Luton Safeguarding Children Board

Serious Case Review
Child F

Nicki Walker-Hall

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Executive Summary

Context

This serious case review (SCR) was initiated by Luton Safeguarding Children Board (LSCB) following the sad death of Child F at home, in October 2013, at the age of eight weeks; the review is about the family. The cause of death was unascertained however neglect features strongly in the background to the family. This review makes reference to a recent Child E SCR. The Child E SCR had similar features of neglect but differed as a criminal prosecution was sought. The Child E SCR was taken into consideration when the decision was made that this case met the criteria for an SCR.

The Children

There were six children within the family; at the time of Child F's death their ages ranged from 13 years to 8 weeks. All the school age children attended the same school throughout their childhoods.

Summary of Case

Prior to the review period

This family were known to agencies in Luton from 2001. Concerns identified were:

- Late booking for pregnancies
- Failure to attend health appointments/ school
- Head injury (Child 2) reportedly as a result of a fall off the settee
- Ingestion
- House fires
- Domestic violence
- Inadequate housing/ frequent house moves
- Poor supervision of the children

The children were placed on the child protection register under the category of neglect for a six-month period from April 2007. Following de-registration concerns continued and the case remained open to the local authority social care long term team. During this period sibling 2 had two attendances at A&E, school requested a professional meeting to discuss concerns including, falling asleep in class, head lice, presenting hungry, no coats, tired, poor lunchboxes, turning up with the night before McDonald's boxes, tummy aches, injuries and there was a suggestion by the social worker that the case should again be considered under child protection arrangements. Following discussion with the manager the Social Worker was advised to arrange a package of intensive support to reinforce the previous work from 2007 – this did not happen.

The school drew up a contract with the family in an attempt to address the concerns.

During the review period

The review period is from January 2010 until 17th October 2013, the date of Child F's death. The case was closed by Children's Social Care (CSC) at the start of the review period. The

closure was made by a team manager who had no contact with professionals or the family. The family did not comply with the contract drawn by school; they agreed to take certain actions but then didn't follow through with them and avoided further discussions.

Other issues noted in school during the review period are as follows:

All children	illness, housing issues children reported as presenting dirty and arriving late stating that there was no one up at school time to help them on-going concerns regarding health, hygiene, attendance, safety, and supervision
Parents	failure to attend meetings and were non-compliant
Sibling 1	presenting hungry
sibling 2	presenting with a burn to his neck, head lice and no socks sustained a burn to his arm not-collected from school presented without a coat or jumper, prolonged toothache low self-esteem self-worth withdrawn and upset suspected to be lying or stealing in school, fighting talking of injuries sustained from his younger brother, including a scar from a penknife and
sibling 3	ill-fitting shoes and head lice

Some health professionals had concerns regarding late or cancelled development checks, late immunisations, no access visits, neglectful home, no answer to telephone calls, failure to respond to child's health needs, refusal of home visits, no improvement in home, safety in the home and multiple house moves.

The Police attended two domestic violence incidents between father (the alleged aggressor) and mother, at or near the home and a domestic dispute in a vehicle.

The Urgent Care Centre and GP practice were aware of delayed immunisations, non-attendance at scheduled appointments, and loss of medication.

The health visitor, nursery nurse and children's centre had concerns around safety in the home including safe storage, clutter, sleeping arrangements, lone parent, lifestyle impacting on child and domestic violence.

These issues are largely the same as those which led to child protection registration in 2007 and whilst some assessments were made none were triggered by indicators of neglect; no

one assessed these issues as meeting the threshold for child protection and no interventions were introduced by children's social care to address the children's needs or improve their lived experiences and outcomes.

Child F was last seen by professionals 6 days prior to death at a Safe at Home[1] assessment, Child F was asleep in bed surrounded by pillows next to a hot radiator; overheating in babies has been linked to cot deaths. Advice was given and information shared within health. On the day of Child F's death he was found by father on the bed deceased.

Summary of Findings

Some of the findings within this case are for single agencies, others relate to wider multi-agency issues. Neglect was not hidden in this case but when assessed was graded as 'low level' by CSC. The pervasive nature of long term neglect was not recognised. There were factors present in this case that are known to be potentially life threatening in the first year of life; those factors were known to practitioners involved in the case. Some action was taken with a Safe at Home assessment however the concerns identified within the assessment were not referred, as per policy, to CSC for investigation.

Information sharing from agencies to CSC was variable, information sharing from CSC to partner agencies was poor and there were limited attempts by CSC to gather information from partner agencies during assessments. The Midwifery Service demonstrated good information sharing with CSC at the point of Mother's pregnancy booking appointments and when the children were born, opportunities to share information about address changes and admissions were not taken. The lack of response to the Birth Notification following sibling 5's birth left the family without a health visiting service and no health visitor input until aged 1. At times school shared information with health which should also have been shared with CSC. Health visiting, children's centre and Urgent Care Centre staff did not share information with CSC when indicators of neglect were known to them.

Thresholds being applied within CSC throughout the period under review were inconsistent, idiosyncratic, and focused on immediate presenting problems without evidence of taking sufficient account of identified risks from the past. Social Workers in the Referral and Assessment Team report there was an understanding that if possible assessments 'should not be triggered'. The lack of response from CSC to neglect acted as a barrier to other agencies, in particular the school, further referring concerns; a comprehensive assessment was not completed. The school were left to manage the issues they referred without the support of CSC and without the case being managed within a statutory framework.
The threshold applied to Domestic Violence (DV) incidents within CSC appears different to those applied for neglect as all DV referrals triggered a response and initial assessment. There was also a lack of CSC response to physical burns and injuries, with no consideration

[1] A Safe at Home Assessment is completed to identify hazards in the home and provide useful tips on how to eliminate or minimise the risk of an accidental injury

of the need for Section 47 inquiries to be initiated or the need for medical opinion to be sought.

Tools available to frontline practitioners were not generally used, for example no DV tool was used as part of an overall assessment, no vulnerability assessment tool was used by health visiting and no neglect assessment tools were used by any agency as part of an assessment of neglect – Graded Care Profile would have been useful at a number of points. CSC did not recognise the need to complete a core assessment until 2013.

Behaviours of sibling 2 were not seen in the context of the circumstances in which he was living. A number of factors influenced this. A lack of intervention from CSC, the criteria for CAMHS provision and a culture of school learning mentors working exclusively to the requirements of head teachers, meant that sibling 2's behaviour was left to school learning mentors to address when specific health services may have been better placed to undertake this work. There was limited direct school nurse input throughout the period of the review.

Escalation, there was no consideration that the indicators known to CSC required any social care intervention until the core assessment in 2013. The school, in particular made significant efforts to involve CSC but a lack of response meant over time they either gave up, changed focus onto the children's behaviours or ended up taking on more responsibility than they should. In total there were six referrals made. When external agencies received inadequate responses to their concerns there is no evidence they challenged the response, sought child protection supervision or requested their concerns be escalated. Frontline staff within Education did escalate their concerns to the Head Teacher in-line with expected practice at that time however at the time there was no culture of escalation within or between agencies.

Management Decisions to close episodes of social care involvement were flawed. On the first occasion (January 2010) the decision to close does not reflect the true level of concern within partner agencies, regarding the family, at that time. The decision was made on a single agency basis. Assumptions were made that no agency contact in the preceding ten months equalled no concern and led to an overly optimistic response. It appears partner agencies were not aware a decision was being made to close the case or that the case had remained open, therefore there was no opportunity to challenge CSC when this decision was made. On the second occasion (Summer 2013) the manager believed a child in need meeting had been held as instructed. The closing summary is based on beliefs that agencies agreed there had been an improvement in the situation for which there is no evidence. There is only one supervision session on the children's CSC case file, when a core assessment was in progress, demonstrating a lack of managerial oversight of the case.

Recording practice is a concern. Recording within social care was poor and did not assist managers in their decision making. Conversations between all professionals often went unrecorded. The Referral and Assessment Team did not record all contacts to the Team. Recordings that were made were not balanced and according to social workers were

focussed on negative rather than positive aspects of the family thus skewing the readers' view of the family. Additionally the voices of the children were either not sought or didn't feature within records meaning their experiences, wishes and aspirations were largely absent from assessments. The dynamics within the family were not represented in any records.

Delay was a recurring feature. The failure to follow through recommendations of the S47 assessment (2013) as a result of staff sickness, confusion around a child in need meeting, poor recording and a belief that external agencies had indicated the children's situation had improved, left known concerns unaddressed; as a consequence the children were left in unsatisfactory circumstances.

Relevance to wider context of safeguarding children where neglect is an issue

It has not been possible to conclude whether the sad death of Child F could have been prevented by the professionals involved as the cause of death is unascertained. What is clear is there were a number of factors known to increase the risk of child death present in this case. Brandon et al indicate that "To guard against catastrophic neglect, children need to be physically and emotionally healthy and have a safe, healthy living environment"[2]. Child F was not living in a safe, healthy living environment; this was known to some professionals but was not addressed prior to his death.

The response to neglect within this case brings into question whether other children may be suffering as a result of unrecognised neglect?

During the period under review there were some underlying issues across Luton impacting on professional's response to neglect. The lack of experienced trained professionals able to recognise and respond to indicators of neglect and use the locally preferred neglect tool meant the cumulative impact of neglect was unknown. There is evidence that policies and procedures designed to protect vulnerable children were not followed and the advice from some managers, at times, acted as a barrier to social workers in the Referral and Assessment Team initiating assessments.

There is evidence in this case that the children were left living in risky and neglectful situations without this prompting referrals or assessment.

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[2]Brandon, M., Bailey, S., Belderson. P and Larsson, B, (2014) The Role of Neglect in Child Fatality and Serious Injury. Child Abuse Review, Volume 23, Issue 4, pages 235–245, July/August 2014

The NSPCC in a systematic review of all Serious Case Reviews in 2009-2011 concluded that practitioner's needed to be supported by a system that allows them to make good relationships with children and parents and supports them in managing the risks of harm that stem from maltreatment, including harm from neglect and the way that neglect can conceal other risks and dangers.

The review has been aware throughout its work of the Serious Case Review undertaken in relation to Child E, who died in early 2014, which reached very similar findings. It has not been in a position to consider how far these difficulties have been addressed. The review has heard that there remain difficulties in recruitment in some key areas and high proportions of newly qualified staff. In the absence of improvements in staff skill and training and better managerial oversight the risk that a similar episode could occur remains.

What will the LSCB do in response to this?

Sections 4 and 5 set out findings and challenges for Luton LSCB. The LSCB has prepared a separate document which describes the actions that are planned to strengthen practice in response to the findings and recommendations of this serious case review.

1.1 Reason for Review

1.1.1 This review was commissioned by Luton Safeguarding Children Board (LSCB) following the sad death of Child F on 17th October 2013. Child F died at home at the age of eight weeks. The cause of death was unascertained however neglect features strongly in the background to the family, (though it was not cited as a contributory factor in the death) and there were concerns this case had similar features to the Child E SCR a further review being conducted concurrently featuring neglect. Although the Child E SCR had similar features of neglect it differed as a criminal prosecution was sought. The Child E SCR was taken into consideration when the decision was made that this case met the criteria for an SCR.

1.1.2 The Serious Case Review Group met in September 2014 following referral from the Child Death Overview Panel (CDOP) and agreed that the death was consistent with the Local Safeguarding Children Boards Regulations 2006 (Regulation 5) that requires a Serious Case Review be undertaken where the abuse or neglect of a child is known or suspected and the child has died.

1.2 Methodology

1.2.1 This review has made use of the underlying principles of a systems based review exploring the multi-agency system in place to support families and safeguarding children. The methodology is contained in full as appendix 1 and was underpinned by the requirements contained within Working Together 2013.[3] A Review will:

- Recognise the complex circumstances in which professionals work together to safeguard children;
- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Be transparent about the way data is collected and analysed; and
- Make use of relevant research and case evidence to inform the findings.

1.3 The SCR Process

1.3.1 The LSCB brought together a panel of experienced managers and professional advisors to oversee the review. The membership of the panel is contained as appendix 2. The panel drew up terms of reference and these are included in their entirety in appendix 3. These provided a framework for the single agency reports, Individual Management Reviews (IMRs) commissioned from the agencies that had

[3] Education Department (2013) Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children. London NB: This methodology meets the requirements of Working Together (2015) which came into force during the period of this review.

contact with this family.

1.3.2 These reports made use of existing records, policies and procedures as they related to the professional response to this family, and interviews with the professionals directly involved in the case. The panel met on a number of occasions to review the single agency reports, develop an analysis and to consider the draft reports provided by the overview author. The overview author accompanied IMR authors in interviewing some key individuals and managers. The analysis and conclusions of this report have been reviewed to ensure they are reflective of the experiences of the professionals involved.

1.4 Period Covered by the Review

1.4.1 The review covers a 46 month period of time from January 2010 leading up to and including the October 2013, the date of the critical incident.

1.4.2 The government has introduced arrangements for the publication[4] in full of Overview Reports from Serious Case Reviews. This report has been written in the anticipation that it will be published. Consequently the information in the report:

- Is appropriately anonymised;
- Takes reasonable precautions not to disclose the identity of the children or family;
- Protects the right to an appropriate degree of privacy of family members;
- Avoids the possibility of heightening any risk of harm to these children or others.

1.5 The Family

Child F	Died aged 8 weeks
Relationship to child subject of review	Age at November 2013
Mother	31
Father	32
Sibling 1	13 yrs.
Sibling 2	12 yrs.
Sibling 3	11 yrs.
Sibling 4	8 yrs.
Sibling 5	3 yrs.
Mat Grandmother	Not known

The family were of Pakistani origin although mother was born in the UK.

[4] See Working Together 2013

1.6 Family Involvement in the review process

Family members were offered the opportunity to contribute to the review and meet the reviewer on two occasions. Regrettably this was not taken up and the family has subsequently left the UK.

1.7 Limitations

1.7.1 A number of professionals who were involved in this case no longer work for their respective agencies, namely the health visitor, a social worker and some education staff. Whilst these practitioners have not contributed to the review their managers have provided additional contextual information so as to enable the review to understand practice at the time, capture learning and inform recommendations. Other staff were absent from work during the period when the review was being undertaken.

1.7.2 Lack of family involvement has limited the authors' understanding about how professionals attempted to work with family members, as well as reducing the opportunity to talk to the older children about their lived experiences.

1.7.3 Aspects of the family e.g. origin, race, religion and culture have been difficult to explore as a result of limited professional and no family involvement.

2. Synopsis of Previous Involvement

2.1.1 This family was known to agencies from 2001 when Mother made a late booking with the antenatal service for her first pregnancy with Sibling 1. Late booking was a feature of her first four pregnancies. There were further indicators of neglect known to services within health including failure to attend routine health appointments, a head injury and an ingestion of body lotion for Sibling 4.

2.1.2 The family were referred to Children's Social Care in 2004 however it was not until two house fires in 2006 that there was any significant involvement. The Police investigated the main fire; it was suspected sibling 2 had played with a lighter leading to the fire. Attending Police officers raised concerns regarding the state of the home and noted child protection concerns around supervision and possible neglect. Although parents were interviewed no charges were brought.

2.1.3 The case proceeded to child protection conference in April 2007; concerns, at that time, included inadequate accommodation, state of the family home, poor supervision of the children, children not brought to health appointments, immunisations out of date, and marital stress. In light of these concerns all the children were placed on the Child Protection Register under the category of neglect for a six month period.

2.1.4 During this period of registration Child 1 sustained a burn; there were conflicting

accounts of how the burn occurred. There were incidents of Domestic Violence[5] but despite these concerns those involved felt the family were making progress. Following removal from the Child Protection Register the Long Term Team[6] continued to work with the family under a family support plan and working agreement undertaking parenting assessments, relationship work between the parents, budgeting, housing support, legal status support for Father, and keeping safe work with Child 1 until closing the case in 2010; at which point there had been no input for 10 months.

2.1.5 Between Oct 2007 and Dec 2009, there were at least 8 contacts into CSC relating to Domestic Violence, injuries, and failures to attend. School also made at least 2 contacts to health and made multiple attempts to set up a professionals meeting in order to discuss and manage their continued concerns.

2.1.6 The school made a decision in December 2009 to put in place a contract between the parents and school; a single agency attempt to manage the deteriorating situation when other avenues seemed to be limited.

3 Concise narrative of professional involvement with the family

3.1.1 This outline of the professional involvement with Child F and family covers a 46 month period from January 2010 up to October 2013, the date of the critical incident. The records pertaining to all the children have been reviewed and where deemed relevant will be referred to. This section does not provide any comment, analysis or conclusions as these are set out in the subsequent sections of the report.

<u>January 2010</u>

3.1.2 At the start of the time frame Siblings 1, 2, 3 and 4 were an open case to children's social care long term team. There was no evidence of social worker involvement and no direct work for 10 months prior to the case closure by a team manager, not an allocated social worker, and this was without discussion with partner agencies.

<u>November 2010</u>

3.1.3 Police reported a domestic violence incident between mother and father where mother was assaulted, to CSC. Mother declined to make a complaint. Father was arrested for common assault. CSC completed an initial assessment, but took no further action; family workers within the school were noted to be taking action to improve the children's attendance. The police took no further action as they deemed the incident did not pass the threshold test for prosecution.

<u>July 2011 – March 2012</u>

3.1.4 Mother was seen by a community midwife; she was reportedly 8 weeks pregnant with Sibling 5. The midwife completed an information sharing form because there had been previous social services involvement. She discussed it with a social worker

[5] Domestic Violence is a pattern of behaviour which involves violence or other abuse by one person against another in a domestic setting

[6] Long Term Team provided long term support to families in line with their assessed needs

from the Referral and Assessment Team and was informed the case had been closed; she shared the information with health visiting.

3.1.5 Mother attended all her antenatal appointments. Sterilization was planned but later declined just prior to delivery. The midwife visited mother and sibling 5 three times prior to discharge.

3.1.6 In January 2012 there was a contact to CSC with general child care concerns, no action was taken.

<u>September 2012 – November 2012</u>

3.1.7 Sibling 5 had a nine day hospital admission for viral meningitis, receiving IV fluids and antibiotics. Mother accepted the offer of some weaning support from the health visitor which was later declined.

3.1.8 CSC were informed the family were to be evicted but record this as 'for information only'. Sibling 2 was reported to be fighting in school on two occasions. On one occasion no adults came to collect the children from school and sibling 2 had been given this responsibility despite being unwell. There were general concerns regarding the children's presentation; father was seen to be rather forceful to sibling 2 over a forgotten jumper.

3.1.9 Poor school attendance was believed to be impacting on sibling 1's ability to sustain friendships.

<u>December 2012 – February 2013</u>

3.1.10 Sibling 2 was referred to CSC after talking in school about injuries sustained from his brother using a pen knife. CSC sent the family a supervision letter reminding them of their 'responsibilities'. No assessment was completed and the school were informed no further action was to be taken. Mother complained to school regarding the referral.

3.1.11 Sibling 5 presented with health concerns; Salbutamol had been lost in a house move. Sibling 5 failed to wait; the health visitor was informed. Sibling 5 failed to attend a follow up audiology appointment; the health visitor completed a Pre CAF checklist[7].

3.1.12 There was a DV referral in respect of mother. Mother reported she was 4 months pregnant and scared to return home, she requested hostel accommodation. Mother indicated significant relationship difficulties; the case was referred to the Honour Based Violence (HBV) team. A home visit followed; father was deemed capable of caring for the children, hostel accommodation was subsequently declined by mother who returned to the family home. A strategy meeting was held (s47), an assessment completed which concluded the incident 'did not put the children at risk'. No offences were noted and the Police decided no further action was needed.

3.1.13 Ongoing concerns regarding 'low level' neglect, disguised compliance, and the demeanour of the children were referred for prevention and early intervention and a meeting arranged. The 1st meeting was cancelled by the social worker, the 2nd

[7] Pre CAF checklist - seeks to standardize for all agencies the information that is being recorded by professionals about a child.

meeting was cancelled by mother and the 3rd meeting was attended by a newly allocated social worker.

3.1.14 Sibling 5 had a respiratory tract infection and attended A&E. The health visitor was informed. Sibling 1 was seen by the school nurse and growth monitored. The community midwife completed a pregnancy booking at home, completing an information sharing form regarding the DV which she sent to the health visitor.

3.1.15 Sibling 3 attended with swollen genitalia and was admitted to the children's ward where child protection issues were considered and excluded, she denied anyone had hurt her. Paediatricians concluded she had possible gratification syndrome, this was reported to the social worker and it was agreed this would be assessed as part of the section 47 enquiries. The health visitor tried to act on the community midwives notification of DV by visiting the family but they were first away and then out.

3.1.16 The social worker visited sibling 3 in school and referred the child to the school nursing team for assessment. Concerns continued with regards to sibling 2's behaviour, he was getting into fights, displaying poor behaviour, and had very low self-esteem. School family support workers worked with sibling 2 who responded well to praise and targets.

<u>March 2013 – July 2013</u>

3.1.17 The health visitor gained access to the home. Missed audiology appointments were discussed and sibling 5 was re referred. Mother was asked about DV. Mother was aware of where to seek help and support and was strongly advised to attend all appointments. Mother indicated she was 12 weeks pregnant, under the midwife, and due to be evicted due to rent arrears; they were seeing the council that day. Following two failed visits the 1 year developmental check was completed by the community nursery nurse; no concerns were noted.

3.1.18 School contacted the social worker for an update on progression of the Section 47 assessment and were informed there was to be one further visit and then the Intensive Support Team (IST) were to work with the family.

3.1.19 A child in need meeting was convened by the school; inviting the school nurse, who shared the recording on SystmOne with paediatric audiology, child health and health visiting. The planned child in need meeting did not take place having been cancelled once by the social worker and once by the parents.

3.1.20 There were address changes x 2 within a month.

3.1.21 Sibling 5 continued to have health problems, was admitted for shortness of breath and discharged on oral steroids and inhalers.

3.1.22 There was a domestic dispute in the family vehicle at Luton town centre. No offences were noted and no information was shared with other agencies.

3.1.23 Sibling 5 attended audiology clinic and was referred to Ear, Nose and Throat (ENT) (copied to GP, H/V and parents) for further assessment and treatment and discharged. Sibling 5 subsequently attended ENT, moderate hearing loss remained but she was developing well. Parents were to observe and review in 6 months.

3.1.24 Sibling 3 failed to attend for the result of her endocrine test. There was a plan to invite for further appointment in 6 months' time; this didn't happen.

3.1.25 CSC received a letter from Housing re Section 184 homeless application. There were further concerns regarding Sibling 2's behaviour in school, he was verbally abusive to two girls in his class. Mother continued to access midwifery care.

3.1.26 A health visiting handover sheet was completed following reallocation due to the family's move. The school nurse chased up new address details and requested the date for the child in need meeting; school agreed to inform when it was received.

3.1.27 The school nurse contacted the Referral and Assessment Team. There was confusion around the date the next child in need meeting would be held following cancellation. She was informed the last social care visit was in February 2013 and the case was now closed. The Section 47 was recorded as complete, however on further exploration the core assessment was not complete nor was a pre-birth assessment in respect of Child F. Mother was due to give birth in September. The Referral and Assessment Team worker planned to speak to her manager and contact the school.

3.1.28 Confusion regarding the family's address led to ineffective visits by professionals. The community midwife continued to home visit. The family moved again.

<u>August 2013 – October 2013</u>

3.1.29 Child F was born by planned Caesarean Section at 37 weeks weighing 2.65Kg. Whilst mother was an inpatient father reportedly became 'distressed' on the postnatal ward about Child F's feeding and a perceived lack of support towards mother; he was swearing at staff and security were called. Mother and baby were discharged two days later with a verbal handover between midwifery and the health visitor. The community midwives continued to home visit until day 10.

3.1.30 In September the health visitor did a joint home visit with the community nursery nurse, Child F appeared content and alert. A home visiting questionnaire was completed. Mother indicated she often had mood swings but was fine with plenty of family support. Father smoked and domestic abuse was identified. Safety around the home was discussed and a Safe at Home visit was to be arranged. Vulnerability Risk Assessment (VRA) was not completed at this point. Mum was encouraged to attend child health clinic.

3.1.31 There were concerns regarding sibling 2 not going into school; on one occasion he ran off from school staff. Mother was visited at home and abdicated responsibility to the school. School contacted the health visitor and class teachers were asked to monitor closely so a concise chronology could be collated.

3.1.32 A Sure Start family worker and fire officer attempted to complete the Safe at Home visit but got no access.

3.1.33 The school family workers visited the home because the children were late for school. They noted the outside of the home was untidy with a full open dustbin and four black bags surrounding the bin. The lid of the bin was open; on top were uncovered nappies with flies around them. The family workers were concerned as it was suspected the children were alone. Mother eventually came down and

explained she was tired and had been upstairs with baby. The school left a message for the health visitor.

3.1.34 Child F attended the Urgent Care Centre and was diagnosed with possible infantile colic, prescribed infacol and nasal drops and advised to see the GP as required.

3.1.35 Sibling 2's behaviour continued to be challenging in school; he was rude and aggressive towards adults.

3.1.36 The school nurse contacted the Referral and Assessment Team for update and was informed the S47 had been completed. Significant improvements were reported by the Referral and Assessment Team and the case closed. The school nurse had no outstanding concerns so closed the episode of care.

3.1.37 At the same time school had become increasingly concerned, they contacted the health visiting service. The school family worker shared concerns regarding the school age children' attendance, lateness, presentation and walking to school on their own. The health visitor subsequently made a cold call with no access.

3.1.38 The health visitor persisted doing an unannounced joint visit with the nursery nurse. Concerns from school were all discussed but were denied by mother who stated she would be removing her children from the school. Risks in the home were identified and discussed, cigarettes butts were strewn all over the lounge and close to the window curtain. Mother blamed the smoking on her brothers, and was reminded of the dangers and of the fire in a previous house. A Safe at Home visit by Sure Start was arranged for 11th October 2013. Mother agreed to tidy the home; the health visitor planned to review and complete a Graded Care Profile. Mother agreed to attend 'Stay and Play' sessions at the health clinic however did not attend. The health visitor shared the outcome of the visit with the family worker at the school.

3.1.39 A professionals meeting was arranged for the 18th October 2013. Child F was seen again in the Urgent Care Centre with a history of crying when awake for 3/52; treatment for colic had no effect. Reassurance was given and a GP review advised.

3.1.40 Initially there was a no access visit by Sure Start for the Safe at Home assessment, however it was completed later that day. As well as safe storage issues there was no safety gate or smoke detector. Child F was asleep in bed surrounded by pillows next to the hot radiator – this was discussed as unsafe.

3.1.41 This was the last professional contact prior to the death of Child F.

4.0 Appraisal of practice

4.1 Introduction

4.1.1 The following section will appraise the practice of those agencies involved with the family. It will make reference to the IMRs provided by each organisation, adding context, where appropriate, to makes sense of what may have influenced practice and decisions made. Comment will be made on any systems issues that have been identified and raise issues for consideration by the LSCB.

4.2 Luton and Dunstable University Hospital

4.2.1 The community midwifery service demonstrated some good practice in regards to information sharing. They made good use of the historical information held within the service to inform their decision making, communicating with Children's Social Care at the beginning of each pregnancy and at discharge. There was opportunity for increased communication with involved agencies during Child F's pregnancy e.g. on admission to hospital of mother and when the family changed address.

4.2.2 An incident of father swearing on the ward requiring security to be called, was communicated to the social worker however this information was not shared with the GP or other involved professionals. No attempt was made to discover whether this information was acted upon.

4.2.3 Following sibling 5's birth in March 2012 a birth notification was received by the health visiting service as is usual practice. The notification did not trigger the usual health visiting response and it is not clear it reached any health visitors caseload. This was not believed to be a widespread problem, however it was significant as it reduced the potential to offer early advice, support and help.

4.2.4 In line with procedures a safeguarding referral was made by a nurse following the attendance of child 3 with swollen genitalia, however when the results of the endocrine screen rule out an underlying endocrine problem no further contact was made to CSC, nor was the outcome of the referral sought. This brings into question whether the hospital continued to retain some responsibility for the problems they referred until it knew action had been taken (see section 5.2).

Issues for consideration by the LSCB

Is the system within the hospital and between the services sufficiently robust that all births are notified to health visiting services?

4.3 Cambridge Community Services

4.3.1 The services offered by this agency were health visiting (including community nursery nurse) and school nursing. The children's records were available for review however mother's historical paper records were unavailable to the IMR author making it difficult to get a full picture of the family dynamics and history prior to 2010.

4.3.2 During the period under review this family did not receive the level of provision to match the apparent needs of the children and family.

4.3.3 There was no involvement of health visiting services from the start of the review period until March 2012 despite the birth of sibling 5 and the historic neglect concerns. The lack of response to the birth notification for sibling 5 resulted in sibling 5 not receiving even the universal offer. Had notification been responded to, alongside the previous information on the family, this should have resulted in prioritisation for a new birth visit. This would have afforded an opportunity for assessment that was missed

4.3.4 The health visiting service received notification of a number of A&E and Urgent Care Centre attendances before an attempt was made to see the family. Each notification provided opportunity for assessment. It is not known whether identified poor administration systems led to a situation where the health visitor was unaware of the A&E notifications or if a clear decision was made not to follow these up.

4.3.5 Notably, once a decision was made to follow these notifications up, there is evidence of cold-calls and a number of appointments being made followed by non-attendance and no access visits; this further delayed the health visitor seeing child 5, thus child 5 was not seen until aged 1 year.

4.3.6 The case never moved from the universal service offer, the lowest level of involvement afforded to all families. The following concerns were known to the service:

- Development checks late or cancelled
- Late immunisations
- No access visits
- Neglectful home
- No answer to telephone calls
- Failure to respond to child's health needs
- Refusal of home visits
- No improvement in home
- Grubby appearance, clothes not fit for purpose as reported by the school
- Eviction
- Multiple house moves
- Domestic violence

4.3.7 The family should have been assessed as requiring greater input from the service, however the lack of assessment of risk would appear to have been a contributory factor. Tools were available e.g. a Vulnerability Risk Assessment (VRA) or a Graded Care Profile (GCP), use of which would have benchmarked the standard of care given to the children and provided opportunity for dialogue with the parents. An intention to use the Graded Care Profile was never followed through, this mirrors the findings in the Child E review. There were few staff who had been trained to undertake Graded Care Profiles and consequently the use of the Profile had fallen into disuse.

4.3.8 Once the health visitor gained access to Child 5, issues known to the health visiting service prior to the visit were not documented as being addressed e.g. domestic violence and the health needs of all the children. Additional issues noted during the visit did not lead to a vulnerability assessment being completed nor were they flagged as a concern to CSC. The health visitor was however persistent in pursuing Child 5 attending audiology testing and eventually succeeded.

4.3.9 On one occasion the health visiting service was informed of a Domestic Violence incident by the midwife and followed this up with a discussion with mother during a routine visit; this was good practice. Health visiting were aware that CSC knew of the

incident but made no direct contact with a social worker; as a result they were unaware a S47 assessment was in progress.

4.3.10 The health visiting service was informed of an incident where father was agitated and had to be removed by security whilst Child F was in Hospital to the. This is not documented within CCS records and it has not been possible to discuss this further with the health visitor. What is known is the administrative support for this health visiting team was part-time and located away from the team thus making communication and recording more complex; the author cannot be confident the system supported effective communication between the professionals.

4.3.11 Poor recording was evident when children's centre staff report discussion with the health visitor and community nursery nurse following a Safe at Home Assessment. This was not recorded and there was no evidence the health visitor acted upon the information received. Co-location of services can be a positive aid to communication but there is a danger that it can unwittingly lead to informal communication through closer relationships which then goes unrecorded.

4.3.12 It is important to understand the context within which CCS was working throughout the review period as this reportedly had a significant bearing on practice. Strategic reorganisations, changes in governance arrangements and a change of provider at the beginning of the review period had a negative impact on both the delivery of strong and consistent leadership and management across CCS and the community health economy and staff morale.

4.3.13 In 2011 the government published A Call to Action which led to a substantial increase in health visiting numbers across England. For Luton this meant a workforce growth of 260%; from 26.88 WTE health visitors as at 31.1.2012 to 70 WTE by 31.3.15 which has not quite been achieved. Previous reports had recommended average caseload sizes of around 300/WTE (CHPVA 2007). By 2013 the caseload sizes had decreased from 600 to 455/WTE as more health visitors came into practice. In order to train more health visitors the number of Clinical Practice Teachers (CPT) was increased and the clinical practice teaching model amended from a 1:1 to a 3:1 relationship with additional clinical support being provided by health visiting mentors. At that time the qualifying criteria to undertake health visiting training changed and the course was open to all registered nurses irrespective of date of registration to the NMC. Anecdotal feedback from the CPTs and experienced health visitors within Luton suggests that, at the time of writing, there had been a negative impact both on the workload of experienced health visitors and the level of experience of newly qualified health visitors.

4.3.14 In addition one health visiting team worked separately from the other four teams; with an acting up team lead for two years. There was a high turnover of staff within this team and insufficient support; this coupled with a reduced amount of administrative support appears to have had a negative impact on the consistency and quality of practice; this family were served by health visitors from this team. As of April 2015 there continued to be challenges within the services including stability with regard to commissioning arrangements, management structures and difficulties

with recruitment and retention of front line practitioners. There has been a recent review of CCS and recommendations made.

4.3.15 When a proposed multi-agency meeting called by the school was cancelled due to lack of social work attendance, there was no evidence that advice support or consultation was sought by the health visitor or the school nurse or consideration that any further action or intervention was necessary. A contributory factor may well have been the lack of support within the team at that time however the result was the drift in this case went unchallenged by both the health visiting and school nursing services.

Issues for consideration by the LSCB

Are the local arrangements and responses to domestic violence robust and do they enable those professionals in a position to respond and support those affected by domestic violence to do so?

Is CCS making progress on the recommendations from the service review (April 2015)? Are the progress reports from CCS identifying the weaknesses as well as strengths? Is the LSCB challenging the details in the progress reports? Are the LSCB clear what aspects of the Healthy Child Programme are being delivered? Is the LSCB assured the services within CCS are delivering a service which meets the local populations' needs?

Is the system for reviewing and recording information within the health visiting service needs sufficiently robust that all verbal contacts are recorded, written contacts are acknowledged and both receive an appropriate response?

4.4 Urgent Care Centre

4.4.1 The Urgent Care Centre provides a bridging service between General Practice, Out Of Hours GP services (GP OOH) and the acute setting of the hospital Emergency Department. This family appropriately used the Urgent Care Centre when they were unable to get an appointment with their own GP or the practice was closed.

4.4.2 Although the centre had limited involvement with the family during the period under review a number of issues, such as delayed immunisations, non-attendance at scheduled appointments and loss of medication were known and as such were evidence to indicate some level of neglect within this family. These issues were recorded on SystmOne[8]and technically available to GPs if they used the same system. This was not the case for this surgery.

4.4.3 Of note even use of SystmOne does not mean GPs would automatically see information recorded by other professionals as theses entries appear in separate sections of the record. This means just recording electronically does not enable others to effectively follow up concerns.

[8] SystmOne is a centrally hosted clinical computer system used by healthcare professionals in the UK predominantly in Primary Care.

Lack of active information sharing meant information known within the Urgent Care Centre was isolated from health partners and other agencies; staff were not taking an active role in safeguarding. When issues were noted staff did not establish if these were being addressed and there was also no consideration of the need to refer what was known to other services, including CSC.

Issues for consideration by the LSCB

Are staff within the Urgent Care Centre being enabled to actively share information through conversations with involved practitioners?

Are Urgent Care Centre staff fulfilling their safeguarding children responsibilities in line with LSCB policies and procedures?

4.5 GP practice

4.5.1 The GP practice had limited involvement with the family and was marginal to the direct work that was being carried out by other agencies in relation to the children. The practice saw the children for routine asthma checks, post-natal checks and childhood ailments only during the period under review.

4.5.2 The practice received information regarding delayed immunisations, non-attendance at scheduled appointments and loss of medication that indicated some level of neglect within this family. This information was within the children's individual records as a result of notifications of attendances at A&E, the Urgent Care Centre and through midwifery, however the GP did not piece all the information together. The GP was on a different electronic recording system to other health services and could only access the midwives information as they were able to input directly on the system.

4.5.3 There was no system to assist the GP to link all the information within the family and as a result they did not identify any issues which prompted discussion with other health colleagues or CSC. The GP practice were unaware of any involvement of CSC throughout the children's lives and therefore weren't aware of other agencies concerns regarding neglect nor that they had been on the child protection register or open to the long term team. The GP was only aware of one domestic violence incident between the couple inputted by the midwife, but was not aware of whom was the victim and who the perpetrator. On one occasion CSC records indicate 'the surgery' reports no concerns; there is no corresponding record in the GP IMR which suggests poor recording practice when enquiries are made.

4.5.4 It is usual for GPs to hold all the information regarding the health of all their patients. The system within this GP practice did not assist them to do so; this was coupled with the GPs not seeing it as their role to pull this information together. A lack of information sharing and gathering from other agencies meant the GP practice did not have information on the known social circumstances and were not able to contextualise new information they received.

4.5.5 GPs are often seen as the health professionals who hold the greatest information in health; this was not the case here. Sometimes, as in this case, the GPs do not know families well. When seeing someone for a consultation GPs have approximately ten minutes which provides little time for any discussion over and above the presenting health issue. GPs as health providers were expected to follow DoH (2005) guidance around Routine Enquiry regarding domestic violence and abuse in all health settings and be prepared to offer support and guidance, alongside recognition of the risks posed, there is no evidence this was done. When violence is known, GP's need to be further enabled by their partner agencies to respond to incidents of domestic violence. The lack of information from the police and CSC regarding domestic violence incidents coupled with, no information being shared regarding the incident on the maternity ward where father is removed by security limited the GPs knowledge of the issues within the family and opportunities to discuss this further were lost.

Issues for consideration by the LSCB

Are arrangements in place between the CCG, GPs and NHS England to raise the quality of GP engagement in safeguarding?
Are current safeguarding processes and practices across agencies in Luton including the sharing and gathering of information from GPs and GP practices?

4.6 Education

4.6.1 All the school age children within this family went to the same school within Luton and were therefore well known to the school. The school worked very hard throughout the period of the review to meet the needs of the children and adopted a child focused approach.

4.6.2 The school were well placed to identify and respond to issues of neglect and made a number of contacts to Children's Social Care prior to and during the review period; they often got a poor response. Indeed just prior to the period under review, they put in place a contract with the parents as a single agency attempt to manage the deteriorating situation within school when other avenues seemed to be limited; sadly, on this occasion if they had contacted Children's Social Care they would have been made aware the case was still open. The inconsistent response to school staff referrals clearly impacted on their actions, Children's Social Care had demonstrated a clear lack of acceptance and progression of referrals in the past. The thresholds being used within CSC were not clear to all agencies and escalation processes were yet to be embedded in practice, this coupled with no culture of challenging CSC decisions left school in an almost impossible situation.

4.6.3 The school contract was a simple tool to assist the school and family to be clear around expectations. It articulated schools expectations around homework, reading, presentation and routine, breakfast and bedtime routines and involving sibling 1 in family life at home; it set out key areas the family were to work on, however when the family failed to adhere to this contract no further consideration of referral to

children's social care was made thus leaving the children's needs unassessed and unaddressed.

4.6.4 When school staff reached the limits of what they could achieve, they did try to involve others e.g. health visitor. However, despite school continuing to share their concerns other agencies didn't always act, and at times children's social care involvement was required. Again, as a result of previous responses by children's social care to schools concerns, school became inconsistent in their decision making as to whether to refer their concerns.

4.6.5 On subsequent occasions when school did inform and refer issues to children's social care, the response received did not result in an improved situation for the children. No supervision was sought around this case, however there was no robust process around supervision at this time.

4.6.6 In addition, during the review period, school had many leadership changes. At each point of change, processes within the school also changed resulting in a perceived disruption to general safeguarding delivery.

4.6.7 When CSC failed to report back from meetings or on actions they were taking, the school made little attempt to ascertain the outcomes. The school should have satisfied itself that social care were taking action. The school chronology demonstrates the school had identified numerous neglect concerns around attendance, presentation, hunger, do not attends, disguised compliance, illness, avoidance and house moves. Such issues appear to have persisted as far back as 2007 when the family where removed from the CP Register (category of Neglect) with little change.

4.6.8 The school recognised that the family needed more support and services but it is only with the benefit of hindsight, after Child F's death, the school recognises they were dealing with a case of continued neglect. Staff stated there was little if any training available at that time in relation to the cumulative impact of neglect and while they continued to report into social services there was little evidence of concerns being raised from other agencies. The escalation process which enabled practitioners and agencies to escalate their concerns if they were not happy with the response was not commonly used at that time, it is now embedded in the practice of the school.

4.6.9 While school staff considered initiating a CAF and completing a GCP at different points, family engagement was such that this did not happen.

4.6.10 The school continued to hold and tried to manage the family and issues known to them. Over the review period, the school put in place a number of single agency interventions in an attempt to improve and sustain improved outcomes for the children and family.

4.6.11 The school took the lead on multiple occasions to try to arrange professional meetings. Whilst significant concerns were noted and work was done with sibling 2 by the Family Workers that brought about improvement in his demeanour and behaviours, this was not sustained when the family's home circumstances changed following eviction.

4.6.12 There were, at times, alternative options open to school. They could have involved the school nurse. They did consider making a referral to CAMHs for psychological and behavioural support for sibling 2, but the case didn't meet the threshold however there was no consideration of a referral to paediatrics for medical opinion on injuries.

Issues for consideration by the LSCB

Are school staff being enabled to challenge partner agency decisions and escalate their concerns?
Are the pathways for referrals within and between services across Luton that support children and young people, clear to all agencies?

4.7 Police

4.7.1 The Police had limited involvement with the family but did visit and have access to the family home following two domestic violence incidents and a joint visit with Children's Social Care. These visits provided opportunities to speak to the children, view their living conditions, assess their interactions with their parents and consider any risks there maybe.

4.7.2 As per protocol, on each occasion the police attended the home address due to a domestic abuse situation a referral was made to Children's Social Care as a result of children being present or their living conditions. The DASH[9] risk assessments for these incidents were graded as medium which didn't meet the threshold for MARAC[10]. There were no criminal proceedings brought.

4.7.3 Police contacts with the couple away from the home received a different response with no referral to CSC.

4.7.4 There are comments regarding the untidiness of the house which were recorded in a child at risk report submitted alongside the referral. However there was opportunity to secure evidence of the conditions by means of either photographs or video footage, which should be submitted along with the child at risk report and used in the decision making as to whether there were grounds for criminal proceedings; this was not taken.

4.8 Children's Social Care

4.8.1 Children's Social Care were involved with this family for a number of years from 2004 including a brief period where the children were placed on the child protection register under the category of neglect in 2007.

4.8.2 At the point this review commenced a single agency decision was made, at team manager level, to close the case. Lack of intervention for an extended period led the manager to believe there were no ongoing concerns and make the decision to close the case. Children's Social Care were working in isolation from their partner agencies and a lack of data gathering by the manager coupled with incomplete information

[9] DASH (2009) Domestic Abuse, Stalking and Harassment and Honour Based Violence
[10] MARAC – Multi-Agency Risk Assessment Conference

sharing from partner agencies led to an, at best, optimistic view that no contact meant all was well in the family.

4.8.3 On both occasions the case was closed to Children's Social Care the decision to do so was taken by a manager following a period of inactivity with no recorded or verified evidence of an improvement in outcomes for the children, and therefore cannot be justified.

4.8.4 The case was opened on two occasions during the period under review, on both occasions this was as a result of domestic violence incidents. Multiple referrals for other issues, e.g. eviction/homelessness, physical injuries and significant concerns for the children did not lead to re-opening of the case suggesting domestic violence was seen as a greater risk than other forms of abuse and the threshold being applied inconsistent.

4.8.5 An initial assessment following the first domestic violence incident sought no information from health visiting, a decision was taken on this incomplete assessment that no further action was required.

4.8.6 There was a pattern where opportunities for assessments were largely not taken and assessments, when started, were not thoroughly executed. The following issues were noted:

- inconsistent data gathering e.g. information gathered from school but nothing from health,
- absent or poor risk assessments and where risks were identified these were not followed up with a constructive plan of intervention,
- where intervention was identified as necessary, delay in progression of the referral to another service and their refusal to accept the referral on the basis of the completeness /accuracy of the assessment, led to no further action

4.8.7 General issues within the referral and assessment team in terms of sickness and high caseloads were compounded by poor recording practice and infrequent supervision for all but very 'high risk' cases. There was evidence on file that this family was discussed in supervision on just one occasion during the S47 assessment in 2012. Whilst a document containing supervision standards was in place, those involved indicated an absence of awareness for some staff of their existence. In discussion it was clear that the standards around supervision were frequently not achieved as although supervision was generally arranged, because of pressures of work it was often cancelled.

4.8.8 The social worker who conducted the S47assessment from December 2012 did not have information from health visiting and the GP as they had not been successful in obtaining that information before a period of absence. Coincidentally there was an attendance for sibling 3 in February 2013 at A&E with swollen genitalia during this assessment which hospital staff referred to Children's Social Care and were informed it would be addressed as part of the section 47; there records demonstrate no evidence it was.

4.8.9 The assessment was clear regarding the families need for support noting, 'the family are just about managing with five children now', and 'the family will be stretched beyond their capabilities with the arrival of a sixth child'. However it was also noted that concerns were 'not at the level of child protection' but 'issues need to be addressed'. There was no core assessment completed. There was delay in onward referral for support from the Intensive Support Team (IST) which was, in turn, refused on the basis the assessment was incomplete and out of date; IST requested a Core Assessment and Pre-birth Assessment be completed to identify strengths and that a plan be formulated to address the concerns before they would accept the referral; this never happened.

4.8.10 It is important to recognise the context within which the service was working. The Referral and Assessment Team had several changes to the structure of the team. During the review period the Team were restructured from being just the Assessment Team to becoming the Referral and Assessment Team and had developed a backlog of work. There were a significant number of inexperienced staff coupled with a high staff turnover. It was also considered that the workloads were very high. In early 2013 a number of staff left the team because they did not feel comfortable with the change of role and the Team were carrying a number of vacancies. There were issues about staff sickness and this included the allocated worker for this family being absent for two significant periods of time. There were four different groups of workers undertaking duty on a weekly basis with little consistency in how the Team presented to outside agencies who would often speak with a different worker each time they made contact, even about the same child. This inconsistency was exacerbated by the fact that each Deputy Team Manager responsible for duty had a different approach and this was reflected in their interpretation of the threshold criteria.

4.8.11 Individual social workers felt under pressure to avoid 'triggering an assessment' during the review period when there were particular pressures with workloads. This mirrors the findings in a 2012 Community Care survey of 242 social workers, where 60% said they felt pressure to "downgrade" neglect and emotional abuse cases and 59% said that it was "quite" or "very" unlikely that children's social care would respond swiftly to children suffering neglect[11] suggesting this was a national issue and not unique to Luton.

4.8.12 This stance meant social workers were left looking at 'alternative interventions' and 'managing risks differently'. In addition there were few staff who had been trained to undertake Graded Care Profiles and consequently it had fallen into disuse.
As a result of lack of activity in the case, the absence of the assessing social worker, a misconception that a child in need meeting had gone ahead and the issues had resolved to a level that other professionals had no concerns, the case was once again closed. As in the previous case closure this was done by a manager with no direct involvement with the family and based on flawed understanding rather than

[11] Community Care (2013) Social workers unlikely to act quickly on neglect cases.

information recorded on the case file. Despite all the contributory factors it remains difficult to understand how the manager came to their decision and with hindsight they recognise this was neither appropriate nor acceptable.

Issues for consideration by the LSCB

Are all contacts and referrals receiving a proportionate response from the Referral and Assessment Team in accordance with LSCB procedures?
Are current supervision policies including a requirement to discuss cases of neglect? Is current supervision practice within CSC meeting internal supervision Standards? If not what are there barriers to achieving the Standard?
Are the systems and process in place to monitor the progression of all cases open to children's service aiding safe practice? Does the system identify period of inactivity in a case to prompt a review of the case?
Are step up and step down arrangements within C & LD contributing to delay in transfer and acceptance of cases and the offering of support and services to families?

4.9 Children's Centre

4.9.1 The children's centres involvement was limited to a Safe at Home assessment requested by the community nursery nurse working as part of the health visiting team, five weeks prior to Child F's death. The referral contained limited information but stated 'previous history of domestic abuse' 'past history of fire in the home in a previous house', the identified needs are listed as 'safety concerns' with the support required. There was no indication the children had previously been on child protection plans. There was no challenge to the level of information provided at referral.

4.9.2 Children's centre workers were persistent when initial attempts to complete the assessment were not successful. The assessment took place six days prior to Child F's death and concentrated on what was visually noticeable in terms of clutter, unsafe storage of cleaning fluids, make-up etc. and unsafe sleep position of Child F on the bed next to a hot radiator. There was ready acceptance of the explanation given that Child F usually slept in a Moses basket without checking this further.

4.9.3 The results of the assessment were shared verbally with the health visitor and community nursery nurse later the same day; there was no record of any planned intervention agreed by the health visitor or community nursery nurse. The arrangements for information sharing between the Children's Centre and the Health Visiting service were often informal and may have been due to their co-location, however these informal discussions were not always recorded resulting in incomplete case files.

4.9.4 The workers from the children's centre did not sufficiently identify or respond to the indicators of neglect identified during the safe at home assessment. As in the Child E SCR, which also included a safe at home assessment, the author concluded that whilst this was "a potentially useful assessment the findings needed to be

incorporated into a wider and more holistic understanding of the children's day to day experiences". This did not happen in either case and the lack of referral to Children's Social Care meant there was no joined up assessment and analysis of the environmental, child and parenting factors.

4.9.5 The children centre workers relied heavily on an assumption that the health visitor had more influence when working with families and as such felt the parents would be more likely to listen to the advice offered from this service. This coupled with a culture of avoiding initiating CAFs indicated a lack of understanding of their roles and responsibilities when it came to safeguarding children within a multi-agency context, this may have been due to lack of confidence or avoidance of actively managing safeguarding concerns. Brandon et al., (2009)[12] in their research found practitioners can lack confidence in taking responsibility for the assessment of the impact of neglect on a child's development, believing that someone else is better placed to act or make a decision.

4.9.6 The staff within the Children's Centre did not seek support and supervision with regards to this case. Supervision was commissioned for the staff but was not used when concerns emerged.

Issues for consideration by the LSCB

Are Children's Centre staff clear in regards to their individual responsibilities to safeguard children and act upon information they receive as part of their work?

Have Children's Centre Staff got the confidence and skills to be able to independently make safeguarding referrals?

5 Thematic analysis incorporating the terms of reference

5.1 Response to Neglect

5.1.1 The effect on practitioners of working in areas of high poverty and deprivation appear to have played a significant role on practitioner's understanding of and response to neglect; the two issues need to be separated. As Rosenberg and Cantwell cited in The Bridge report on Baby Paul (1995) state, "The distinction must be made between neglect caused by financial poverty, which can be alleviated by financial help, and that caused by emotional poverty. These may co-exist but relief of the former condition does not relieve the latter."

5.1.2 There was a consistent and worrying lack of recognition and robust response, across the agencies, to multiple indicators of neglect. The nature of the concerns identified, began to change over time. This might have been as a result of lack of action by Children's Social Care. The schools focus shifted onto the behaviours of the children rather than the neglect issues within the family. All agencies were aware of some of the indicators of neglect, Children's Social Care were aware of them all. The response

[12] Brandon M, Bailey S, Belderson P, Warren C, Gardener R. and Dodsworth J.(2009). Understanding Serious Case Reviews and their impact.

of agencies to neglect across Luton needed to become active and pre-emptive. The following list demonstrates the indicators of neglect known to Children's Social Care at the point in June 2013 when the case was closed:

- Inadequate housing (two bedroom property).
- Child 5 sharing parent's bed.
- Numerous changes of address / evictions.
- Significant rent arrears.
- Financial uncertainty / unemployment.
- Hazards at home (e.g. wires from ceiling near top bunk).
- Poor school attendance for all of the children.
- Unsure as to who was to pick up the children (left at school late on occasions).
- Child 2's aggressive behaviour in school.
- Few toys or games at home.
- Concern about lack of stimulation at home.
- Parents not supporting education of children (no homework, etc).
- Parents refusing help with resources at home for children.
- Parents do not engage with professionals in school. Not attending meetings.
- Inadequate or poor and dirty clothing.
- Children arriving at school unfed.
- Unhealthy environment
- Children quiet and withdrawn. Suffering episodes of ill-health.
- Prescribed medication lost
- Children expected to take inappropriate responsibility.
- Little guidance or routine for the children.
- Oldest child living away from immediate family and 'detached'
- Parents providing inadequate supervision

5.1.2 These indicators were classified as 'low level neglect' and there was no recognition that these children might be in need of protection. The pervasive and accumulative nature of neglect was not responded to by agencies with a statutory duty to do so. In addition sibling 3 was exhibiting self-gratification behaviours, without an underlying medical condition (there was no further exploration of the cause). There were recorded incidents of domestic violence perpetrated by father on mother and sibling 2 had physical injuries that went without investigation.

5.1.3 As in the Child E case, which also featured neglect, the tools available to assess neglect in Luton were not used in this case, and although during the course of 2015 plans were being put in place to ensure professionals used appropriate tools to assess neglect, as of October 2015 they were not being used consistently across Luton. The vulnerability risk assessment tool available to health visitors was not completed and was only completed if the health visitor deemed it necessary. The home safety assessment was completed however the findings needed to be incorporated into a wider and more holistic understanding of the children's day to day experiences. No professional group used the Graded Care Profile. Staff were unable to use this tool unless they had received training – training was ceased and whilst there are now

plans to reintroduce the training, the fast and continuous turnover of staff needs to be recognised. The lack of use of neglect tools led to individual practitioners making subjective, and what may be perceived as personal judgements as to whether the children circumstances were neglectful or not.

5.1.4 There appeared to be a somewhat narrow understanding of what constituted neglect. In interview, a social worker stated it didn't appear a neglectful home, when she visited. Professionals were aware of numerous house moves leading to instability for the family and severe over-crowding but the impact of these issues was not explored nor were they considered neglectful and therefore not shared with other agencies or referred to Children's Social Care. In contrast when a school family worker visits there was a clear description of both the garden, the home and the children.

Issues for consideration by the LSCB

Is there agreement amongst partner agencies on the most appropriate tools to use to assess risk and neglect? Are the tools for assessing risk and neglect available to all professionals to use? Are there sufficient numbers of staff trained in the use of these tools? Is there clear guidance on use of these tools? Has usage been audited?

Are professionals learning from national research on neglect? How can professionals be better supported in Luton and within their organisations to identify and respond to neglect?

5.2 Referrals and Information Sharing

5.2.1 In general there was an inconsistent approach to information sharing and making referrals, by all agencies. Referrals and information sharing were seen as singular events rather than a continual process requiring, at times, further contact to be made when new information came to light or to ascertain the progression and outcome of referrals and assessments.

5.2.2 When referrals were made or information was shared with Children's Social Care, this was not sufficiently considered in the context of what was already known about the family. Information was not used to form an overall picture of the children's lives and lived experiences. There was only one referral that identified a core assessment was needed.

5.2.3 The Police were consistent in referring domestic violence incidents in the home to Children's Social Care however this was not extended to the incident outside the home. The system for sharing information about Domestic Violence did not ensure that professionals working with the children in other agencies received this very important information. For instance the health visiting and school nursing service did not routinely receive this information and had mother not been pregnant no health professional would have been notified.

5.2.2 The school were frequent referrers of their concerns to Children's Social Care however the lack of positive response and action to address the concerns or even accept the contact as a referral, acted as a barrier to further referrals. They became inconsistent in their information sharing, sharing some concerns but not all and not always following up the outcome of their referrals. In a bid for external assistance in managing their concerns the school had discussions with other agencies in isolation from Children's Social Care; those agencies were similarly limited in the actions they could take.

5.2.3 According to the Education IMR, in September 2010 a call was made into Children's Social Care following the presentation of sibling 2 with a burn. Advice was reportedly given and followed by the school. This advice didn't include the seeking of a medical opinion. There was no corresponding record of this contact within Children's Social Care and the contact was not progressed as a referral. This contact was an opportunity to review concerns, investigate and assess the risks for the children.

5.2.4 Information shared with Children's Social Care regarding eviction and homelessness was not viewed as a referral but for information only; again there was opportunity to assess the impact of this change in circumstances on the children and family.

5.2.5 No information is shared, or referral made to Children's Social Care latterly regarding the concerns and safety issues within the family home from either the health visitor, nursery nurse or children's centre worker. As in Brandon et al. (2013)[13] "Professionals were tolerant of dangerous conditions and poor care".

5.2.6 There was no active information sharing by Urgent Care Centre staff throughout the review period.

5.2.7 There was no evidence ante-natal services were provided with the history of the family from other professionals, however the community midwife made good use of her access to the G.P notes during both of the pregnancies. This allowed her to gain information regarding previous medical history and to place a copy of this information in the hospital maternity record. Ante-natal services advised Children's Social Care that mother was pregnant with sibling 5 and was attending appointments; this is recorded on the CSC file.

5.2.8 There was no evidence that a birth notification was known to or acted upon by the health visitor and no direct handover between services. The impact of this was the health visiting service were not triggered to offer a service and sibling 5 received no health visiting service.

5.2.9 There was clear communication from ante-natal services to CSC and the health visitor during Child F's pregnancy. The community midwife also advised them of the birth of Child F although this was not recorded on the CSC file. The community midwife completed information sharing forms for both the pregnancies in the review period which were shared with health visiting by the safeguarding team, and the G.P was given a copy by the community midwife. In addition the issues raised in the

[13] Brandon, Bailey Belderson, and Larson (2013) Neglect and Serious Case Reviews

information sharing forms by the community midwife were discussed via the phone with social care.

5.2.10 Opportunities for further information sharing during Child F's pregnancy were missed. The community midwife knowing the family were an 'open case' should have advised when the family moved house and the hospital midwife should have referred the concerns regarding fathers behaviours on the ward during the pregnancy.

5.2.11 There was no evidence that ante-natal services were part of the section 47 strategy meeting following the domestic violence incident during Child F's pregnancy, nor had they received information from the police or CSC. Instead the midwife, unacceptably, found out this information from mother a month later when she visited the family home for a routine ante-natal visit.

5.2.12 On discharge of Child F from midwifery care the community midwife handed over the care to the named health visitor via the telephone; this had a positive outcome with health visiting services pursuing access in a timely manner. However the community midwife did not share information of changes of address with other involved professionals or agencies and this contributed to delay.

5.2.13 All the above facts demonstrate an inconsistent and concerning level of information sharing.

5.2.14 Lack of recording of information shared by partner agencies has led to incomplete records within CSC, the GP practice and CCS. This is significant in terms of being able to make a holistic assessment based on all that was known and was especially concerning within Children's Social Care who were reliant on this information to identify deteriorating situations, effectively assess the level of risk, and establish whether the threshold for a Section 47 enquiry had been met.

<u>Issues for consideration by the LSCB</u>

Is the system and process around notification of all Domestic Violence incidents within Luton sufficiently robust that it ensures information regarding all violence between couples is being shared with agencies able to support and assist?

Are the IT systems being used across Luton supporting professionals to accurately record information?

Is recording practice across Luton ensuring information being shared between agencies is both recorded and used to inform assessments and action plans?

Are agencies in Luton continuing to own concerns they have identified post referral to CSC? Do they remain proactive after making a referral? Is new information received by an agency post referral being shared with those making assessments of risk? Are referrers following up the outcome of their referrals to Children's Social Care?

5.3 Assessments

5.3.1 There were many opportunities for assessments to be completed across all agencies throughout the period of the review. Each of the events highlighted within the concise narrative provided an opportunity for professionals to undertake an assessment however during the review period there was only one developmental assessment, an incomplete core assessment and a home safety assessment.

5.3.2 Staff were not sufficiently curious when there were changes in the family's circumstances. In the context of this case, an occasion when the community midwife visited mother at her mother's home should have evoked the question, why. The community midwife stated in interview that there were no concerns about the family situation, home environment or presentation of mother's other children. Brandon et al. (2013)[14] in their study of serious case reviews found that households where there were more than four children were at increased risk and that a healthy environment was a key safety feature. However during Child F's pregnancy the family moved numerous times, the reasons for this were not explored by health staff nor the impact assessed. In addition Children's Social Care staff talked of the family's living circumstances being 'temporary' but on further exploration the family had been in 'temporary' accommodation for 18 months; a large proportion of a childhood.

5.3.3 Post Child F's birth the health visitor identified some key safety issues however a Vulnerability Risk Assessment (VRA) was not completed. Given the known concerns and without access to the health visitor it is difficult to understand why. In addition mother identified she often had mood swings; no assessment of her mental health was completed. Mother identified she had family support but the nature of this support was not explored further. Mother was encouraged to attend the child health clinic the following week however it's unclear whether the health visitor took into account mothers' reluctance to attend appointments or engage with professionals. The co-existence of domestic abuse and poor mental wellbeing are known to have a significant impact on children's outcomes and parent's capacity to provide appropriate care. The impact of living in these circumstances for these children was not assessed or addressed.

5.3.4 CSC had opportunities to undertake assessments on all occasions they were contacted by other agencies. Only domestic violence incidents sparked them to do an initial assessment. There was limited data gathering and the assessments were concluded with limited information from health. Initial assessments did not reflect on what it was like for these children living with domestic violence and abuse – something they had witnessed throughout their lives. There was lack of analysis of the potential impact of the parent's behaviours and the living conditions on the children's safety, wellbeing and future outcomes. Research highlights how difficult it is for children living in households where domestic violence and abuse features. The

[14] Brandon, Bailey Belderson, and Larson (2013) Neglect and Serious Case Reviews

domestic violence and abuse risk assessment completed by the Police was not used in the context of a wider holistic assessment.

5.3.5 Contacts from housing were marked as for information only but should have been opportunities to proactively work with this family. Brandon et al[15]in their analysis of serious case reviews indicated the most startling environmental feature was the number of families who were noted in reports to have moved frequently (more than a third).

5.3.6 The reasons for eviction, and the impact of poor and inadequate housing was never assessed properly. Issues around the couples' finances were not explored and a number of house moves in a relatively short time frame should have elevated the case into statutory processes.

5.3.7 Research tells us one important way for children to stay safe is for their living conditions to be safe and healthy. A safe living environment is a basic precondition for a safe relationship between children and their caregivers thus the need for decent living conditions for these children.[16] The chronology indicated an escalation in other concerns when frequent house moves commenced, with an increase in failures to attend health appointments, deteriorating behaviours of sibling 2, illness for sibling 5 and lack of engagement of the parents. The children's experience of the house moves, the reasons for these moves and the impact on the children and family are not known.

Issues for consideration by the LSCB

Are agencies taking sufficient account of historical information when determining if an assessment is required?

Are professional's sufficiently curious and taking account of the risks and impact of inadequate housing, poor living conditions, evictions and house moves on children?

5.4 Managerial Oversight

5.4.1 There was little evidence of managerial oversight within any organisation. Actions taken were largely by frontline practitioners. Where managers were involved in decision making within CSC this did not result in positive progression of the case. Decisions were made in the absence of the allocated social worker and in isolation from partner agencies (see section 4.8); managers did not ensure the actions they recommended had been completed prior to case closure.

5.4.2 Frequent changes in Head Teacher meant issues raised by teachers did not receive a consistent response. Mangers within all Health Organisations had no awareness of

[15] Brandon, M. et al.(2008). Analysing child deaths and serious injury through abuse and neglect: what can we learn?: a biennial analysis of serious case reviews 2003-2005.

[16] Brandon, M. et al. (2011) Neglect and serious case reviews Systematic analysis of neglect in serious case reviews in England

this family as it had not been raised in supervision because frontline practitioners did not recognise the need.

5.4.3 The manager within Children's Social Care who closed the case in 2013 indicated she felt pressurized to close cases at that time. It has been acknowledged that this was not appropriate but it is felt that Managers are now having a better overview of cases and are more 'hands on' in relation to signing off decisions.

Issues for consideration by the LSCB

Is sufficient account being taken by agencies of the risks posed when there are changes to structures and key roles?

Is the process for case closure in CSC ensuring needs identified during assessments for individual children and their families have been addressed?

Are managers making sufficient use of recorded information?

Do policies and procedures assist professionals to safely close cases and direct them to address gaps in information through contact with partner agencies before a case can be closed?

Are partner agencies being notified of case closures?

5.5 Ethnicity, religion and language needs of the children and family

5.5.1 All of the agency Management Review's indicate there were no specific concerns about how organisation responded to the cultural needs of the family. Their country of origin was noted and the language spoken. Both mother and father were Urdu speakers, the midwife was an Urdu speaker but indicated she had no need to do so as mothers English was so good.

5.5.2 No consideration was given to father's level of understanding; when he was upset on the ward no interpreter was used. Without access to the family this could not be explored further. Mother and father were noted to be first cousins, but the relationships and dynamics within the family were only partially explored when mother spoke to workers when there were considerable relationship problems. There was suggestion that mother felt under some pressure from within her family to remain within the marriage.

5.5.3 Fathers English was reported to be not as good as mothers, the impact of this was not assessed however the school made arrangements for an interpreter on one occasion and on other occasions mum took on this role. All interventions and communications from the school were reported to be fact based as they would be for any family involved; recording suggests the needs of the family were taken into consideration by the school.

5.5.4 CSC records contain little comment despite sibling 1 living with maternal grandmother for much of her life; the notes were generally inadequate and not comprehensive and in the absence of any comprehensive assessment the issue of

culture both within the family unit and with the extended family was not adequately explored.

5.5.5 When Child F died leaflets to explain Sudden Unexpected Death in Infancy and the processes that would follow, were not available to the family as they had not been translated into Urdu; this was identified in the regulation 28 coroner's report to prevent future deaths.

Issues for consideration by the LSCB

Are agencies taking sufficient account of parents' level of understanding if their first language is not English?
Are issues of ethnicity and culture being adequately assessed?
Are agencies providing information leaflets in all the main languages spoken across Luton? If not is there a system for sharing the information through an interpreter?

5.6 Voice of the Child

5.6.1 There was little understanding of the children's views and little evidence that professionals used opportunities to talk to the children about their experiences e.g. the impact of multiple house moves, the impact of living in cramped circumstances. This mirrors the findings of five evaluations completed by Ofsted in 2010 that concluded there was a failure to see, listen to or take account of the perspective of the child or children at the centre of a review. (Ofsted 2011).

5.6.2 In 2013, as part of the S47 enquiries the social worker did speak to the children. They spoke fondly of their father but not so much about mother. Sibling 1, although living away from the home did have a relationship with her siblings and visited the family almost daily. The reviewer was told that within Children's Social Care records there was greater emphasis on the negatives within the family rather than the positives; this has also had an impact as aspects of the children known to the worker not being recorded.

5.6.3 Due to the limitations as discussed in section 1.7 it has not been possible to gain a greater picture of the children.

Issues for consideration by the LSCB

Are professionals taking opportunities within their work to see, listen and take account of children's perspectives?

6. Conclusion

6.1.1 It has not been possible to conclude whether the sad death of Child F could have been prevented by the professionals involved as the cause of death is unascertained. What is clear is there were a number of factors known to increase the risk of Child Death present in this case. Brandon et al (2014) indicate that "To guard against catastrophic neglect, children need to be physically and emotionally healthy and

have a safe, healthy living environment".[17] Child F was not living in a safe, healthy living environment.

6.1.2 The response to neglect issues within this review brings into question how much continuing risk there is in other cases? It is too early to be confident that learning as a result of this and the Child E case have effected a change in response to neglect.

6.1.3 During the period under review there were significant issues within services across Luton. The lack of experienced trained professionals able to recognise and respond to indicators of neglect and use the locally preferred neglect tool meant the cumulative impact of neglect was unknown. There is evidence that policies and procedures designed to protect vulnerable children were not followed and the advice from some managers, at times, acted as a barrier to social workers in the Referral and Assessment Team initiating assessments.

6.1.4 There is evidence in this case that the children were left living in risky and neglectful situations without this prompting referrals or assessment.

6.1.5 The NSPCC in a systematic review of all Serious Case Reviews in 2009-2011 concluded that practitioner's needed to be supported by a system that allows them to make good relationships with children and parents and supports them in managing the risks of harm that stem from maltreatment, including harm from neglect and the way that neglect can conceal other risks and dangers.

6.1.6 The review has been aware throughout its work of the Serious Case Review undertaken in relation to Child E, which occurred in early 2014, and reached very similar findings. It has not been in a position to consider how far these difficulties have been addressed. The review heard as of October 2015 that there remain difficulties in recruitment in some key areas, (health visiting, midwifery and social workers) and high proportions of newly qualified staff. If there is an absence of improvements in staff skill and training and better managerial oversight the risk that a similar episode could occur remains.

[17] Brandon, M., Bailey, S., Belderson. P and Larsson, B, (2014) The Role of Neglect in Child Fatality and Serious Injury. Child Abuse Review, Volume 23, Issue 4, pages 235–245, July/August 2014

Appendices

Appendix 1 – Methodology

The methodology used to conduct this review involved all involved agencies producing a chronology. The chronology was then integrated.

All agencies were to produce Individual Management Reports based on the template provided.

An Overview Author was appointed who had sight of individual agencies associated policies and procedures, recent local serious case reviews, audits, and some service reports to the LSCB. The overview author conducted conversations with practitioners and managers from Children's Social Care and Community Health Managers to gain context.

The serious case review panel provided scrutiny to the draft Overview Report.

Independent Chair, SCR group
Business Manager, LSCB
Designated Doctor, Luton CCG
Safeguarding in Education Manager, LBC
Det. Superintendent, Beds Police
Principal Solicitor, LBC
Designated Nurse, Safeguarding Children, LCCG
Senior Learning & Development Officer, LBC/LSCB
Learning and Improvement Coordinator LSCB
Social Worker, Early Intervention Team, LBC
Administrator, LSCB

- What information about the history of the family was provided to ante-natal services by other professionals? How did it inform the care provided?
- How was relevant information transferred from ante-natal services to other professionals (including particularly the health visitor and GP)?
- How successfully did the new birth visits and other early health assessments identify all of the relevant issues? Did this lead to appropriate service provision for the children in the family?
- How were concerns about possible neglect addressed? (this should include all possible signs of neglect including for example poor physical conditions, presentation of children, DNAs, poor attendance and take up of services)
- How were concerns identified in the school addressed? What was the role of professionals based in the school in identifying and responding to safeguarding and wider welfare concerns? How were concerns held by the school brought together with those of other professionals?
- How did the local authority become involved? Were the thresholds used correct? If not, what factors influenced decision making?
- How were decisions about reducing the level of intervention by the local authority made? When this happened was it justified by the positive indicators about the health and well-being of the children?
- Did the agency have information relevant to domestic abuse in the family? How were these concerns addressed?
- How were the particular ethnic, religious and language needs of the children and family identified and understood?
- Has your review of practice established any other significant findings?
- What arrangements were in place for the supervision of staff during the period under review and how were they implemented?
- In relation to each of the findings set out above please explain the individual, team and wider organisational factors that influenced the provision made?
- What lessons has the agency learnt as a result of the review of services provided to the family?
- What improvements can the agency make immediately?
- Has the review conducted by the agency identified any wider lessons for safeguarding services?