were not sufficiently recognised as indicators of harm, or potential areas of harm. This appears to have been partly due to the difficulty that professionals had in gathering, and articulating, the cumulative impact of the children's experiences, and 'naming' this as neglect. This was compounded by the limited membership of the MAT meeting. This restricted membership limited the amount of information shared, and led to opportunities for multi-agency challenge being missed – this resulted in an overly optimistic view about the parent's ability to provide care to the children in the future. **This is explored further in Finding 1**

Two weeks prior to the injury to Sibling 1 in August 2011, the Early Intervention Social Worker from the Multi-Agency Team (MAT) was preparing to close the case. There was no plan for future involvement, by the multi-agency team (MAT) or from specialist services, at this point. These decisions were made on the basis that the family did not meet the threshold for intervention at either the MAT threshold, or at a higher level of service provision. The decision was not challenged by managers, within this service, or by multi-agency partners. **The issue of multi-agency ownership is explored further in Finding 2.**

Phase 2- Professional response following injury to Sibling 1: August 2011 - November 2011

In August 2011, Sibling 1 was observed to have bruising to her eye and this was referred to the Children and Young People's Service. The initial investigation and core assessment were good. There was good partnership working between the respective agencies. A child protection medical was held promptly and the core assessment, completed by the Social Worker, was of a high standard. There was a delay in the timing of the Initial Child Protection Case Conference (ICPCC). It is unclear what led to this delay. Delaying child protection conferences increases risks to children and is contrary to procedural guidance[8].

It is the view of the Review Team that information, shared at the ICPCC, suggested that the short and long term risks to the children were sufficient to progress to a more robust level of intervention, and that a decision should have been taken to seek legal advice. Pursuing this course of action would have set a clearer framework, and timeframe, within in which services could have been provided. In the event, legal advice did not form part of the child protection plan- this falls below best practice standards**.** The Review Team explored the reasons why legal advice was not sought, either when the social work

[8] The London Child Protection Procedures: 2010

manager signed off the core assessment, or at the ICPCC. It was not possible to ascertain a definitive reason for this. **This is discussed further in Finding 2.**

Phase 3 – Longer term work with the family November 2011-December 2012

- ***Functioning of child protection conferences and core groups.***[9]

The children in the family were the subject of child protection plans from Child I's birth, in November 2011, until Child I's death, in July 2013. Although child protection conferences and core group meetings were generally held within required timeframes, there were no separate pre-birth assessments, or conferences, held on the new infants. Instead, discussions about risk to Child I and Sibling 3 took place alongside the discussions on risk to the other children in the family. This had a detrimental impact on the planning for all the children – the specific needs of the new infants were not considered, nor the critical nature of the increased risks posed by the growth of the family – this was contrary to procedures.

The plans and the membership of the conferences and core group meetings remained largely constant from the Initial Child Protection Case Conference (ICPCC), and throughout the period the children were the subject of child protection plans. This was despite the changing circumstances in the family that included the birth of a fourth child (Sibling 3), and a number of incidents of harm to the children. Multi-agency staff, providing services to Child I and to siblings 2 and 3, were largely unrepresented. Key professionals, who could have provided first-hand accounts of their work with the family, either did not attend, sent a substitute or were not invited. This restricted the range and quality of information shared, and led to plans that did not respond adequately to changes within the family. **The reasons for this are discussed further in Finding 4.**

Professionals involved at this time felt Mother was doing her best to care for the children. She was noted to make efforts to keep the house in a reasonable state of cleanliness and order, to have sufficient food in the house, to ensure the children attended school and children's centres, and kept various appointments. Professionals noted many occasions, when both mother and father showed their love and affection for their children. However, the onus of professional intervention was disproportionately slanted towards the provision of more and more support services. Critical aspects of plans, made at the child protection conferences aimed at protecting the children from harm, were not implemented in a number of areas.

For example, child protection conferences repeatedly made recommendations for a specialist parenting assessment, and there appeared to be a view within the group that an adequate response could not be provided to the family until this assessment had been conducted. Requests to fund this assessment were declined. In the absence of this assessment, the multi-agency team became 'stuck'. There were opportunities to challenge the position that had been reached, but these opportunities were not utilized. The conference chair, the multi-agency team and their respective managers, neither effectively challenged this lack of 'specialist assessment', nor made a decision to move on without it. A state of

[9] Core Groups are the multi-agency team who have responsibility for implementing the child protection plan. The Case Group, referred to in this report, is made up of all front line practitioners who had involvement with the family, only a small number of these professionals were members of the Core Group.

'stalemate' persisted for a significant period of time. **The functioning of core groups and child protection conferences, and the lack of challenge of decisions, is explored further in Findings 2 and 4.**

- ***Assessment of neglect and response***

During the review period, difficulties in understanding the concept of neglect manifested in a number of ways, across the multi-agency network. This included difficulties in:

- Understanding what neglect meant to professionals representing different expertise/specialisms.
- Articulating and framing professional observations/concerns, in a way that supported the assessment of risk.
- Little consideration of the cumulative impact of neglect.
- Lack of decisive action in response to concerns.
- A tolerance of drift.

The children's delayed development was indicative of neglect, there was evidence of:

- Unmet emotional needs in the eldest children.
- Lack of supervision of all the children, leading to a number of injuries.
- Lack of proper care of the children's medical needs.
- Developmental delay seen in all the children.
- A home environment where conflict and anger was present.

Overall, professional interventions were characterised by a superficial response to the presenting issues. The needs of the parents and the children were viewed in isolation, and services were provided to address each of the presenting needs. These presenting issues/needs were symptomatic of neglect, yet whilst many of the interventions dealt with the symptoms, the whole picture was not brought together by any of the agencies, either individually or collectively.

None of the services effectively dealt with what was driving the neglect, or put another way, the causes of neglect. Judgments about progress were predicated on mother's ability to access the services offered, and the children's response to the services. These judgments were made on the basis of the 'here and now' evidence, not on the overall picture. This resulted in a pattern of interventions and service provision which lacked an overall coherence. This had a direct impact on the way in which the parents understood what they needed to do, to bring about meaningful change in the parenting of the children.

In cases of neglect, where children are suffering significant harm, the assessment of risk is highly complex. To address this, the cumulative picture must be viewed, the drivers and causes of the neglect must be identified and the impact on the individual children scrutinized. Only when this happens, can effective decisions be made. It was the view of the Review Team that, had information been effectively shared and analyzed within a suitable neglect framework, there was sufficient knowledge within the multi-agency group, to obtain a clear picture of parenting capacity, and of the consequent need to place the case within legal proceedings. The absence of support provided through the use of appropriate assessment frameworks/guidance/tools inhibited professionals in their work. **The underlying difficulties in conceptualizing and assessing neglect are explored further in Finding 1.**

- ***Ownership***

The data gathered in this review suggested that various professionals rarely offered an opinion, in a way that influenced how risk was assessed or how safeguarding decisions were made. Interagency work was marked by an absence of professionals taking responsibility to ensure their professional observations, and opinions, were given due weight in influencing the safeguarding of the children. During the course of this SCR professionals spoke about the risks to the children, but there were inconsistencies in how this was recorded in the case records, and in discussions at the child protection conferences, core group meetings and in the child protection (s47) investigations. It was the view of the Review Team, this indicated a reluctance to take full ownership of the decision making in relation to risk. This led to risk assessment, and decisions made in response to evidence of risk, being incident driven and left largely in the hands of the social worker and case conference chair. **This is explored further in Findings 2 and 5.**

- ***Supervision and challenge***

The workings of the multi-agency team lacked effective management, leadership and supervision. This was replicated across each of the agencies represented. There was little data to suggest that a significant number of key professionals, from across the multi-agency group, received effective supervision. There was no evidence found to suggest that an overview of the work was provided, within or across the different agencies. Instead, each agency proceeded along their own individual path.

Opportunities to take an overview are provided within existing processes, such as through supervision and multi-agency meetings. Case conferences are chaired by a members of staff who do not provide line management to the multi-agency group. They are well placed to facilitate how the multi-agency group view the 'bigger picture', but this did not happen in this case. Managers in the Children and Young People's Service were noted to provide comment on the case, but provided no challenge to the status quo. An existing multi-agency Lambeth Safeguarding Children Board protocol that outlines the need to work jointly with adult services to safeguard children, where parents have learning difficulties, was not followed. The lack of compliance, with this protocol, was not questioned. There was no evidence to suggest that any system or process had been put in place, to facilitate compliance with this protocol.

A protocol in place in the CYPS, which ensures senior management review of children who are the subject of child protection plans for eighteen months, was initiated but was not concluded. Hence, an opportunity for senior management overview, at this critical juncture, was missed. The Review Team established the reason this protocol was not followed was due to a decision to change this protocol, at the time this case was referred for senior management review. This resulted in a vacuum, in which no additional oversight of the case was provided.

There was a persistent absence of effective challenge by safeguarding partners. This absence of respective multi-agency systems fulfilling their responsibilities, to provide intra and inter-agency scrutiny and challenge, played a significant part in the way in which the case drifted**. This is explored further in Findings 2, 4 and 5.**

- ***Provision of services***

There is an excellent range of family support services available in Lambeth. The wide range of services provided to the family included specialist health visiting, a community outreach worker, home start, a number of services from two children's centers, enhanced midwifery support, a health early intervention worker, and enhanced support from a school. Many of these services were excellent in addressing the individual developmental needs of the children. It was clear to the Review Team that, overall, the quality of many services is of a high standard. In addition, there were many examples of excellent professional practice, and a clear dedication to meeting the children's needs.

However, viewed holistically, and with the benefit of hindsight, it was clear to the Review Team that, overall, the multi-agency provision was confused. Many services did not know that another service was involved, and a number of services were duplicated. There were assumptions made about the nature of the services being provided- this left gaps in service provision. This was particularly noted in relation to the absence of any coherent multi-agency plan/action to prevent accidents within the home. **This is explored further in Finding 2.**

- ***Balancing the needs of the parents with risks to the children***

Throughout the period under review, both parents were frequently observed to be hostile and aggressive, and, in a number of areas, resistant to change. Many professionals worked very hard to engage the parents, in order to access the family home, or to ensure the children received services outside the family home. Observations of parental behaviour were described, but not analysed or articulated explicitly in a way that contributed to a professional opinion of risk. The emotional needs of the parents dominated much of the work of the multi-agency group. Parental behavior frequently disrupted the functioning of meetings and the implementation of plans. When challenged, father would often become verbally abusive and threatening, particularly to a number of social workers. This meant that social workers often felt unable to challenge his behaviour for fear of reprisal, and worked hard to engage with father and to avert his rage. These emotional needs of the parents eclipsed the needs of the children- this was not sufficiently recognised or acted upon. **This is discussed further in Finding 6**

- ***Hearing the voice of the child***

During the course of this review it was difficult to gain a picture of Child I and his siblings. Their personalities, their likes and dislikes and their relationships, were largely unrepresented in the data gathered. There were good attempts by social workers to work directly with Sibling 1, in order to elicit her voice. However, during this work, Sibling 1 was found to be reticent. There was information available to suggest that Sibling 1 was silenced by the actions and words of her parents, but this was given insufficient attention.

Due to the age, and communication needs, of the other children in the family, direct work to elicit their voices through the spoken word was not possible. There was a range of information available that should have enabled professionals to interpret the children's voices. Observations, detailed in social work reports, revealed the children would seem 'oblivious' to the anger and hostility of the parents, and

maternal family members, and to exist 'as if they were in their own bubble'. These were good examples of the children being observed at home that provided opportunities to gain important insights into their worlds. Other professionals noted their observations during parent-child interaction, or through what they saw displayed in the children's behaviour, but few saw the world through the child's eyes. This left the voices of the children unrepresented in the evaluation of risk, and in the provision of services. **This is explored further in findings 3 and 6.**

- ***Compliance with procedures***

The four children in the family were suffering from harm associated with neglectful parenting. However, professional practice showed a seemingly contradictory pattern in which professionals placed significant emphasis on investigating and 'proving' some physical injuries, at the expense of considering numerous other indicators of neglect. There were a number of bruises observed on the children, and a number of concerns were identified that provided medical evidence of neglect. There were two occasions when concerns were investigated (under s47 of the Children Act 1989), triggered by concerns about physical injury to the children. However, there were also occasions when concerns were not the subject of multi-agency investigation under the required procedural framework[10]. These concerns included the significant weight loss experienced by Sibling 3, a significant finger injury to Sibling 3, a burn on Sibling 1, and bruises seen on Sibling 2 and Child I. The lack of investigation of these concerns meant that information about the injuries either was not shared, or, when it *was* shared, it was not given sufficient weight in the consideration of risk. **This is discussed further in findings 2 and 5.**

- ***Balancing risks and strengths***

The child protection conferences, and the assessments of the family, identified the strengths in the family. This is expected safeguarding practice. However, in this case perceived strengths were given undue weight in comparison to risks. Considerable emphasis was placed on the support provided by members of the extended (maternal) family, and this support was cited as a strength throughout the period of time the children were the subject of child protection plans. There was sufficient information available to suggest these strengths offered false reassurances, and posed additional risks to the children. This was not fully acknowledged, or understood, by the multi-agency group. **This is explored further in the additional learning.**

- ***Parental learning difficulties***

The learning difficulties of the parents were "obvious" to the multi-agency group. These difficulties were not sufficiently understood in order to inform risk assessment and service provision. Father had been assessed by the Children's Looked after Mental Health Service (CLAMHS) as a teenager, when it was concluded he was functioning at half his chronological age. In terms of his future, the assessment concluded: *"we would not expect him to ever manage his daily tasks fully independently"*. Mother's presentation suggested to professionals that she had a learning difficulty, and it was understood that

[10] The London Child Protection Procedures 2010

she had been the subject of a statement of special educational needs (SEN), when at school.

On many occasions, father was observed to be in the sole care of the children at home. Practitioners believed, and on occasions observed that, whilst they were in his care, he did not provide adequate supervision to the children. He was often pre-occupied with loud and violent video games, and seemed 'oblivious' to the children's emotional needs. Father rarely engaged with the services provided to the children, he did not adequately feature in assessments, aimed at understanding parental roles, or in plans and services put in place to improve parental capacity.

When assessing the care the children were being provided with, and when targeting interventions, the assumed learning difficulties of the parents were responded to sympathetically. However, the way in which these difficulties impacted on the parenting of the children was not given sufficient attention. There was no consideration given to obtaining learning disability support services for the parents in their own right.

The existing Lambeth Safeguarding Children Board protocol (September 2010), is very clear about the joint work that is required between adults and children's services. Namely, that individuals who have a learning difficulty and are parents are entitled to a services from Adult Social Care learning disability services, and should be referred by children's services. This protocol was not followed, and the need to make a referral to, and work with, adults' services was not identified by any members of the multi-agency group, or their managers. Failure to follow the required protocol had the effect of silencing the voices of both the parents and the children. Written agreements, minutes and assessments, neither took proper account of parental learning difficulties, nor provided this documentation in a form that would have permitted parental understanding. The experiences of the parents, in being involved in the complexities of the child protection processes, were not understood, and as a result the support provided to the parents in these processes, whilst well-meaning, was ill-informed. The needs and experiences of the children, living with parents who had learning difficulties, were unknown. **This is explored further in Finding 3.**

- ***Written agreements***

Written agreements were used in response to safeguarding concerns, to supplement the protection planning. These written agreements were put in place in order to provide the Local Authority with parental assurances that the maternal grandfather would be supervised in his contact with the children, and that the maternal grandmother would stay with the family to support the early care of Child I. These agreements were not shared with a significant number of multi-agency group members. Both agreements were immediately, and consistently, breached by the parents. There was no action taken in response to these breaches, and the written agreements remained unchanged. At best these agreements were benign: they provided no added protection to the children. At worst, they served to undermine the protection of the children by providing a false sense of security. **This is explored further in Finding 7.**

Phase 4- Professional response to Sibling 3's 'failure to thrive': December 2012 - May 2013

Minutes from the child protection conferences, recordings on file, and reports from the Case Group, suggested there were a number of assumptions made by the multi-agency group. These assumptions were not adequately articulated or assessed. A number of these were held onto, regardless of information available to suggest the assumptions were based on a false premise. This included an assumption that the children's basic care needs were being met.

There were times when the parents were not able to meet the children's basic care needs. When Sibling 3 was seen by the family GP for his 8 week developmental check, he was found to have lost weight and was below his birth weight. The GP, and members of the child protection conference, assumed that his weight was being measured, and plotted, by health professionals in the community. This was a reasonable, but incorrect, assumption. Proper management of Sibling 3's weight did not happen, and fell short of expected standards.[11]

Medical investigation concluded there was no medical reason for this loss of weight. Implicit in this conclusion, and in the actions taken by the GP, was that Sibling 3 was not being fed an adequate amount of milk. The loss of weight was reported to Children's Social Care (CSC), but there was no multi-agency child protection response to this incident.

Members of the Review Team expressed significant concern about this loss of weight, and the potential dangers to Sibling 3. It was the view of the Review Team this was evidence that the neglectful parenting, Sibling 3 was receiving, could have serious consequences.

This critical safeguarding incident should have led to an immediate investigation under s47, a strategy meeting and, in the view of the Review Team, Sibling 3 should have been the subject of urgent paediatric review in hospital. This would have allowed a more thorough health assessment to identify underlying causes, and a more robust multiagency review of the neglect threshold. Instead, there was no s47 investigation and no strategy meeting. The child protection plan remained unchanged. **This is explored further in Finding 5.**

At a Review Child Protection Case Conference (RCPCC), in May 2013, a recommendation was made to seek legal advice, with the view to place the case within legal proceedings. This recommendation was not made in response to Sibling 3's failure to thrive, it was made in order to achieve funding for a specialist assessment. The recommendation was not acted upon with sufficient speed, and the case continued along the same path. **This is explored further in Finding 2 and in the Additional Learning.**

Family Perspectives

The perspectives of Child I's parents were gained during a meeting involving the Lead Reviewers, both mother and father were present. The purpose of the meeting was to gain an understanding of parental experiences. This was not an investigatory interview, in that it was not an opportunity to establish fact or to challenge parental perspectives. The meeting was held in an attempt to understand how mother and father experienced the services that were provided, and to see this period of time through their eyes. The following is a summary of this meeting:

[11] The Review Team attempted to understand what lay behind the reason Sibling 3's weight was not the subject of required monitoring standards. A definitive reason could not be established.

At the start of the meeting, both Mother and Father reported that they did not understand what they needed to do to change the way in which they provided care to their children. Mother: *"I just did not know what I was supposed to be doing".* This remained a theme throughout the meeting.

When Mother was asked how professionals viewed father's role in the family, she replied: *"Social Services wanted me to leave father with the kids more often…….. That was their solution to make him do more".* Mother went on to describe the parenting routines within the household that included the different responsibilities for bathing the children: "(*Name of father) would bath the boys and I would bath the girls….. (Name of father) would help the girls to put on their pyjamas after their bath".* The range of information, provided by the parents, suggested that the role of father, in the parenting of the children, had been critical in a family where there were 4 small children.

The parents spoke about not getting the help they needed and of feeling let down by the agencies, and a number of professionals, providing support to them. When asked what support they felt they had needed, mother talked about needing help with the children's routines and with parenting skills. She spoke about waiting for support from an organization (which she named), but said that this had not been provided. She spoke about the kind of support she would have received at home, had the funding for this help been agreed.

Whilst the parents were positive about a number of professionals, they felt angered and frustrated by others. When mother was asked about the things she would have wanted to change, about the services she received, she answered: *"Don't talk down to me, talk to me as an adult instead of talking to me as if I am a child (I hated them for that)".*When speaking about the meetings she attended (core groups and child protection conferences), she talked about how difficult she had found these meetings. *"I felt ambushed …I never saw any of the reports before the conference……people said things at the meeting that they had not told me about before…….I could not read the reports or the minutes.* It was observed by the Lead Reviewers that during these discussions mother appeared to be demonstrating her frustrations in being within a process that she experienced as on one hand patronising, and on the other as showing a disregard for her needs.

The Lead Reviewers noted mother seemed to have a slight speech impediment. Mother was asked if she had any difficulties with her hearing. She stated that she had, and described receiving treatment as a young child for "a hole in my ear drum". The Lead Reviewers subsequently confirmed that mother had a glue ear and repair of a ruptured ear drum in childhood, and wondered whether this had affected her speech development. Mother described problems with her hearing, particularly in hearing someone who is placed some distance from her. She demonstrated the distance at which she found it difficult to hear, and showed how near somebody would need to be in order to hear them. The Review Team were left wondering whether this would have had an impact on her engagement in meetings, particularly case conferences, where members sit some distance away from each other in a formal setting. It was concluded that the problems mother identified with her hearing, combined with her learning difficulties, would have placed additional strain on mother, in attending these meetings.

Summary of Findings

The Review Team has prioritised **7 findings** for the LSCB to consider. They relate to five categories of underlying patterns. The reader will observe many of the findings are interlinked, this is the nature of the systemic patterning found within interacting/overlapping systems.

Findings	Category
Finding 1: There is an insufficient understanding across the multi-agency professionals of the concept of neglect, and how to understand and articulate the cumulative impact this has on the health and development of individual children. This results in children continuing to experience neglect, despite input from professionals from across all agencies.	Multi-agency working in longer term work
Finding 2: The lack of full multi-agency ownership of how children are safeguarded means that there is insufficient professional challenge and debate, compromising the quality of safeguarding work.	Multi-agency working in longer term work
Finding 3: The confused professional response to families where parents have learning difficulties has a detrimental impact on safeguarding work.	Tools
Finding 4: There is a lack of rigour in ensuring that child protection conferences and core group meetings are functioning effectively.	Management Systems
Finding 5: When children are already on a child protection plan, there is a tendency for additional concerns not to be investigated through the correct child protection process. The assumption is that this will be addressed at the next child protection conference or core group.	Multi-agency working in response to incidents/crises
Finding 6: Despite clear procedural guidance for working with families who are hostile and aggressive, such behaviour still tends to disrupt the effective functioning of the child protection process. The result is an adult focus that distracts professionals from identifying and responding to the risks to individual children.	Family-Professional interactions
Finding 7: There is a tendency to use written agreements to support child protection arrangements. The effectiveness of written agreements, as a tool to ensure parents do what is required of them, is questionable.	Tools

Additional learning is detailed in the final part of this section.

Findings in detail

This section represents the **main learning** from this case review for the LSCB and partner agencies. Each finding is set out in a way that illustrates:

- How does the issue feature in this particular case?
- How do we know it is not peculiar to this case? What can the Case Group and Review Team tell us about how this issue plays out in other similar cases/scenarios **and/or** ways that the pattern is embedded in usual practice?
- How prevalent is the pattern? What evidence have we gathered about how many cases are actually or potentially affected by the pattern?
- How widespread is the pattern? Is it found in a specific team, local area, district, county, region, national?
- What are the implications for the reliability of the multi-agency child protection system?

The evidence for the different 'layers' of the findings comes from the knowledge and experience of the Review Team and the Case Group, from the records relating to this case, and other relevant documentation and from relevant research evidence.

Seven priority findings were chosen because they represented areas of practice which were significant in how this case was managed, but which also reflected wider patterns of practice and the systems which underpin that practice.

The remainder of this section explores the 7 Findings.

The Findings

Finding 1: There is an insufficient understanding of the concept of neglect and how to understand and articulate the cumulative impact this has on the health and development of individual children. This results in children continuing to experience neglect, despite input from professionals from across all agencies.

Placing this finding as the first finding of this serious case review reflects the important systemic implications of this issue in how children are safeguarded, both locally and nationally.

The term 'concept', used in this finding, has been intentionally chosen by the Review Team to reflect the complex considerations required in safeguarding children from neglect. To a greater and lesser extent, this finding is echoed in a number of significant features detailed in other findings presented in this report, demonstrating the complexity of this safeguarding issue.

How did this feature in this case?

Throughout this case, it seemed that professionals struggled to articulate a professional opinion in a way that contributed to the assessment of risk. Professionals appeared to struggle to synthesize and make sense of knowledge, from across services and over time, to form a holistic picture of the neglect the children were experiencing. Each of the incidents/concerns were responded to separately, and considered in isolation, by different parts of the professional network, but their longer term cumulative impact was not assessed.

Child I, and Siblings 1 and 2 were all observed to have developmental delay, both in terms of their motor development and their speech and language. This was believed to be as a result of the poor stimulation the children received at home. The package of intensive services, provided to each child, allowed these developmental needs to be progressed from what services unanimously agreed was a 'low base'. There was little evidence to suggest these needs were met at home. The fact that progress was predicated on individual service provision, not on the parenting received by the children, was not given sufficient weight in the assessment of risk.

Concern about the ability of parents to be aware of, and to meet, the emotional and behavioural needs of all the children**,** was identified by a wide range of professionals. Recordings of these observations were characterised by descriptive, episodic accounts.

There were various observations, noted in the case records across agencies that questioned parental ability to provide adequate supervision in the home, to ensure the children were protected from

household hazards. A number of bruises were seen on the three youngest children and a burn was observed on Sibling 1, all of which were regarded as being caused by a lack of supervision at home. The home environment, and the injuries noted on the children, suggested that the parents did not understand the risks posed within a home where there are young children. This was illustrated in a home visit made by a SW, when a large mattress fell onto Sibling 2, parents did not attempt to remove the mattress and showed no concern about the dangers to the children. When professionals visited the family home, and observed potential hazards, these were largely brought to the attention of the parents. However, there was no effective overview of the ongoing risks or of the parents' ability to anticipate them.

On a number of occasions mother and father were noted to handle the children 'roughly'. There were a number of incidents that were suggestive of poor hygiene, and there was a pattern of inconsistent administration of prescribed medical treatments. These incidents were either simply recorded, or dealt with as they arose, by separate parts of the multi-agency team. The meaning of these, in the context of neglect, was overlooked.

When Sibling 2 was seen by the GP for a review of her eczema, the GP noted a number of bruises. She was concerned about these bruises and made a referral to the SW. The SW arranged a child protection medical. This medical concluded the bruising was likely to be accidental. However, the Paediatrician noted her concern about neglect of Sibling 2's nappy rash and eczema, and expressed concerns about the supervision of Sibling 2. Information shared, by the GP and Paediatrician, also included concerns about mother's 'rough handling' of Sibling 2 and questioned mother's ability to adequately respond to Sibling 2's emotional needs. The strategy discussion that followed, concluded the 'concerns were not substantiated', the basis of this decision was that the bruising was thought to be accidental. No further action was taken.

These examples illustrate the way in which the whole picture was not brought together by the multi-agency network. Whilst there were core group meetings and case conferences these were marked by, what appeared to be, a lack of a framework about how to conceptualize what was being witnessed in the family. The use of concept is necessary to cognitive processes such as categorization, memory, decision making, learning and influence - all of which are necessary if neglect is to be understood.

How do we know it is not peculiar to this case?

When exploring with the Case Group how professionals assess and intervene in cases of neglect, it was apparent there was a lack of clarity and understanding about how neglect can be successfully assessed and measured, and a lack of awareness of the tools that are available in the assessment of neglect. It was equally unclear what menu of services are needed to make a difference to the experiences of children who are neglected. Case group members used the terminology of "neglect", and gave examples of occasions when they observed evidence of how neglect can manifest. However, it was clear there existed no framework in which professionals were enabled to conceptualize this neglect.

The Review Team explored whether, in Lambeth, there was access to specialist advisors. It was clear, there are no such advisors in relation to neglect.

Case group members gave other case examples of children who are subject to a child protection plan under the category of neglect, where they are unclear how to work with the family in order to achieve required changes. They spoke of the high numbers of children who are the subject of a child protection

plan as a result of neglect, and of the length of time these children often spend subject to a child protection plan.

Members of the Review Team and Case Group shared their experiences of working with neglect. Case group members spoke of how difficult it can be to articulate the evidence of neglect. They spoke of their frustrations in seeing the neglect of children, but of feeling ill equipped to know how to make the desired changes. There was a lack of clarity about when a case had met a threshold, requiring escalation to a higher level of intervention (such as a referral to Children's Social Care), or in order for legal intervention to be achieved. Staff representing the CYPS spoke about the legal threshold for neglect being high and of this possibly influencing the thinking/mindset of front- line staff, when working with neglect. Members of the Review Team, with experience of providing supervision/management guidance in cases of neglect, spoke about these cases often not being prioritised for discussion by front-line staff during supervision. Overall, the response of the case group was characterised by both confusion and despondency.

How prevalent/widespread is the pattern?

Being able to respond effectively to cases of neglect is particularly important given the high frequency of these cases, both locally and nationally.

Local data shows that, in June 2012, there were 320 children who were the subject of a child protection plan in Lambeth. Of these, 252 (78.75%) were the subject of a plan under the category of neglect. In June 2013, there were 334 children subject of a plan, of these 220 (65.87%) were the subject of a child protection plan for neglect. Data regarding duration shows that, in June 2012,102 children were the subject of a child protection plan for over 18 months. The available data does not break down these figures into category. However, based on the numbers of children subject to a plan as a result of neglect in June 2012, this data would suggest that the majority of these cases were the subject of a plan, under the category of neglect, for over 18 months. This data supports the views of the Review Team and Case Group that neglect cases form a significant proportion of child protection cases in Lambeth.

This pattern is also borne out nationally. National figures for England (DfE 2012- 2013) show that the number of children subject to child protection plans under the category of neglect, far outnumber the numbers of children categorized as suffering from other forms of abuse. At the end of March 2013, of the 52,680 children subject to a plan, 21,600(41%) were the subject of a plan as a result of neglect.

The difficulty in maintaining a focus on risk, in neglect cases, has also been shown to be a national, as well as a local issue. Recent evidence from SCR's highlights the risks to children, who are the subject of a child protection plans, under the category of neglect:

> *For 59 children, a CP neglect plan was in place at the time of their death or serious harm, for the other 42 children the plan had been discontinued. This shows that some children living with substantiated neglect may be at risk of death, not just long-term developmental damage….Neglect was therefore by far the most frequent category of child protection plan in our serious case review sample, as it is nationally".*

This research goes on to identify the correlation between neglect cases and drift, and the difficulties presented to professionals in assessing and effectively intervening in such cases.

"*The possibility that in a very small minority of cases neglect will be fatal, or cause grave harm, should be part of a practitioner's mind-set. This is not to be alarmist, nor to suggest predicting or presuming that where neglect is found the child is at risk of death. Rather, practitioners, managers, policy makers and decision makers should be discouraged from minimizing or downgrading the harm that can come from neglect and discouraged from allowing neglect cases to drift".*[12]

What are the implications for the reliability of the multi-agency child protection system?

This finding raises important questions about how children are safeguarded from neglect, and the challenges presented by the complex and cumulative nature of neglect. The experiences of practitioners in this case suggest that additional support is required to help professionals to keep track of, and make sense of, the 'whole picture' emerging in neglect cases – often over long periods of time, and across a range of different agencies. If professionals are not equipped with the necessary knowledge, tools, guidance, framework and support, they will struggle to achieve the required changes in families and the safeguarding of children will be compromised. It is therefore vital that multi-agency safeguarding partners are sufficiently equipped to safeguard children in this complex area of work.

Finding 1: There is an insufficient understanding of the concept of neglect and how to understand and articulate the cumulative impact this has on the health and development of individual children. This results in children continuing to experience neglect, despite input from professionals from across all agencies.

Neglect is a complex safeguarding issue that requires a complex response. Unlike other forms of abuse neglect may not be easily observable in a single incident. Rather, numerous pieces of evidence must be pieced together over time, and across agencies, in order to gain a holistic picture. This case has suggested that practitioners in Lambeth do not currently have access to the tools and support that would facilitate this way of working.

Issues for the Board and member agencies to consider:

- What are the ways in which the children's workforce can be supported in identifying, assessing and intervening in cases of neglect including how the cumulative impact is assessed and measured?
- What tools can be used to promote the conceptualisation of, and work with, neglect?
- How will LSCB sufficiently equip practitioners and services in working with neglect in line with their role, remit and responsibilities?
- What services are available that can promote sustained change in parenting and successfully safeguard children?

[12] Brandon et al 2013: Neglect and Serious Case Reviews

- How are complex cases, where children have been the subject of a child protection plan for a prolonged period of time for neglect, effectively reviewed and monitored by multi-agency partners?
- How will LSCB know there have been improvements in these areas?

Finding 2: The lack of full multi-agency ownership of how children are safeguarded means that there is insufficient professional challenge and debate, compromising the quality of safeguarding work.

"*Safeguarding is everyone's responsibility"* lies at the heart of statutory guidance, and practice, dictating how children are safeguarded. Working Together 2013, The Munro Review of Child Protection[13], and various SCRs, research and associated literature, repeat the mantra that children can only be safeguarded within a multi-agency partnership characterised by shared responsibility.

The term 'ownership' is not used within relevant statutory guidance. It is used in this finding to define the collective responsibilities of the whole safeguarding partnership.

If ownership is present, this is characterised by shared responsibility for assessments, analysis, plans and outcomes, and features professional challenge and debate across multi-agency partners, across systems and processes, and across management hierarchies. The mechanisms by which such shared ownership is exercised in practice is through the interventions made by agencies, multi-agency meetings (such as child protection conferences, core groups and strategy meetings), internal agency meetings, through information sharing, through guidance provided by senior members of an organisation, and through supervision.

"Safeguarding is everyone's responsibility: for services to be effective each professional and organization should play their full part". [14]

This case has suggested that the lead role of Local Authorities, as defined in statutory guidance to co-ordinate the protection of children, has been interpreted to mean that, in practice, the Local Authority owns the responsibility to protect children from harm, rather than this being a shared responsibility.

How did this feature in this case?

Inherent within all the findings presented in this report is a question that relates to how multi-agency 'ownership' is played out in practice. There are a number of examples in this case, across multi-agency partners and within the multi-agency group, illustrating the absence of the defining features of ownership.

[13] Professor Eileen Munro 2011: The Munro Review of child protection: Final Report A child- centred system
[14] Working Together to Safeguard Children: HMG 2013

In addition, there was data found suggesting that, in practice, the assessment of risk, analysis of the risks and decision making, was believed to rest solely with the Children and Young People's Service (CYPS), in the form of the allocated social worker, rather than a shared responsibility.

Intra and interagency ownership.

Inter-agency ownership, and intra-agency ownership, is critical, if children are to be protected from harm. Inter-agency ownership is characterised by multi-agency teams working together to jointly share information, assess risk, co-ordinate and provide services, within a partnership that demonstrates joint ownership and accountability for a child's safety and their outcomes. Intra-agency ownership is characterised by how individual members and teams, within organisations, work internally to prioritise, work in unison, and share accountability, to ensure children are protected from harm and achieve positive outcomes.

Intra- agency ownership: In the child protection plans made for the children, the need for a specialist assessment formed a central part of the plans. This recommendation was made at the Initial Child Protection Case Conference (ICPCC) in November 2011. This recommendation was discussed at each subsequent case conference and core group meeting, and carried through the child protection plans for all the children under the timeline under review. This recommendation was never implemented.

On a number of occasions, the Social Worker (SW) approached her line manager (deputy team manager), spoke to the conference chair, and to a variety of senior officers up the management line in the CYPS (including the team manager, head of service, and relevant assistant directors), to request funding for this assessment. These discussions persisted throughout the period of time the children were subject to child protection plans. No agreement was ever given, to fund this assessment. At the last case conference, in May 2013, a recommendation was made to seek legal advice. The reason given for this recommendation was that, if the case was in legal proceedings, funding for an assessment would then be released. In reality, the issue about a specialist assessment was secondary to the need to place this case in a legal framework.

There is an existing CYPS protocol that details how services provided to children in need, who have been the subject of child protection plans for eighteen months, will be reviewed by senior managers. Close to the critical eighteen month point, in line with this protocol, the case was referred by senior managers to the next senior management level. Due to a proposed, but unresolved, proposal to change this protocol, the case was not the subject of senior management review. As a result, no guidance was provided to either the social worker or the chair.

These examples illustrate the lack of intra-agency ownership, and accountability, for the front line practice in this case. Despite the involvement of the independent chair, and a significant number of managers within the CYPS, no management guidance or constructive challenge was provided to the SW or to the chair, to unlock the stalemate that persisted. The case drifted in this stalemate for one year and eight months.

Interagency ownership: There were six child protection conferences and thirteen core group meetings during the period under review. These multi-agency forums provided a further opportunity to challenge the drift in this case. No effective challenge was raised by the multi-agency group and no escalation processes were used.

Opportunities to challenge were presented through the supervision provided to the multi- agency front line practitioners, by their line managers/specialist child protection leads. There was no evidence found to indicate these practitioners were being provided with supervisory guidance that effectively challenged the way in which the children were being safeguarded.

A further example, of how the lack of ownership featured in this case, relates to the contribution of professional opinion in assessment, analysis and decision making. The lack of ownership, demonstrated in how professionals shared their opinions about risk, is illustrated in the examples given in Findings 1 and 5, where professional opinions, in relation to evidence of neglect found during the medical of Sibling 2 and inherent within the concerns about Sibling 3's failure to thrive, were not the subject of sufficient focus, analysis, scrutiny and debate. The absence of effective challenge by the respective medical professionals led to the gravity of these matters, and the importance they had in contributing to an assessment of risk, being lost.

These examples illustrate how the multi-agency safeguarding practice, including inter-agency and intra-agency challenge, the sharing of information and professional opinion, and in the provision of timely services, was marked by an absence of inter-agency ownership, and accountability, for how the children were safeguarded.

How do we know it is not peculiar to this case?

The view of a significant number of case group members, from agencies other than children's social care, was that the assessment of risk and decision making in safeguarding children was not something they were party to or had influence over. Case group members were confident about the assessment of risk within the confines of their own agency/area of specialism, but not when it came to how children are safeguarded by the multi-agency team.

"…..*It is left to CSC to decide (because in a way the buck stops with them)".*Case Group Member

During individual conversations with case group members, and during the wider discussions with the Case Group at case group meetings, frequent references were made to the assumption that "*as Children's Social Care are the lead agency, then responsibility for children subject to CP plans rests with them"* and further that: "*if a child is the subject of a child protection plan, we all (*other safeguarding partners*) will stand back and breathe a sigh of relief."*

Members spoke of reporting concerns about children to Children's Social Care and, in effect, leaving the decision about next steps in hands of the Social Worker.

Members of the Case Group spoke about the child protection process, and the position of the Case Conference Chair, citing the Chair as the person with responsibility and authority to offer challenge. In describing this, case group members were not able to see how they themselves possessed the responsibility, and necessary authority, to offer challenge themselves. On further discussion about this aspect, for a number of case group members, it was clear they had not been given a previous opportunity to consider this issue, both in terms of how they might assume the responsibility for challenging others, or to reflect on how this might be done, including through escalation.

Members of the Case Group spoke about the supervision they received in their safeguarding work. It was clear, from their contributions, that for some there was no formal structure within which they could access such supervision. For others, they were unclear who would be providing this supervision, and how they could access this. Case group members, who had a formal supervision structure in place, were invited to discuss the supervision they received. These case group members spoke about the lack

of frequency in this supervision. Some experienced an inconsistency in professional/practice supervision/supervisors. A number spoke about the absence of reflective supervision, in their current safeguarding work, and demonstrated a desire to receive this kind of management support.

Concern, both about the supervision provided to staff within the CYPS, and the lack of effective inter and intra-agency challenge and debate, has been identified in a recent SCR in Lambeth.

How widespread is the pattern?

There are many examples in serious case reviews, research and associated literature, of how the lack of effective checks and balances, within multi-agency safeguarding systems and mechanisms, allow for individual and group fallibility to affect judgement and decision making in how children are safeguarded. The absence of challenge, reflective supervision and effective sharing of professional opinion, inhibits multi-agency risk assessment, decision making and action. It is the view of the Review Team that this occurs within a landscape where shared ownership of how children are safeguarded is not put into practice. Research and serious case reviews often provide examples of how this lack of ownership plays out in practice.

"A lack of an effectual response, particularly in those cases where the child had a child protection plan, may well have actually increased the risk to these children, since other agencies made their concerns known under the assumption that they would be dealt with, when in reality there was a lack of liaison between agencies, and no clear plan." [15]
"Findings from the Analysis of Serious Case Reviews also demonstrate that the problem of joint responsibility has not yet been fully resolved. For example, the 'silo' working mentality continues to be a repeated feature of cases which go seriously wrong. Achieving cultural change and getting agencies to work together is extremely challenging and requires cross-sector commitment." [16]

What are the implications for the reliability of the multi-agency child protection system?

Statutory guidance and relevant procedures outline the responsibilities of safeguarding partners in the safeguarding of children, as detailed above. Responsibilities are overarching and apply to all safeguarding partners.

Ensuring the correct balance between the leadership role of the local authority, compared to the shared responsibility by partners, is a challenge for every local authority. This case has suggested that, in Lambeth, despite the existence of multi-agency processes and procedures, there is a strong emphasis amongst partner agencies on the fact that the final responsibility for safeguarding lies with children's social care. This appears to lead to a lack of ownership by other agencies, evident in a lack of multi-agency challenge of social care decisions, and a lack of contribution of professional opinion in assessment, analysis and decision-making.

[15] Brandon et al: Neglect and Serious Case Reviews 2013

[16] Professor Eileen Munro: The Munro Review of child protection: Final Report A child- centred system 2011

Shared ownership and responsibility between agencies and professionals that have different roles and expertise, and at different stages of intervention (including universal, targeted and specialist services), is required if children are to be protected from harm and their welfare promoted. To invest in one service the sole responsibility for owning how children are safeguarded, is unsafe. No one system, process, agency, individual or team can possibly create safety.

"Children are best protected when professionals are clear about what is required of them individually, and how they need to work together. Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children".[17]

Finding 2: The lack of full multi-agency ownership of how children are safeguarded means that there is insufficient professional challenge and debate, compromising the quality of safeguarding work.

"Safeguarding is everyone's responsibility" is a rhetorical statement unless it is evidenced in the ownership of how children are safeguarded at the front line, and through management hierarchies.

The challenge of safeguarding children is, as this report has demonstrated, multi-faceted. It presents challenges to individuals, professionals, multi-agency teams, processes, systems and governance arrangements. In this landscape, a safe system is predicated on partnerships characterised by ownership, reflective supervision, professional challenge and debate across and within the safeguarding partnerships. It is essential that these critical features become a reality in how children are safeguarded.

In order to achieve this, there must be constructive relationships between individual practitioners, and their respective agencies, characterised by an open dialogue about how to ensure the correct balance is struck between the leadership role of the local authority, compared to the shared responsibility by partners in safeguarding work. Unless this takes place, front line practice, demonstrating this shared ownership and responsibility, will continue to be compromised.

Issues for the Board and member agencies to consider:

- Does LSCB recognise this lack of shared ownership in any other safeguarding areas/arenas?
- How effective is LSCB in modelling shared ownership?
- How are partnerships defined and advanced at a senior level, and how are such partnerships echoed throughout organisations and seen in the services provided at the front line?
- How can the LSCB promote dialogue and debate about what shared responsibility for safeguarding, led by the local authority, looks like in practice, to ensure that ownership is

[17] Professor Eileen Munro: The Munro Review of child protection: Final Report A child- centred system 2011

shared as fully as possible?

- How does LSCB evaluate how the shared responsibility to safeguard children is put into practice?
- How will LSCB nurture a safeguarding culture where professionals express their opinions in a way that contributes to an assessment of risk?
- What steps can be taken to cultivate healthy challenge and debate across management hierarchies, teams, services and systems?
- How will LSCB satisfy itself that sufficient rigour is being applied to reviewing children who are the subject of child protection plans for over 18 months?
- How will LSCB know that there have been improvements in these areas?

Finding 3: The confused professional response to families where parents have learning difficulties, has a detrimental impact on safeguarding work.

Parents with a learning disability may face particular challenges in the task of parenting. When there are concerns about children, and protective services are involved, adults with a learning disability may also need additional support to engage with these services.

Lambeth Safeguarding Children Board recognised the need to guide adults' and children's services in this complex area of work and in response a protocol was put in place to govern the work. This was published on the LSCB website in September 2010[18]. This protocol provides clear guidance to practitioners providing services to children and families on the process for referring to, and working with, Adult Learning Disability Services. There is an emphasis placed on referring adults, when additional support may be required for an adult whose children are involved in a child protection process.

This case has suggested that this protocol is not followed, even when there is consensus amongst the professional group that a parent has a learning disability. This weakens the support provided to parents, and children, and contributes to a confused multi-agency response.

How did this feature in this case?

There were many professionals, from across a range of agencies, involved with this family over a period of many years. Throughout the involvement of professionals and services, it was widely assumed that both parents had a learning disability. In our conversations with the case group, frequent reference was made to parental learning disability, and examples given of the difficulties the parents appeared to have in comprehending what professionals were asking of them.

[18] Safeguarding children of parents/carers with learning disabilities (LD). Protocol between learning disability services and children's services: Lambeth Safeguarding Children Board Sept 2010

However, despite this widespread assumption, the extent of the parents' difficulties, and how these difficulties impacted on their parenting capacity and response to service provision, was not assessed, or fully understood during the review period. No referral was made to Adult Learning Disability Services on behalf of either parent, and it did not appear that this option was considered by the multi-agency group at any stage.

It is unclear why a referral was not considered. Father had been assessed by Adults' Social Care Learning Disability services prior to the period under review, but found not to be eligible for services. However, this does not appear to have influenced practitioners' thinking – indeed most of the practitioners involved with the family were not aware of this previous referral. Furthermore, a new referral was required, given that he was now a parent. It was unclear why the LSCB protocol was not known about or followed.

It seemed that additional support to understand the parents' learning disabilities, and tailor support accordingly, would have been beneficial both to the parents and the children in this family. Our conversations, both with the case group and parents, suggested that the family sometimes struggled to understand what was expected of them by professionals.

"*No one told us why the children were on a plan……. they said we were neglecting their needs but I did not know what this meant".* Mother

This understandably led to distress and frustration for the parents, and a feeling that they were being criticised by professionals. For example, when we asked Mother if professionals had discussed accident prevention with her or Father she responded:

"No they never did… they just kept criticising….. They told me that … (name of Sibling 3) needed to be allowed to crawl around the floor, as he was in a walker a lot, but when I let him do that and he had a bruise on his head, they criticized me for that".

Neither parent was able to read, but this did not seem to be taken in to account by professionals working with them. Mother expressed her frustration at being sent written conference reports, which she could not understand. There was also significant use of written agreements – this is discussed further in Finding 7. Having additional support from a specialist learning disability service could have supported professionals in understanding the needs of, and communicating with, the parents more effectively.

The high level of vulnerability of the parents in their own right also meant that, at times, professional input and energy focused on them, to the exclusion of a focus on the children. The lack of an informed response to parental difficulty led to misunderstandings and confusions. Although a range of services were provided, a number of services were duplicated, such as parenting support. This was provided by three different agencies, at the same time, under the time line under review. None of the individuals, providing these services, knew what the other service was providing. There were assumptions made about the nature of the services being provided, as demonstrated in the assumptions made about how accident prevention was being discussed and effectively managed within the home. Again, the review team questioned whether seeking help from Adult Social Care services for the parents in their own right could have left the children's services freer to focus on the needs of the children and led to a greater unity in the service provision.

How do we know it is not peculiar to this case?

Discussions with members of the Review Team, and the Case Group, endorsed the view that these issues are not confined to this case alone. The LSCB protocol[19] was published at a time when the early intervention teams were providing a service to the family, and remained in place during the timeline under review. It was clear in the discussions with the Case Group, and the Review Team, that this protocol was not known about, nor used as it was intended, across a range of families where parental learning difficulties are thought to be present. Case Group, and Review Team, members spoke about the ongoing and pervasive difficulties in achieving joined up working between adult and children's services, across multi- agency partners. As a consequence, it was clear that members of the case group resigned themselves 'to going it alone', when working with parents who were believed to have learning difficulties and, other than securing funding for an external assessment of learning difficulties, they could not identify any other way in which they, or family members, could be supported.

The Review Team learnt that, in response to these difficulties, a new process of case referral had been recently set up between children's and adult services. It is early days in the planning and implementation of this process, hence at this point, the impact of this new process on this critical area of work is unknown.

How widespread is the pattern?

The difficulties encountered, in achieving joined up adult and children services, and the impact this has on safeguarding children, is detailed in a plethora of research and serious case reviews.

There is also much written about parents with learning difficulties, and the overrepresentation of these parents in child protection processes:

> "*Parents with learning disabilities are at a higher risk of becoming subject to child safeguarding procedures and are an overrepresented group in child protection conferences and court proceedings; it is estimated that between 15 to 22 per cent of parents involved in child protection conferences and care proceedings have a learning disability"*
>
> *Brandon et al. 2009*

And the obstacles they face within these processes:

> *"Parents with learning disabilities are a group affected by multiple disadvantages and experience a higher risk of not receiving the support they need".*[20]
>
> *"Parental learning disabilities are rarely highlighted in serious case reviews although our analysis of these reviews has shown that there are often indications that parents had learning problems which were not assessed or addressed".*[21]

[19] Safeguarding children of parents/carers with learning disabilities (LD). Protocol between learning disability services and children's services: Lambeth Safeguarding Children Board Sept 2010

[20] Bauer: Investing in Advocacy Interventions for Parents with Learning Disabilities 2013

[21] *Brandon et al* : New Learning from serious case reviews: a two year report for 2009-2011

The challenges faced by multi-agency practitioners, in providing services, is detailed in research and literature. This research suggests that service provision is often characterised by "*a confused multi-agency response"*[22].

What are the implications for the reliability of the multi-agency child protection system?

Parents with a learning disability can face particular challenges in parenting and, where there are concerns about children, engaging with family support and child protective services. This is recognised in the LSCB's protocol on safeguarding children of parents with learning disabilities. This protocol outlines as a key purpose: "*To enable practitioners to provide joined up service responses to families where the needs of adults can impact upon the welfare of children".*

A protocol alone will not support front-line practitioners to safeguard children, or ensure parents with learning difficulties are provided the support they require. However good a protocol, in the absence of a robust strategy of implementation, protocols alone have no value in the protection of children.

This case has suggested that, when parents are thought to have a learning disability, family support and child protection services do not consider referring to adult learning disability services as a way of securing a better understanding of their needs, and obtaining additional support in order the strengthen the safeguarding of children.

This means that parents are not benefiting from services which might be available to them in their own right, and to support them through the child protection process. It also means that children's services are trying to 'do it all', potentially meaning that focus on the children is lost.

Finding 3: The confused professional response to families where parents have learning difficulties, has a detrimental impact on safeguarding work.

Lambeth SCB's protocol on safeguarding children of parents with learning disabilities aims to promote referrals, as appropriate, from children's services to the Learning Disability Team, and joined-up working thereafter. This case has suggested that there is a lack of awareness of this protocol, and a lack of mechanisms in place to facilitate this protocol being followed. This means that parents can lose out on support, the safeguarding of children is at risk of being compromised, and the existing multi-agency network does not benefit from the expertise and support provided by specialist learning disability teams.

Issues for the Board and member agencies to consider:

- What actions have been taken by the Board to support how the LSCB Learning Disability protocol is implemented on the ground?
- What actions have LSCB taken to review the protocol and to evaluate impact on the lives of children and families?
- What more needs to be done to support implementation?

[22] Mc Graw: What Works for Parents with learning difficulties?2000

- How will the Board know that multi-agency early intervention services and specialist services are working in line with this protocol?

- Do LSCB know how many children, who are the subject of child protection plans, are living with parents who have learning difficulties? How will this be reviewed to ensure these families are receiving services in line with the existing protocol?

- How will the new process of case referral to the adults learning difficulties team be evaluated?

Finding 4: There is a lack of rigour in ensuring child protection conferences and core group meetings are functioning effectively.

Statutory guidance, contained within Working Together 2010 (and in the later edition in 2013), and The London Child Protection Procedures, outline the process and purpose of child protection case conferences, and core group meetings. The purpose of child protection conferences is; *"to bring together and analyse relevant information and plan how best to safeguard and promote the welfare of the child and to make recommendations on how agencies work together to safeguard the child in the future".* Core groups have a responsibility to share information and to develop, and implement, the child protection plan.

Child protection conferences provide an opportunity to scrutinise membership of the case conference and core group, and to examine how core groups are implementing the child protection plan. Decisions, about membership, rests with the chair of the case conference. In line with statutory guidance and procedure, decisions about attendance should be based on the need to ensure that the conference is in a position to fully consider, and understand, the individual needs of the children. Therefore membership should reflect the changing needs of the child, as the child grows and develops, and the changes in family circumstances.

The stated 'Reason for the Conference', serves the purpose of succinctly outlining the risks that are present. It is referred to at the beginning of each child protection conference, thereby framing the subsequent conference discussions. It is recorded at the front of the child protection conference minutes, these minutes are distributed to the multi-agency group. This section of the conference minutes provides critical information, on which professionals often rely to inform their knowledge of the safeguarding risks, in the lives of children with whom they are having contact, in their day to day work.

The London Child Protection Procedures provide guidance on holding pre-birth child protection conferences: *"A pre-birth conference should be held where a child is to be born into a family or household that already has children who are subject of a child protection plan and should take place as soon as practical and at least ten weeks before the due date of delivery, so as to allow as much time as possible for planning support for the baby and family".*

This review has identified several issues that are impairing the effective functioning of child protection conferences and core groups:

- The lack of separate or parallel pre-birth conferences and the implications of this.
- Membership and attendance of multi-agency practitioners at child protection conferences and core group meetings.
- Lack of clarity in plans on the changes needed in the parenting of the children.
- The lack of importance placed on 'The Reason for the Conference'.

How did this feature in this case?

The children were all subject to child protection plans from Child I's birth, in November 2011, until Child I's death, in July 2013. Child protection conferences, and core group meetings, were largely held within required timeframes. However, in a number of respects, the way in which the core groups and conferences operated was less than optimal.

Pre-birth child protection conferences: During the investigation of the injury to Sibling 1, mother was known to be pregnant with Child I. Child I was born nine days before the Initial Child Protection Conference. There had been no pre-birth assessment and no pre-birth conference. Sibling 3 was born sometime later, and again there was no pre-birth assessment, the Child Protection Review Conference, on the other children, was brought forward. Discussions, about the new infants, were integrated into these conferences. Hence, discussions about risk and plans were 'rolled up' into the existing child protection conferences for the other siblings. This had a detrimental impact on the planning for all the children – the specific needs of the new siblings were not given sufficient consideration, nor the impact of increasing family size on the needs of the individual children or on their safety.

Information sharing and membership at child protection conferences and core group meetings: Throughout the period the children were the subject of a child protection plan the plans, and the membership of the conferences and core group meetings, remained largely the same. This was despite the changing circumstances in the family that included the birth of a fourth child, and a number of incidents of harm to the children.

The core groups were all held at Sibling 1's school. They were either chaired by the social worker, or by a representative from the school. Multi-agency staff, providing services to Child I and siblings 2 and 3, were largely unrepresented at both the core group meetings, and child protection conferences. Key professionals, who had direct contact with Child I and siblings 2 and 3 and with their parents, either did not attend, sent a substitute, or were not invited. This was illustrated in the lack of attendance of health professionals, and staff from a children's centre, who were seeing Sibling 2 on a daily basis. In the case of the latter, children's centre staff were unaware Sibling 2 was the subject of a child protection plan. In the case of the former, professionals, across a range of health services including A&E, GP's, midwifery, paediatricians and specialist services, were largely unrepresented, or where they were represented, this was through the health visitor, or occasionally through a representative from the service. Agencies did not question or challenge the absence of their multi-disciplinary partners.

As a result, the conferences and core groups were not attended by the range of professionals, who could provide a first-hand account of their involvement with the family. This was particularly relevant when health information was discussed. During these times the chair, or other members of the core

group or conference, were left to interpret the meaning of the information. This resulted in the dilution of information, and important nuances that are so essential in cases of neglect being missed.

The impact was illustrated in how father's role in the family was considered. Father did not attend child protection conferences, or core group meetings, and was rarely seen outside the family home in a parenting capacity. He was seen on various occasions at home, providing care to Child I and to siblings 2 and 3. He was often seen by staff at the Children's Centre, when he took and collected Sibling 2 from the Centre. At home, father was observed to be unable to pre-empt the needs of the children, or to show an awareness of the potential household hazards. The perspective of staff from the Children's Centre, was that father took the responsibilities of taking and collecting Sibling 2 seriously. He was normally always on time, and showed kindness to Sibling 2. It was also evident, to these professionals, that he had limited ability to follow guidance, or instruction. He was described by a number of professionals, who visited the family home, as being 'the fifth child in the family'. These voices were not reflected in the child protection conferences, or core group meetings. This had an impact on the range of information shared, this information was critical in understanding father's role and in informing the plans.

Implementation of Child Protection Plans: Case conference recommendations made, in relation to parenting capacity, included father as part of the child protection plan. This included the need for the core group to be clear about what needed to change in order for the children's needs to be met. In the absence of information, or understanding, about father's role and capacity, the core groups focused on the parenting capacity of mother, specifically in relation to Sibling 1. The discussions that followed, focused on the provision of services. Core group meetings did not adequately detail the changes required in mother's or father's parenting capacity, father's role was largely absent from the plans detailed at both child protection conferences, and core group meetings.

Reason for the child protection conference: The stated 'reason for the child protection conference', gave a full account of the original injury to Sibling 1, and referred to an assortment of other concerns. The way in which the information was presented, was characterised by a narrative account of family functioning. These accounts focused on the adults within the family. Neglect was not named, and there was little reference to the impact of this neglect on the individual children. This was repeated throughout the child protection conferences, on all the children, and was recorded within the minutes distributed.

How do we know it is not peculiar to this case?

Input from the Case Group, and Review Team, highlighted that a number of the practices observed, were common in Lambeth. For example, it is not unusual for pre-birth conferences to be integrated into a review case conference, held in respect to other children in the family.

"It is common for discussions on the risks to children pre-birth to be included in a conference on the other children in the family and it is not clear that this is a separate pre-birth conference ……either in the conference itself or in the minutes". Case Group Member.

There was a divergence of opinion within the Review Team about whether this was typical in Lambeth. Holding pre-birth chid protection conferences in parallel to existing review child protection conferences was identified as 'common practice', although whether these were held as specifically delineated pre-

birth child protection conferences, or whether they were integrated into an existing child protection conference for other children in the family, was unclear.

The experience of members of the Review Team, and Case Group, showed that scrutiny of case conference membership, and core group meetings, was not common practice. There was an assumption that whoever was named on the list of professionals to be invited, were the right professionals to be there. A member Case Group commented; "*It can be the case that the membership of the child protection conference and core groups has not been thought through"*.

Members of the Review Team, and Case Group, recognised the absence of key health professionals, particularly GPs and those representing specialist services, such as consultant paediatricians, as a common feature of child protection conferences. They regarded the sending of a substitute or a report, in place of attending personally as a common, but necessary, solution to the demands of their busy working life. The LSCB Child Protection Report (*'Local Authority Data from Framework')* examined child protection data between October 2012 and December 2012, including attendance at child protection conferences. This showed that, of the GP's invited to attend child protection conferences, 26.32% of GP's either attended or sent a report and 50% of Consultant Paediatricians.

Members stated that the minutes of the case conference kept them updated regarding the risks and plans made for children. They acknowledged that it was often difficult to read the whole report, before seeing a child, and so were largely reliant on the category used and the section that detailed 'The Reason for the Conference'. Members recognised that 'The Reason for the Conference', is commonly 'cut and pasted', from one conference to the next This appears as the reason for all the children in the family being the subject of a child protection plan, regardless of their age and development, or regardless of changes in the family. This was identified as happening 'routinely' across a number of cases in Lambeth.

"In case conference minutes, it is common to see what seems to be cut and pasting sections from one conference to another" (Case Group member).

Members spoke about their experiences of core group meetings in Lambeth. There was information provided to suggest that core group meetings are normally always chaired by the social worker allocated to the case, or by a representative from another agency. It was the view, of a number of Case Group members, this led to a lack of seniority/ authority in the meetings. In addition, it was clear that, for a number of agencies, there was a confusion about their specific role and remit, in being a member of this group. Case Group members made the following comments:

"*There is a lack of buy in by members at core group meetings".*

"The remit and conduct of the core group should be clearer"

"The chairing needs to be more robust"

"There is a common lack of clarity about the role of core group members, this needs to be explicit"

Concern was raised about the quality of the case conference minutes and the length of time it can take to receive a copy of these minutes. Members spoke about inaccuracies and typing errors.

There has not been a recent audit in Lambeth in relation to the functioning of core group meetings/child protection conferences, hence hard data on this issue was not possible to locate.

How widespread is the pattern?

The Review Team shared their experiences of working in other local authorities /county councils, this experience suggests that 'The Reason for the Conference', is often 'cut and pasted' from the Initial Child Protection Conference, into subsequent conference minutes. This appears as the primary reason for the child protection conference, on the case conference records for all the children, regardless of how long the children are subject to a plan, or whether information is available to suggest that the risks to the children have changed. They also identified a pattern where core groups are often chaired by the social worker, or other members of the core group.

Available literature and relevant SCRs, examining pre-birth conferences, membership of core groups, child protection conferences and information sharing during key meetings, within the child protection process, reveals these to be critical components in child protection planning. Whilst it is widely accepted that any weaknesses, in these areas, poses a threat to the effective functioning of these meetings, there is no national or local research examining these issues. There have been a number of Serious Case Reviews that have identified the risks, posed to children, when these weaknesses are present.

What are the implications for the reliability of the multi-agency child protection system?

When children are made the subject of a child protection plan, their names are added to a list that is circulated as an alert to services/establishments. A formalised process of information sharing through a meeting chaired by an independent case conference chair, then follows. To assume that, once activated, this process provides the necessary safeguards, within which a child is protected, is an unsafe assumption. This process does not, per se, protect children from harm.

A safe child protection system is predicated on the contribution of the Interagency Group. Core groups, and child protection conferences, are key forums that facilitate this interagency protection of children. This case has suggested that there are a number of ways, in which these are not working optimally in Lambeth, including the timing of pre-birth child protection conferences, the practice of integrating discussion of risk to unborn children into review child protection conferences, insufficient membership, gaps in information sharing and a lack of focus on the individual needs of the children. These gaps inhibit multi-agency partners in providing protection to children.

On the surface, the repetitive use of the 'Reason for the Conference', may seem of little significance. However, in practice this frames professional discussion at child protection conferences and, if professionals are in any way reliant on this section of the case conference minutes, copying over this reason from one conference to the next, can skew a full understanding of the risks to the child.

Finding 4: There is a lack of rigour in ensuring case conferences and core group meetings are functioning effectively.

Statutory guidance and procedure sets out the responsibilities of core groups, and child protection conferences. This includes the need to ensure full membership, of these meetings, and the need to effectively plan for the protection of children.

"The core group should develop an outline of the child protection plan, set out what needs to change by how much and by when in order for the child to be safe and have their needs met.... Core groups must implement and refine the child protection plan." [23]

Responsibility for monitoring the effectiveness of the core group, rests with the child protection conference. Case conferences, and core groups, provide a framework and structure that enables the multi-agency protection of children. If this is not working as it should, the protection of children is compromised.

Issues for the Board and member agencies to consider:

- How does the LSCB undertake their statutory responsibilities to maintain an overview of how the child protection conference and core group process is operating in Lambeth?
- Is the LSCB satisfied that the agencies are clear of their role and remit in core group meetings and arrangements have sufficient authority to allow required tasks to be completed?
- How will LSCB consider what arrangements need to be in place that allows for full participation of the multi-agency group in child protection meetings?
- What are the constraints in trying to improve practice in the areas identified? How will these be overcome?
- How will LSCB know there have been improvements in this area?

[23] The London Child Protection Procedures 2010

Finding 5: When children are already on a child protection plan, there is a tendency for additional concerns not to be investigated through the correct child protection process. The assumption is that this will be addressed at the next child protection conference or core group.

The London Child Protection Procedures detail the requirement for all incidents of harm to children, where abuse or neglect is believed to be a factor, to be investigated under section 47 of The Children Act 1989. This section of the Act states the local authority has a duty to investigate when; "they *have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm."* And further that *"the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare"*

The London Child Protection Procedures state that strategy meetings/discussions, should always be held; "*whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm".*

These requirements apply to all children. If a child is the subject of a child protection plan, due to the inherent complexities of these cases, there is added emphasis on the need to hold a strategy meeting. This case has suggested that on a number of occasions, when responding to an incident of suspected harm, these procedures are not followed.

How did this feature in this case?

In this case, there were a number of bruises seen on the children and a number of incidents that, in the view of the Review Team, should have triggered s47 investigations, and strategy meetings. On two occasions, relating to explicit concerns that the children had been the subject of physical abuse, s47 investigations were initiated. On a number of other occasions, when concerns were noted by multi-agency professionals, and reported to the Children and Young People's Service (CYPS), the response was to note the concerns in the case file, and to consider what outcome was required. On some occasions, action was taken in the form of a home visit and/or a call to a member of the multi-agency network. On other occasions, the concern was simply noted on the case file. A number of these concerns were recounted within reports to case conferences. These concerns were not the subject of s47 investigation and so concerns, decision making and action, were not the subject of timely multi-agency decision making and scrutiny.

This was demonstrated when Sibling 3 was seen by the family GP for his eight week check. On this occasion, Sibling 3 was brought by his maternal grandfather to the GP Practice for his routine check. On weighing Sibling 3, the GP identified that Sibling 3 had lost weight from his original birth weight; he was found to weigh 3.87 kg. The GP was very concerned by this loss of weight. A feeding chart and high formula milk were given, and an appointment scheduled for the following week. The GP referred Sibling 3 to the 'Rapid Access Team', based in a local hospital. She reported her concerns, that Sibling 3 was 'failing to thrive', to the health visitor and social worker.

Sibling 3's failure to thrive was discussed at the next core group meeting two days later. The information from the GP was noted by the core group, the Health Visitor reported 'no concerns', and no

other action was taken. The SW visited the family home two days after the Core Group Meeting; the concerns were not discussed with the parents.

The GP continued to monitor Sibling 3 at the surgery. A month later, the health visitor discussed the feeding of Sibling 3 with the parents. Data reveals that no other action was taken, by the multi-agency team, over this critical period of time. After a period of prescribing high formula feeding, review and monitoring by the GP, Sibling 3's weight sporadically increased.

Some five months later, in May 2013, there was a review child protection case conference (RCPCC). By this time, Sibling 3 had gained satisfactory weight. The GP did not attend the child protection conference, but detailed her concerns in a report to the conference. Included in this report was the outcome of the medical investigation by the Rapid Access Team, that Sibling 3's failure to thrive did not have a medical cause**.** The case conference noted these concerns, but the gravity of the information was lost. The GP presumed that the SW and multi-agency group understood that this failure to thrive was as a result of neglect. This presumption was not correct, and the conclusion that this was evidence of neglectful parenting, was not given sufficient weight and meaning by the multi-agency group.

Whilst the child protection plan, made at this conference, included a new recommendation to seek legal advice, this was not in response to this critical incident. This recommendation was made, in order to achieve funding for a specialist assessment. Overall, it was the view of the review team that not investigating the concerns about Sibling 3's weight within a s47 framework contributed to the confusion amongst the multi-agency group about the cause and significance of this failure to thrive.

How do we know it is not peculiar to this case?

The Review Team were struck by the importance of this issue, and attempted to uncover data to explain what may lie beneath this finding. It was not possible to source any hard data on this matter. However, members of the Review Team and Case Group identified this was not unique to this case. Examples were provided of cases involving children, who were the subject of child protection plans, where either a core group, or a case conference, were brought forward, in order to discuss incidents of harm, rather than initiating a s47 process. Experience of the Case Group suggested that this was most likely in cases of neglect. The Case Group gave examples of cases where a concern about a child, who was subject to a child protection plan for neglect, were reported but did not result in a s47 investigation or an earlier child protection conference, or review by a child protection chair.

Information from the Children and Young Peoples Services, confirmed there is no system for auditing or reviewing this practice, apart from through the established case conference process. At such times, chairs may make recommendations, in respect to an incident, and may remind participants of the need to instigate s47 investigations, as indeed the chair did in this case, but this does not guarantee compliance.

A recent Serious Case Review in Lambeth questioned: *"Whether the ineffective management of the Section 47 investigation represented a pattern of working in the individual FSCP Team, and possibly more widely*". During the course of this previous SCR, the Review Team were provided with evidence to suggest this was not a widespread pattern. Data from this review suggests this issue is more widespread than previously thought.

How widespread is the pattern?

The experiences of the Review Team and the Case Group, in other local authorities/county councils, suggests that if a child is the subject of a child protection plan, there can be an assumption that this process is sufficient to provide for necessary information sharing and multi-agency decision making. Case Group members recognised this to be particularly relevant when working with families who are known well, or when neglect is present.

There is no available research to suggest this is common practice, in relation to the generic population of children who are the subject of child protection plans. However, there is a wide range of available research[24] concerning how critical incidents are responded to, when children are living in households where neglect is present. Within this research, and associated literature, a repetitive pattern, characterised by a lack of assertive response to incidents, is identified.

"Social work practitioners frequently postponed taking decisive action pending further assessments of parenting capacity and parental progress".[25]

"*There was drift and lack of a sense of urgency among professionals, even when the risks of harm through poor supervision had been highlighted by a CP plan in the category of neglect."*

"Practitioners and managers should recognize how easily the harm that can come from neglect can be minimized, downgraded or allowed to drift."

Brandon et al: Neglect and Serious Case Reviews 2013

What are the implications for the reliability of the multi-agency child protection system?

Investigations under s47 of the Children Act 1989 are, by their very nature, investigations that confer upon the multi-agency teams a clear structure, timeframe, and decision making process. Equally, strategy meetings place child protection decision making within a clear structure and format that allows for clear, and accountable, information sharing, decision making, and action.

The reason for clear, and unequivocal, information sharing, and accountable decision making, does not have to be repeated here. It is an essential component of the safeguarding system. Whilst the Local Authority are the lead agency, they are dependent on the vital contribution and attendance of safeguarding partners, both in sharing information, in receiving the opinions of other professionals, and in collectively making safe and effective decisions to safeguard children from harm. The s47 process provides the framework within which this happens. It is unsafe to assume the same scrutiny, timeliness and accountability, of decision making, in response to critical incidents, are inherent within other parts of the child protection process, or that such detail can be part of a child protection conference.

[24] See among others :Cleaver & Nicholson, Brandon et al, Farmer & Lutman, Tanner & Tuney etc
[25] *Brown & Ward: Decision making within a child's timeframe 2013*

Finding 5: When children are already on a child protection plan, there is a tendency for additional concerns not to be investigated through the correct child protection process. The assumption is that this will be addressed at the next child protection conference or core group.

This case has suggested that when a child is the subject of a child protection plan, particularly in cases of neglect, concerns are less likely to be investigated under the s47 framework.

Investigations under s47 of the Children Act 1989 and strategy meetings are critical if children are to be safeguarded from harm. Such processes allow for full information sharing, and for this information to be the subject of necessary scrutiny and analysis. To assume that incidents of harm to children, who are already subject to a child protection plan, will be adequately scrutinised, and receive a timely response, through the core group/case conference process, is a flawed assumption. It is an assumption that weakens the protection provided to children, and has the potential of creating unsafe loopholes in the multi-agency safeguarding system.

Issues for the Board and member agencies to consider:

- How will LSCB review the extent to which this is a feature of practice in cases of children subject to child protection plans?
- How will LSCB satisfy itself that this does not feature in cases where children are the subject of significant harm as a result of neglect?
- How will this be the subject of quality assurance activity in the future?
- How will LSCB exercise their governance responsibilities in this area?
- How will the decision making, in relation to decision making about when to commence s47 investigations, be strengthened, to facilitate the involvement of multi-agency safeguarding professionals?
- How will LSCB review and evaluate the action they take?

Finding 6: Despite clear procedural guidance for working with families who are hostile and aggressive, such behaviour still disrupts the effective functioning of the child protection process. The result is an adult focus that distracts professionals from identifying and responding to the risks to individual children.

The child protection process is a system of intervention that involves a multi-agency team, and includes child protection conferences, core group meetings, and interventions dictated by the child protection plan. The attendance of family members, at both child protection conferences and core group meetings, is positively encouraged, and the London Child Protection Procedures (2010) provides helpful guidance, about the steps that need to be taken in these circumstances.

Balancing the rights and needs of care givers, alongside the need to operate a safe and effective safeguarding system, can be challenging. It is widely recognised that, for many families, the child protection process presents a time that invokes a number of difficult emotions, the process itself can feel overwhelming, and can lead to a sense of powerlessness and/or anger. This case has suggested that, despite the available guidance, involving families effectively in the child protection process remains difficult. Where difficulties are not effectively addressed, practitioners' focus can be distracted from the needs of, and risks to, children.

How did this feature in this case?

The unmet emotional needs of the parents, were evident to practitioners. These emotional needs were expressed in their expressions of anger, aggression, and hostility.

Father was known to feel angry towards social workers who, it was believed, he saw as representing his difficult childhood in care. He was often described as responding in an aggressive, and hostile, manner when social workers visited the family home. This behaviour was characterised by aggressive shouting, expressing verbal threats, and using threatening body language. When social workers attempted to speak with him, he would turn the volume up on the violent games he was playing in the front room. A number of social worker's spoke of feeling 'afraid', when visiting the family home.

Mother's behaviour was, on occasions, observed to be hostile and angry, she was described by core group members as often reacting like 'an angry teenager'. In the presence of maternal grandmother, who also consistently showed a level of hostility to professionals, her hostility intensified.

As a result, a number of professionals avoided visiting the family home. If contact could be made with the mother outside this environment, this was pursued. It equally affected the way in which child protection conferences, core group meetings, and visits to the family home, were managed. Professionals worked hard to negotiate access to the family home, and to ensure core group meetings and child protection conferences 'functioned'. Overall, challenge was avoided, and concerns were framed in a way that averted parental aggression. This resulted in an adult focus, where the time and energy of professional input was concentrated on managing, and negotiating around, the needs of the adults. An additional consideration was the presence of the children. The hostility and aggression, from the mother, father and maternal grandmother, was shown, regardless as to whether the children were

present or not. Professionals were mindful of the effects of such behaviour on children, as a result they either refrained from challenging the parents, or made a decision to deviate from a normal course of action, such as speaking to the children after an injury had been noted, fearing the aggression of the parents, and impact on the children. The outcome was that plans could not be sufficiently discussed, or implemented, and the children's voices were lost within the chaotic emotional world of their care givers.

There was a difference of perspective, about the aggression shown by the parents to professionals. For a minority, this aggression was not present. When the Review Team sought data, to examine what lay beneath this issue, it was found that if challenge was avoided, parental hostility was averted. However, if challenge was raised, this typically resulted in an escalation of parental response. This was exemplified in the visit, made by the community midwife, when she visited the home after the birth of Sibling 3. At the start of the visit, father appeared amicable. When he was challenged about his care of Sibling 3's umbilical cord, father's aggression and hostility rapidly escalated.

The history, and patterning, of this behaviour was not understood. There was an assumption made that, beneath this hostility, were the unmet, and unresolved, emotional needs of the parents. This was a correct, but benign, interpretation. It was an interpretation that did not consider the impact of this behaviour, on the children, or sufficiently frame this behaviour, to provide insight into the way in which this behaviour was having a significant impact on the implementation of plans.

The possibility that parental hostility could be attributable to the disempowerment, and frustration, felt by parents, in being in a process that, due to their learning difficulties, was overwhelming and incomprehensible, was not the subject of sufficient consideration.

How do we know it is not peculiar to this case?

Case Group members spoke with passion about the frequent difficulties they have in working with parents who are aggressive, and hostile. They spoke of the barriers this creates in their working relationships, and in the implementation of child protection plans. Case Group members talked about the presence of family members at core group meetings, describing their membership and attendance as a '*prerequisite'* of the group. They spoke about this being upheld, regardless of whether their behaviour disrupts the functioning of the group.

There was no data provided by the Case Group to suggest they were equipped to understand the possible underlying reasons for parental hostility, or parental disruption of meetings, that they encountered in their day to day work. It did not seem that they were supported to view the patterning of this behaviour within a framework, to allow the possible reasons and consequences to be unearthed. Case group members spoke about this aspect of their working life with a sense of resignation, and described dealing with these circumstances as and when they arose in their day to day working life.

Practitioners spoke about their frustration about this issue, and the way in which this can significantly inhibit the workings of core group meetings and child protection conferences. The London Child Protection Procedures (LCPP's) are clear about the steps that should be taken in these circumstances. The Review Team learnt there has been a recent policy put in place in the CYPS in Lambeth, this policy provides guidance and structure for dealing with families who disrupt the workings of child protection processes.

The Case Group did not show any awareness of the guidance, provided by the London Child Protection Procedures, or about what they could do in such circumstances. The existence of the guidance within

the LCPP's, and the recently published Lambeth policy, provides additional information to suggest this issue is not peculiar to this case.

Case Group and Review Team members spoke at length about how the child's experiences, and voice, are lost in such circumstances. They strongly identified with children, who are living in households where such adult hostility features, and where the children are silenced within this environment. A number of Case Group members spoke about the need to improve the practice of interpreting a child's unspoken words: "*Not enough is made of a child's silence, what is the child saying in this silence*?"

How widespread is the pattern?

There are various pieces of research[26] highlighting the problems faced by multi-agency safeguarding practitioners, in working with parents who are hostile and aggressive. Such behaviour is referred to in a variety of ways, such as 'uncooperative behaviour', 'ambivalence', 'non-compliance', or 'highly resistant', and can present itself in a number of different ways. Research has shown that, whilst intimidation and hostility is acknowledged as presenting overt difficulties to practitioners, there is less acknowledgment of how a collection of behaviours, patterning over time, suggests that some families are in fact 'resistant' to interventions.

"Although used in practice, the term 'highly resistant' families is rarely used in the research literature. Families are sometimes characterised as having 'multiple' or 'complex' problems and data are available on maltreatment recurrence, but none of these sources necessarily indicates that a family is 'resistant."[27]

Research, examining these types of behaviours, is unanimous; what all these behaviours have in common, are the effects they have on the functioning of the child protection processes, on the implementation of the child protection plans, and on the child.

"Working with aggressive and resistant parents in child protection is one of the most difficult and risky enterprises in social work for children, workers and agencies. It is also one of the most neglected".[28]

As the Review Team uncovered the data in this case, they were frequently struck by the complex nature of the work with this family, and how the challenges faced by the practitioners has national resonance.

A Community Care/Reconstruct survey[29], of nearly 600 social work and social care staff, discovered that parents, who exhibit such behaviour, can pose a real threat to their children, through the effects this has on the ability of staff to carry out their assessments, and interventions, effectively and adequately.

[26] See amoung others: Calder, 2008; Farmer and Owen, 1998; Littlechild, 2005, 2008a, 2008b; Ferguson, 2011.
[27] Fauth et al: Effective practice to protect children living in 'highly resistant' families' 2010 C4EO.
[28] Littlechild: Working with Resistant Parents 2013
[29] Community Care 2011

"91% of respondents stated that their caseload includes parents who are hostile or intimidating".

"Respondents reported that they had found they experienced loss of confidence in carrying out their work, with their ability to protect children compromised as a result of such behaviour. Some staff reported consequent fear of confronting parents appropriately".

There is no doubt that the formalised meetings, and processes, inherent within the child protection process, is a time of additional stress for families. The Family Rights Group have run a long, and continuing, campaign, highlighting how child protection meetings are not conducive to parental engagement, and identifies the barriers encountered by parents in this process.

In terms of parents with learning difficulties, the issues become more complex:

Research by Booth and Booth[30] reported that parents, with learning difficulties, found child protection conferences '*harrowing and lonely meetings'* where they often did not know what was happening, or who the large numbers of professionals involved were.

"Parents felt they were not listened to and disempowered in the formal atmosphere of over-long child protection conferences where inaccurate statements were often made about their parenting and they were often unable to follow the discussion".

What are the implications for the reliability of the multi-agency child protection system?

Parents, who have their own unresolved emotional needs, are commonplace within families who are the subject of child protection processes. The challenging behaviour of caregivers, has become an accepted part of the safeguarding arena, for all multi-agency practitioners. Within this context, 'seeing it from both sides' is imperative: acknowledging the needs of parents, whilst naming what impact this has on the functioning of the safeguarding system, is the vital balance that needs to be struck. If it is not, the needs of the adults can overshadow the needs of the child, and detract from the safe and effective implementation of the multi-agency child protection process.

[30] Parents with learning difficulties in the child protection system: Experiences and perspectives Booth &Booth 2004

Finding 6: Despite clear procedural guidance for working with families who are hostile and aggressive, such behaviour still tends to disrupt the effective functioning of the child protection process. The result is an adult focus that distracts professionals from identifying and responding to the risks to individual children.

The effective functioning of the child protection process, is an unequivocal fundamental requirement for protecting children from significant harm. Yet caregivers' experience of this process can be difficult, giving rise to behaviours such as threats, verbal abuse, hostility and physical violence. It can also include the lesser recognised features of ambivalence, or detraction. The impact of such behaviour, on individual staff, will vary, but in effect this behaviour constitutes resistance to the involvement of safeguarding professionals. It averts the gaze of professionals away from the children in the family, and impacts on judgements, interpretation and intervention.

This has significant implications for the effective functioning of the multi-agency child protection system. Whilst professionals are spending a significant amount of their valuable time negotiating around such resistance, this can avert professionals from the safeguarding action that is required, and can leave the voices of the parents and children unheard. It has the additional implications of posing a threat to the physical and emotional wellbeing of professionals, and can lead to professional fatigue.

Issues for the Board and member agencies to consider:

- Is the impact of caregivers' emotional distress, hostility and anger on the child protection process recognised by LSCB?
- How effective is the current policy in providing assistance to professionals in identifying and working with families in this context?
- How are the London Child Protection Procedures understood, and guidance implemented, in this area of work?
- What else is in place to assist multiagency professionals in working with families where these issues feature?
- What is in place to enable parents with learning difficulties to engage in child protection meetings and processes?
- How is supervision used to help professionals consider the impact of hostility both on their work to safeguard children and on their own wellbeing?
- How are children, whose emotional needs are overshadowed by those of the caregiver, identified and provided with a means of expressing their voice?
- What else may be needed to assist professionals in eliciting the voices of children and their parents in these circumstances?
- How will LSCB know whether there have been improvements in this area?

Finding 7: There is a tendency to use written agreements to support child protection arrangements. The effectiveness of written agreements, as a tool to ensure parents do what is required of them, is questionable.

The use of written agreements has become custom and practice in safeguarding children and can be found in frequent use when a child is the subject of a child protection plan. Yet legislation, statutory guidance procedure and policy, make no mention of the use of written agreements in the safeguarding of children. The purpose, and value, of such written agreements is unclear. Their use appears to have originated from cases where legal proceedings are anticipated, or are in progress, with the intention of building up a picture of evidence for court. However, the use of these agreements is highly questionable, particularly when a case is outside of legal proceedings. They are being increasingly used in a mechanistic way *as if* they can create safety for the child, when this expectation is unrealistic.

How did this feature in this case?

Whilst the children were the subject of child protection plans, the parents were asked to sign two written agreements. The purpose of these agreements, was to give certain assurances about how the children would be protected from harm.

Written agreements were a repetitive recommendation from all the child protection conferences, and formed part of all the child protection plans. Data was found to suggest that two written agreements, were signed within the same month, in November 2011. The first was signed by mother, whilst she was still in hospital, after the birth of Child I.

This written agreement, was prompted by two specific areas of concern. Firstly, there was a police investigation into a serious allegation, made against maternal grandfather. Secondly, there were concerns the parents would not be able to cope with the care of all the children, after mother and Child I were discharged from hospital.

Hence, this written agreement stipulated a number of requirements, including securing a commitment, from mother, that the maternal grandmother would stay at the family home for the forthcoming 4 days, to assist in the care of the children, and securing a commitment, that the children would not stay in the home of maternal grandparents. Other requirements, included a commitment from the parents, that they would work in an 'open and honest manner with Lambeth C&YPS', and finally, that 'possible action would be taken by the LA', if the written agreement was breached.

The signatures of mother, and the allocated social worker, appear on this written agreement. Information from the case record, and from the allocated social worker, show that this written agreement was signed by mother, on the day she was due to be discharged from hospital with Child I. Signing this agreement, was a prerequisite to discharge.

Two days later, the community midwife visited the family home. She was not aware of the written agreement. On her visit to the family home, she met with the father and maternal grandfather. Maternal grandmother and mother were not at home. All 3 siblings were present in the family home, the house was described as being occupied by a number of adult men, who were playing video games in the front

room. The maternal grandfather was caring for the children, and was keen to let the midwife know that he thought Sibling 2, had a 'neurological problem'; '*as she was often falling and bruising herself*'. He took the midwife into a separate room, and showed her a bruise on Sibling 2. When the midwife questioned the maternal grandfather about the bruise, he became hostile. The midwife felt concerned for sibling 2, and for her own safety. She left the house, and reported her concerns.

The second written agreement was signed, by the mother at a core group meeting. This written agreement, had been a recommendation of the case conference. This agreement outlined details of the child protection plan. The agreement included the requirement that the children would not be cared for by the maternal grandfather, and would not stay at the home of the maternal grandparents.

Sometime later, Sibling 3 was presented to A&E, by the maternal grandfather. His finger nail had been torn out, and was infected. Maternal grandfather explained, to A&E staff, that whilst Sibling 3 and Child I were in his care overnight, Sibling 3 had been injured by Child I. This explanation was accepted as a plausible explanation for the injury. A&E staff were not aware that the children should not be in the care of maternal grandfather. Had they been aware, this may have prompted greater curiosity about this injury.

Father was not asked to sign either of the written agreements. The written agreements were breached by the parents, however, there was no action taken to address these breaches. There was no data found, to suggest these written agreements were the subject of monitoring or review.

Given that both parents were thought to have a learning difficulty, and both were identified in core assessments as being 'unable to read or write', it is unclear how much of these written agreements the parents understood. In a conversation with mother and father, as part of this SCR, mother confirmed that neither she, nor father, were able to read.

There were limits, to how the content of these written agreements were shared with the multi-agency group. The first written agreement was shared, with the mother, and placed on the case file, held within Children's Social Care. It was not shared with the midwives, or any other professional within the multi-agency group. The second written agreement was shared with core group members, but due to the restricted membership of this group, a number of key professionals were not aware of this agreement. The implications were that the full multi- agency professionals, who were responsible for safeguarding the children, were not aware of the agreements, or of the concerns that led to a number of terms outlined within these agreements.

How do we know it is not peculiar to this case?

Information shared by members of the Case Group, and Review Team, identified that the practice of using written agreements, to supplement or to add weight to a child protection plan, was *"routine"* in Lambeth. Case Group members identified, that written agreements are; '*often a recommendation of a case conference'.* Members highlighted their concerns about occasions when the details, in the written agreements, are inaccurate, suggesting the wording has been "*cut and pasted"*, from agreements used with other families. They raised concern that the wording can be "lengthy" and "*difficult to understand"*, and highlighted that the system, for monitoring compliance and taking action when there was a breach of the agreement, was "*ineffective".*

How widespread is the pattern?

The collective experiences of the Review Team members, indicated that the use of written agreements was a long standing, established practice, in safeguarding children. This experience suggested their use was widespread, was often included as a requirement within legal advice, had become a routine recommendation of child protection child protection conferences, and was often referred to under the banner of 'best practice', within 'safeguarding' training.

In an article about written agreements[31] J. Nicolas states the following:

> *"Partnership agreements between social care authorities and parents have been in use for many years, but it is not possible to trace their origins as there is no reference to them in legislation or statutory guidance. I can also find no mention of them in local safeguarding children boards' policies or procedures.*
>
> *Partnership agreements are seen by professionals as one of the tools that can be used to help keep a child safe, yet there is no evidence that they do. In fact, the opposite can be true as they can give a false sense of assurance that the child is safer, because the agreement has been signed by the parent or carer."*

Attempts to uncover relevant research, returned nothing of significance. In the review of the literature, an article, by the BBC, makes powerful reference to their use:

> *"Swansea Council has been condemned for "naive" informal agreements to protect children from abuse, according to a leaked report seen by BBC Wales.*
>
> *A critical report from 2007[32] demanded that the council stop the practice of non-binding written agreements with parents to protect children".*

What are the implications for the reliability of the multi-agency child protection system?

The use of written agreements, have become part and parcel of the child protection system, particularly for children who are suffering significant harm. Written agreements can be found in use, when legal proceedings are being initiated, or when the case is in legal proceedings. In these circumstances, there is a clear and present process, for both monitoring compliance and gaining evidence, the consequences of breaching these agreements are clear.

There is no evidence from research to indicate that use of these agreements provide added safety to children, who are the subject of a child protection plan. At best, the use of these agreements serve a purpose of providing a level of assurance to safeguarding partners, that children will be protected from a specific area of harm. However, this carries with it the inherent risk that, once the agreement is signed, the focus on the specific issue is lost. In addition, using written agreements as part of core group meetings, and gaining the signature of multi-agencies to these agreements, is questionable. The failure to provide copies of these agreements, to the multi-agency group, and the absence of robust mechanisms to enable compliance, monitoring and review, places the multi-agency team in an untenable position.

[31] 'The Guardian Social Care Network' (April 2014) J Nicolas
[32] The Care and Social Services Inspectorate Wales (CSSIW)

A written outline, spelling out some basic requirements of parents who require prompts and reminders in parenting the children, can be useful. However, to detail expectations that are unrealistic of parents, or to assume this provides reassurances that the child will be safeguarded, is a false and unsafe assumption.

The use of written agreements becomes additionally complicated, and highly questionable, when they are used with parents who have a learning difficulty.

Finding 7: There is a tendency to use written agreements to support child protection arrangements. The effectiveness of written agreements, as a tool to ensure parents do what is required of them, is questionable.

The origins of written agreements or partnership agreements are unknown. It is believed they may have evolved from the 'Task Centred' social work practice model, advocated by Epstein and Reid in the 1970s/80s. It is certainly true that legal advice commonly includes a recommendation that written agreements are signed by parents, when legal action is being taken/is being considered.

The merits of written agreements, as a mechanism to protect children from harm, is questionable. These agreements can often be found in use when a child is the subject of a child protection plan. But the setting of unrealistic expectations, the lack of any real consequences when breach occurs, and the lack of a reliable system for monitoring and review, renders these agreements worthless. In their current form and use, written agreements pose a threat to the reliability of the multi-agency safeguarding system.

Issues for the Board and member agencies to consider:

- Are Board members aware of how written agreements are used in safeguarding children?
- What steps need to be taken by LSCB in order to explore how written agreements are used in Lambeth?
- Is this an area of practice that is addressed in any current training/ policy procedure/practice guidance? If so is this guidance/policy procedure fit for purpose?
- What kind of information do LSCB need to identify whether the use of written agreements have a future value in the protection of children?
- How will LSCB know this matter has been progressed, and there are improvements in this area?

Additional Learning

Additional learning points are outlined in the following section of this report. It is the view of the Review Team that due to their potential local and national significance, these are important matters to highlight to the Board.

Additional Learning 1: Is there a pattern in Lambeth of routinely identifying protective factors and strengths in families, as part of the child protection process that results in false re-assurances when the strengths are named but not fully assessed or are given undue weight?

On researching the prevalence of this issue, the Review Team were not completely convinced there was sufficient data to present this as a key finding of this SCR. However, based on the information gathered and in the knowledge that, in line with other LA's/CC's, Lambeth are in the process of embedding a strengths based model into child protection case conferences, the Review Team felt this to be an important matter to be brought to the attention of LSCB. Hence the issue is presented as a question posed to LSCB, with the view to prompt further exploration and debate.

"Historically, when it comes to assessment, direct service providers have largely been trained to identify deficits and pathologies for specialized services. Problem focused assessment often leads to a laundry list of the things that are considered to be "wrong" or dysfunctional with children and their families. Unfortunately, practitioners can become stuck in their view of the child and family because they have too much information about the problem and not enough information about strengths and solutions".[33]

In response to the growing body of research, reflecting the position characterised in the quote above, there was a national move to better identify strengths in work with individuals and families. This has resulted in various assessment models being adopted throughout the country that provide a framework to facilitate a strengths-based approach to working with children and families. Statutory guidance, contained within Working Together 2013, states the requirement that '*child protection plans should reflect the positive aspects of the family situation as well as the weaknesses'.*

This case has suggested that whilst there was no a formal model, procedure or policy, to frame this approach in Lambeth, there is information to suggest that the principles of the strengths based approach were adopted. Whilst in line with statutory guidance, this approach can have the unintended consequence of over-estimating the strengths and resilience in families, thus providing a false reassurance to the professional network.

In this case, information from the core assessments, child protection reports, and from case group members, identified the maternal family as a 'strength'. It was clear, the maternal grandparents were active in the care of the children, and they assisted the parents in ensuring the children attended required appointments. Maternal grandmother was often present at core group meetings, and both were often present during professional visits to the family home.

[33] Rudolph, S.M., & Epstein, M.H. (2000). Empowering children and families through strength-based assessment. Reclaiming Children and Youth.

There was other information, about the maternal family, suggesting that, rather than a strength, the maternal grandparents posed a risk to the children. There was a serious allegation made against maternal grandfather that was not resolved during the time line under review. A cousin of the children, who was living in the home of maternal grandparents, was the subject of a child protection plan, under the category of emotional abuse. He was removed from this home after being subjected to a physical assault. Maternal grandmother was frequently observed to demonstrate hostility towards professionals.

It was clear, from case group members, there was, what seemed to be, a received wisdom, about the maternal family providing a 'safety net' for the children. It was also clear, there were some who held a different opinion about the ability of the maternal family to offer protection to the children. This opinion was expressed during conversations with case group members, but was not sufficiently represented, in the child protection conferences or core group meetings, in a way that informed an assessment of risk.

It was evident, from the contributions of case group members, there was limited knowledge about the concerns held about the maternal family. Each member of the Case Group held different pieces of information, about the maternal family. No complete picture seemed to be available, on which to make a judgement about whether the maternal family strengthened, or weakened, the protection of the children.

When safeguarding children, who are the subject of a child protection plan, it has become expected best practice to clearly articulate the strengths, and protective factors, alongside the risks, in families. This allows for a more balanced view of the family to be taken, and for these strengths to be built upon, to maximise the current and future protection of the children.

This approach is based on extensive research[34].This research concludes that, when working with children, young people and families, using this approach leads to improved outcomes. However, caution is advised in relation to how strengths are assessed, in working with children where harm to a child is known or suspected. [35]

The National and Local Picture

As stated, a number of models structuring this approach, and proving guidance to practitioners in their work in this area, have been introduced across the country. The move, to introduce a strengths based model in the child protection process, specifically within the context of child protection child protection conferences, has been a relatively recent development. A number of county councils and local authorities, have now adopted a strengths based model in child protection case conferences (these models are termed, and known, interchangeably as the 'Strengthening Families' approach or 'Signs of Safety'[36]).During the time line under review, Lambeth had not adopted such a model. It is early days in national implementation, and there is limited research about the long term benefits of such a model, particularly when it is used to safeguard children who are the subject of significant harm. Early experience suggests that, whilst the model can bring some clear benefits, there is a need to ensure the strengths do not overshadow the emphasis placed on risks, and further to ensure that, where strengths are identified, these are subject to the same scrutiny and analysis as the risks. Assessments and plans, that adopt a view of strengths that is overly optimistic, carry an inherent danger of leading to services that replicate this optimism, thus weakening the protection of children.

[34] See among others: Feeley, Russo, Early etc
[35] Signs of Safety in England NSPCC 2013
[36] Turnell et al.

Is there a pattern in Lambeth of routinely identifying protective factors and strengths in families, as part of the child protection process that results in false re-assurances when the strengths are named but not fully assessed or are given undue weight ?

Lambeth commenced piloting the 'Signs of Safety' approach, to child protection conferences, in April 2014. There has been a recent change in the way assessments, child protection conferences and reports to conferences, are structured and formulated. These changes reflect this 'strengths based' approach. It is early days in the implementation of this approach, for children subject to child protection plans, both locally and nationally.

It is unclear, at this point, whether the changes, already made in Lambeth, will address the potential vulnerabilities this case has revealed. As LSCB continue to review the merits of this approach, it will be important for LSCB to consider the possible implications of this issue within the context of child protection conferences, and more broadly, in examining how targeted and specialist services work with families using a strengths based approach.

Additional Learning 2: The tragic death of another child had a significant impact on the multi-agency team and had a detrimental effect on the work in this case.

In March 2013, the social work team, responsible for Child I and his siblings, had learnt of the death of a child, with whom they were also working. This had a significant impact on the Social Work Team.

Whilst contending with the very practical and emotional implications of this death, they were continuing to provide support to this family, and to all the families on their case loads. Due to sickness and staff moving on, by July 2013 the team had only half its capacity. The Team Manager had left and a brand-new Deputy Team Manager was in place, who had previously worked this case. Whilst the team attempted to recover, various agency staff were brought in, who were variable in quality. This meant that permanent members of the team carried more than their share of statutory cases for a while, until the team could be stabilised. It is the view of the Review Team, this would have undoubtedly had an impact on the services this team were able to offer over this time.

In addition, there are very real emotional implications to the work of safeguarding professionals. Hearing of the death of a child and, in addition, working with children who are abused and with adults, who exhibit unresolved emotional needs often stemming from their own traumatic childhood, can be both a professional and personal 'challenge'. Little is written about the impact, on the workforce, of this day to day work, nor on the implications of dealing with the death of a child in a family, with whom they have had regular contact.

As previously identified, there was a wide range of professionals, providing services to this family. A number of professionals, had known the parents for many years. Many of the professionals had known, and worked with the children, from the time the children were born. The death of Child I, was shocking.

Professionals were deeply saddened by the tragedy, and felt a deep sympathy for all members of the family.

During this case review, members of the Case Group demonstrated their anger, frustration, and sadness, in a number of ways. The Review Team witnessed the way in which professionals questioned their professional worth, and how, during their own reflections on practice, they ruminated on critical internal scrutiny of their own actions. This is a natural human response to the death of a child, and indeed can be a necessary part of professional development. However it is unhelpful, and potentially both personally and professionally damaging, if staff are not provided with the right levels and the right type, of support in order to helpfully process the impact of such a tragic event.

When a child dies, who has been in receipt of services from any agency, the experience of the Case Group and Review Team revealed that the first response, is to look to find something, or someone, to blame. This frequently seen natural human response to tragedy, is replicated in the wider societal response. What gets lost in this process, is an evaluation, and informed response, to the human cost, and the implication this has on the safeguarding of children.

Members of the Case Group spoke with feeling, about the emotional impact of the work they do in safeguarding children. Some talked about receiving a level of support, in their day to day work, and in response to learning about Child I's death, although most referred to the limited support they normally receive, and had received, in dealing with the news of Child I's death. They spoke about, and demonstrated, the resultant impact this had on their internal emotional worlds. They were keen for this issue to be brought to the attention of LSCB, in order for LSCB to give thought to how a duty of care can be offered to professionals now and in the future.

The tragic death of another child had a significant impact on the multi-agency team and had a detrimental effect on the work in this case.

The effective safeguarding of children, is predicated on the work completed by staff in their day to day working life. A healthy workforce, is a prerequisite to this work.

Whilst it is recognised, that professionals are expected to work in situations where trauma is present, and indeed professionals acknowledge and accept this as part of their working life, the professional and personal costs of trauma, particularly when a child dies, are underestimated and so unacknowledged. These feelings often remain unresolved. This has an enduring impact on the work of safeguarding professionals, and can lead to sustained personal distress that persists over time.

LSCB are encouraged to examine the ways in which member agencies' duty of care, owed to the safeguarding workforce, is exercised, to ensure professionals are supported in dealing with the emotional impact of the work they undertake, not just in response to the death of a child, but also in their day to day work.

It is the view of the Lead Reviewers, members of the Case Group and the Review Team, that taking steps to address this impact, will allow the safeguarding of children to be strengthened.

Appendix 1: Methodology

Introduction

The case review used the systems methodology developed by the Social Care Institute of Excellence (SCIE) called *Learning Together*[37].The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

The methodological heart of the Learning Together model has three main components:

- Reconstructing what happened – unearthing the 'view from the tunnel' and understanding the 'local rationality'.
- Appraising practice and explaining why it happened through the analysis of Key Practice Episodes (KPE's).
- Assessing relevance and understanding what the implications are for wider practice – using the particular case as a 'window on the system'.

Using this approach for studying a system in which people and the context interact, requires the use of qualitative research methods to achieve transparency and rigour. The key tasks are data collection and analysis. Data comes from structured conversations with involved professionals, case files and contextual documentation from organisations.

Review Team

The review has been carried out by a Review Team led by Accredited Learning Together Lead Reviewers Bridget Griffin and Ghislaine Miller. The Review Team received support throughout the process by the Quality Assurance Officer & SCR Project Support, and the Chair of the Serious Case Review Subcommittee, who took on the role of champion for this review.

Collectively, the role of the Review Team is to undertake the data collection and analysis and author the final report. Ownership of the final report lies with the LSCB as a commissioner of this Serious Case Review (SCR).

The Review Team was made up of nine senior representatives from the different agencies that had been directly involved with Child I. The role of the Review Team Member is to provide expert knowledge in relation to the practice of their individual agency, to contribute to the analysis of practice and to the development of the findings from the review.

[37] Fish, Munro & Bairstow 2009

Review Team Members

Andrew Wyatt	Assistant Director, Multi-Agency Assessment, Family Support and Child Protection (CYPS)
Avis Williams-McKoy	Nurse Consultant, Designated Nurse LCCG
Davina Mackenzie	Consultant Community Paediatrician Lambeth Community Health GSTT
Debbie Saunders	Named Nurse Safeguarding Children, Guy's and St Thomas' NHS Foundation Trust
Frances Wedgewood	Named GP for Safeguarding, NHS Lambeth
Geraldine Abrahams	Head of MAT 2 Service. Early Intervention and Targeted Services LBL
Graham Griffin	Senior Safeguarding Adviser (Schools), CYPS (QA)
Malcolm Ward	Independent Chair, Lambeth Serious Case Review Panel
Rosalinda James	Head of Nursing/Named Nurse Safeguarding Children King's College Hospital NHS Foundation Trust
Rupinder Virdee	Quality Assurance Officer & SCR Project Support CYPS LBL
Russell Pearson	Specialist Crime Review Group, Met Police

Support from SCIE was provided in the form of case consultation, supervision and quality assurance.

Specialist Advice

The Review Team received specialist input, about adults with learning difficulties, to support an understanding of systems and the interpretation of professional practice in this case.

The Acting Head of Adult Learning Disabilities Team, was invited to join a meeting of the Review Team.

This input provided an extremely useful insight into how adults with learning difficulties are assessed and provided with services and assisted the Review Team in understanding the kind of difficulties the parents in this family may have faced. It also helped in bringing sensitivity to how professional practice was appraised. For example, it gave an insight into how the parents may have made sense of the guidance provided by practitioners.

Structure of the Review Process

The SCIE model uses a process of iterative learning, gathering and making sense of information about a case that is a gradual and cumulative process. Over the course of this review there have been a series of meetings between the Lead Reviewers, Champion, Review Team and Case Group members.

Initially there was a meeting between the Lead Reviewers and the Review Team to explain the SCIE Learning Together model and the role of the Review Team in the process. The Review Team then decided the membership of the Case Group based on their individual involvement in the case.

An introductory meeting took place with the Case Group at which the Review Team was also present. At this meeting the SCIE model was explained to the Case Group and their role in the review process was clarified. Case Group members were informed they would be involved in individual conversations with Review Team members and the Lead Reviewers and given the opportunity to reflect on and explain their involvement with the case.

During the course of the review the Review Team met on ten occasions. The Case Group met on three occasions: one for the introductory session and then for two full day follow-on meetings, where the emerging analysis was discussed and challenged. The Review Team were present in these meetings.
The review followed the process, and meeting structures, as outlined by SCIE with additional governance meetings arranged over the course of the review. These meetings involved the Lead Reviewers, SCR Champion, the Independent Chair of Lambeth Safeguarding Children Board (LSCB), and senior managers representing key agencies.

Timeframe and Mandate

In line with qualitative research principles, reviewers endeavour to start with an open mind in order that the focus is led by what they actually discover through the review process. This replaces the terms of reference (that have a specific focus of analysis before the review process has begun) which are a fundamental feature of traditional Serious Case Reviews.

The timeframe for the review was set at the initial meeting between the Lead Reviewers and the Review Team on 8th November 2013. A number of Review Team members were subsequently made aware of a significant history of early intervention services with the parents, this timeframe was later amended to allow a period of this early intervention to be included. The timeframe covered by this SCR is between **May 2010** and **July 2013**.

Within the period under review, seven key practice episodes were identified (covering the period from May 2010 until 23rd July 2013). These KPE's were then analysed in detail to provide insight into not only what happened with Child I but also why things happened as they did. It was from this process of detailed analysis that the learning from the review (presented as findings) was generated.

Sources of Data

The systems approach requires the Review Team to avoid hindsight bias and to learn how people saw things at the time – the 'view from the tunnel'. Identifying and examining Key Practice Episodes allows the Review Team to understand the way that things happened and explore the contributory factors that were influencing the Case Group's working practice. This is known as the 'local rationality'. It requires those who had direct involvement in the case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context.

Data from Family Members

At an early stage, in this SCR, the parents were contacted and invited to contribute to this review. They expressed their desire to engage in a conversation, to provide their perspectives. However, police advised that the status of the parents, as alleged perpetrator and witness in possible criminal proceedings, ruled out the possibility of their participation in this SCR. These proceedings remained ongoing throughout the review.

After a long period of negotiation, with the police leading the criminal investigation by members of the Review Team, agreement was reached for the parents to contribute to this SCR. Both Mother and Father met the Lead Reviewers, and a conversation was held about the services they received under the timeline under review. In this conversation, both Mother and Father were supported by a targeted youth worker, who had known the parents since their childhood.

The perspectives of the parents are reflected within this SCR. A transcript of the conversation will be provided to members of LSCB, to further support the learning from this SCR.

On behalf of LSCB, the Lead Reviewers wish to express their gratitude to the parents for engaging in this process with grace and humility. In addition, thanks are owed to the targeted youth worker who has continued to provide support to the parents in a time of indescribable loss and grief, and continues to provide support to the parents in looking to the future.

Child I's three remaining siblings are too young to make it feasible to gain their perspectives or experiences.

Data from Practitioners

Information was provided by members of the Case Group who were directly involved with the family through a process of individual conversations. They were invited to share their experiences of working with Child I and his family in the context of their knowledge, systems and practice at that time. A total of twenty four conversations were held with individual practitioners, who together formed the Case Group for the review. A lead reviewer and a members of the Review Team were involved in each conversation.

The Case Group attended two multi-agency meetings, to contribute to the analysis and findings and to share their knowledge of the systems as a whole to help understand whether practice in this case had local resonance.

Data from Documentation

In the course of the review the Review Team members had access to the following documentation:

- Integrated chronology
- Data from agency records
- Various correspondence across agencies
- Witten agreements with parents
- Initial and core assessments
- Minutes of child protection conferences
- Child Protection Medicals
- CLAMHS Assessment (Father)
- CYPS Leaving Care Pathway Plan (Father)

- CAF (Common assessment Framework)

Methodological comment

Participation of Professionals

The death of a child is a sad and tragic loss. The practitioners in this case knew this family well and many had been in direct contact with Child I and his siblings. This has both personal and professional implications for the practitioners. Naturally, there are feelings of grief for the child and the family. In addition, all the practitioners in this case demonstrated their heart felt desire to improve outcomes for children, and so with this as their mantra, to be involved in a family where a child has died, can bring about complex feelings about their professional worth. This is perfectly understandable and indeed natural. However, the impact of this should not be underestimated.

Throughout the process the willingness of practitioners to be involved, and make themselves available for conversations and meetings, has been impressive. At the first Case Group meeting over 40 practitioners and their line managers were present. At each stage of the process, Case Group members have repeatedly shown their commitment to engage in the learning, both in terms of systems and in terms of reflecting on their own of practice.

Representation from staff in the Children and Young People's Service in Lambeth, at Case Group meetings, was limited. This had an inevitable impact on how the voice of this service was represented in the Case Group meetings.

Fortunately, there was active participation by a senior manager from this service in the Review Team meetings, this provided a vital link to this service area.

After meeting with the parents, the Lead Reviewers were struck by the absence of housing services, both within the Case Group and the Review Team. It was concluded that this lack of representation, from housing services, resulted in a potential gap in the lessons learnt.

The Lead Reviewers and the Review Team have been impressed throughout by the professionalism, knowledge and experience the Case Group have contributed to the review, and their capacity to reflect on their own work so openly and thoughtfully. Several have remarked that it has been a positive experience to contribute to learning from the tragedy, for others the process has been more difficult. All this has given the Review Team a deeper and richer understanding of what happened with this family and within the safeguarding network and why, and has allowed us to capture the learning that is presented in this report.

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