Serious Case Review

Child D

"Jamie"

Died Age 5 months

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Agreed by the Kent Safeguarding Children Board, May 2018

Kent Safeguarding Children Board

Sessions House
Maidstone, Kent

http://www.kscb.org.uk

Contents

Note: 'Jamie' is a pseudonym, the names of his siblings are also pseudonyms. These have been used to protect their identities.

Note about technical terms used in this Report.

The Report is the outcome of a review of the formal multi-agency safeguarding services offered to Jamie and his family. Technical terms which either relate to the law, guidance or procedures are referred to throughout the report in bold lettering.

For readers who wish to have more detail about these terms or procedures, they can be searched through the Kent & Medway Safeguarding Children Boards' Online Procedures using the online search facility.

http://www.proceduresonline.com/kentandmedway/ or

http://trixresources.proceduresonline.com/nat_key/index.htm

Use of Capital Letters: Initial capital letters are used for services when they were specific to this family; lower case when more general thus, 'School' – the schools attended by the children, but 'school' - more generally or school uniform, school attendance, etc.

1. Introduction

1.1 The purpose of a Serious Case Review (SCR) is to seek to understand what happened and why it happened in the context of local agency and multi-agency safeguarding systems, rather than solely the actions of individuals relating to a single case. It is not an investigation into the death of or harm to a child, but may draw on information from parallel investigations into the cause of death or harm and who was responsible. The primary purpose of a SCR is to identify lessons and changes which may be required as a result of the analysis. The case under review is an example of local working arrangements at the time that the work was undertaken.

1.2 A SCR does not focus solely on the critical incident which has been the reason for the review; in this case Jamie's death. It seeks to learn from the whole case and the way in which agencies have worked with the family and worked together to identify and mitigate any risks to children up to the critical incident. It is not an investigation of the incident, (that is the role of the Courts), but draws on a systemic and causal analysis to understand the dynamics of the helping relationships with the child and family and where changes may be needed in local systems to improve responses in future, similar cases.

1.3 Where possible, a review should be informed by the experiences, views and perspective of the family and practitioners, rather than just from agency records in the light of hindsight. Judgements and lessons should follow from what was known to practitioners at the time or which could or should have been known at the time; not using information which could not have been known.

1.4 A review should be proportionate, seek to understand, explain and evaluate what happened through a systems framework, but not to blame. In learning lessons from the single case, the Kent Safeguarding Children Board (KSCB) and its Partners can see how they apply more widely in the local system and whether any actions should be taken to improve the safeguarding processes. It may also note good practice, to learn from this more widely.

2. Executive Case Summary

2.1 Jamie was the youngest of eight siblings, seven of whom were under 11 and lived in the same, overcrowded home. Initially this was with Jamie's Mother and Father, but in August 2015, shortly before Jamie was born, Mother and Father separated. Mother started a new relationship.

2.2 The case was of a large family of young children living in cramped conditions. Children sustained unexplained injuries, thought to be from lack of supervision or because of unaddressed safety risks. Injuries were not always attended to appropriately. Although there were appropriate questions whether such injuries may have resulted from physical abuse this was not substantiated; they were seen to probably arise from neglect of supervision or caused by the children themselves. Health or developmental needs, health appointments or immunisations were not attended to. The children were, at times, unkempt, dirty, inappropriately or poorly dressed and smelly. At times, they had untreated head-lice; these were denied by the parents, or claims were made that they had been attended to, when they had not been.

2.3 There were concerns about domestic abuse (initiated by both parents) and its emotional impact on the children; the domestic abuse or its impact were denied, despite evidence that the children were aware of it and upset by it. There were also suggestions of alcohol or drug use, including alleged dealing, these were also denied. There were suggestions that the children were coached to not share with professionals what was really happening at home.

2.4 Increasing concerns about the children's welfare and ongoing neglect, with little change in the parenting,

led the primary care and early intervention agencies working to support the family to refer the case to Specialist Children's Services (SCS), in late 2014.

2.5 In January 2015, all five Siblings were made subjects of Child Protection Plans for Neglect. There was continued work from Specialist Children's Services (SCS), Health Visiting, Schools, Nursery and Children's Centre, with support from Housing and Community Services, Primary Care, and Hospitals. Paediatric Services and Police were also involved from time to time.

2.6 Mother's engagement and cooperation with agencies was minimal. Father avoided attempts to involve him in work on improving parenting, although he did at times care for the children. The monitoring of the concerns noted the lack of progress and were stepped up to consider court action to safeguard the children in the spring of 2015, when Mother was pregnant with Jamie.

2.7 There were questions about Mother's ability to sustain changes; at times she seemed to be compliant and at times she was thought to lie.

2.8 From September 2015, Mother's Partner and his cousin, who became a Lodger, were resident in the home, although Mother initially denied this. During this period there was also disclosure by one of the children about possible inappropriate sexual behaviour between the children, although this was not followed up.

2.9 Following the commencement of relationship with the new Partner, agencies noted some improvements in the children's school attendance and care, sufficient for SCS to cease the pre-court proceedings, in the autumn. However, the Partner was not assessed as a carer/parent, although he was frequently involved in the children's care and at times, had sole care of some of them. The Lodger's full history was not fully explored.

2.10 Following claims that their home was too cramped and overcrowded, the family moved home in November 2015, where the Lodger occupied one of the bedrooms intended to increase space for the children. The Review Child Protection Conference also noted some improvements but decided not to remove the children's names from Child Protection Plans until there was more evidence that improvements were being sustained. Jamie was born at the end of the month.

2.11 In December, it was noted that Jude, (a toddler), had an increasing number of bruises and there were still questions about the adequacy of the supervision of the children. Apart from the oldest child, the children moved to a new School in January.

2.12 In February 2016, at a Review Child Protection Conference it was agreed that all the children, except Jude, should cease to be subject of Child Protection Plans and should be stepped-down to Children in Need, based on perceived improvements in the children's care. Jude was maintained on a Child Protection Plan because of continued concern about the unexplained minor injuries.

2.13 In the days following the Conference, Police were called to the house because of a disturbance and assessed that all three adults in the house were drunk and disorderly, and there was use of cannabis. In April, the serious, non-accidental and fatal injury to Jamie occurred and his older Siblings were taken by court order into interim care. The post-mortem revealed Jamie had a head injury and 28 fractures, within 19 different bones, assessed to have been sustained in at least five different events over a ten-week period up to his death. The cause of death was ascertained to be as a result of a serious head injury. The majority of injuries were assessed by expert pathologists and a specialist paediatrician to have occurred in the few days prior to the fatal injury or at the same time. There were a number of fractures to his ribs and legs which were older. Hair toxicology showed contamination of Jamie's system by controlled drugs, not just from external contamination. Findings suggest exposure to amphetamine and occasional

exposure to cocaine throughout the four months of Jamie's life up to the critical incident.

2.14 In July 2017, Mother and her partner were found guilty of causing or allowing Jamie's death and causing or allowing serious physical injury to him. In November 2017 the couple were sentenced to 8 and 13 years respectively. I think it important that this should be clear from the outset.

3. Reason for the review and its focus

3.1 Jamie died in late April 2016. In mid-April, he was taken from home by ambulance to the local hospital in cardiac arrest. He was found to have an acute subdural bleed and bruising to his head and abdomen. He was transferred to a London Hospital for intensive care; his prognosis was very poor. The significant injuries were assessed to be non-accidental. It was agreed by late April that life-support should be withdrawn.

3.2 The post-mortem revealed that Jamie had a head injury and 28 fractures within 19 different bones. These were assessed to have been sustained in at least five different events over a ten-week period up to his death. The cause of death was ascertained to be as a result of a serious head injury. The majority of injuries were assessed by expert pathologists and a specialist paediatrician to have occurred in the few days prior to the fatal injury, or at the same time. There were a number of fractures to his ribs and legs which were older. Hair toxicology showed contamination of Jamie's system by controlled drugs, not just from external contamination. Findings suggest exposure to amphetamine and occasional exposure to cocaine throughout the four months of Jamie's life up to the critical incident.

3.3 Jamie's siblings had been made subjects of **Child Protection Plans**[1] from January 2015; Jamie was subject of a Child Protection Plan from before his birth. Jamie and five of his siblings ceased to be subject to child protection plans in February 2016 and were made **Children in Need**[2]. One older sibling, Jude, remained on a child protection plan because of concerns about frequent unexplained bruising.

Parallel Proceedings

3.4 The Police investigated Jamie's death. As a result, both Jamie's Mother and her Partner were convicted of **causing or allowing the death of a child** and **possession of a class B drug** (amphetamine). They were sentenced to eight years and thirteen and a half years imprisonment, respectively. Jamie's siblings were made the subject of Care Proceedings under the Children Act 1989.

Focus of this Review: Chronic neglect and chaotic parenting versus risk of serious physical injury

3.5 It will be noted that this Review's larger focus is on working with neglectful and chaotic parents and carers, even though the outcome was Jamie's death from non-accidental injury. The analysis of SCRs has shown that neglect has been an important background factor in many cases where children have later died or been injured as a result of physical assault.

Jamie's injuries

3.6 As noted above, the post-mortem showed, in hindsight, that Jamie suffered a number of non-accidental injuries in his short life. Forensic evidence for the criminal trial showed that the majority of these were either at the same time as the critical head injury, or in the few preceding days. No practitioners saw Jamie in those few days. A few of the fractures to his ribs, spine and legs may have been caused on three or four occasions from up to 9 weeks previously.

[1] Descriptions of technical terms can be found at http://trixresources.proceduresonline.com/nat_key/index.htm

[2] Descriptions of technical terms can be found at http://trixresources.proceduresonline.com/nat_key/index.htm

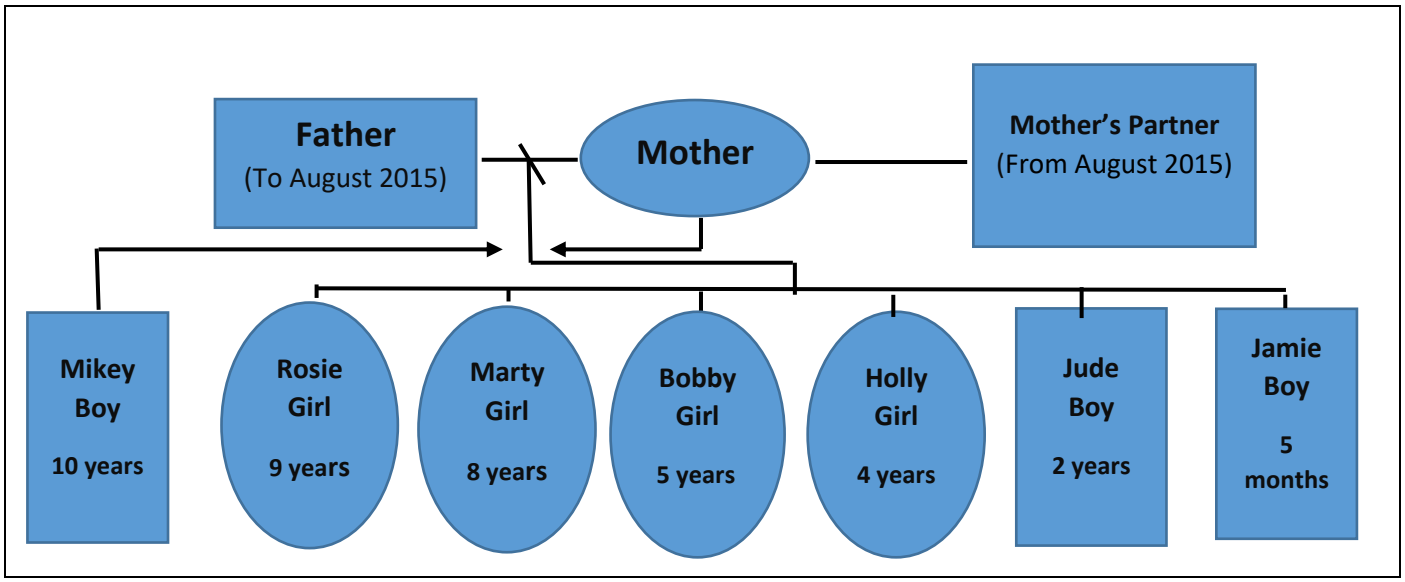
3.6.1 In response to the question, "could these have been identified and acted upon?" research and clinical experience, and expert advice to the court, shows that in babies and non-verbal infants and toddlers, such injuries may not be readily identified even by those who are medically trained. Unless the incident or assault has been witnessed or has been alleged, it is not clinically easy to begin to identify hidden fractures. The child may cry briefly at the time of the fracture and later be fractious for a while, but unless it is known or suspected that the possible cause is a fracture, a baby's restlessness can be put down to other childhood issues such as colic, teething or an infection. Practitioners who saw Jamie in the nine weeks prior to his death noted that he was developing well, saw no such symptoms and had no concern about him physically, nor that he was in any pain or distress. This is common in such cases where injuries which could not have been seen by simple observation or clinical examination, later come to light through radiological examination. As there were no concerns for Jamie's development or that he was being physically harmed, a medical examination would not have been necessary or warranted.

4 Jamie's Family and Household (at the point of his death in April 2016)

Mother			31 years
Mother's Partner			24 years Joined the household in August 2015 (although it was disputed as to whether he was resident there or visiting daily)
Siblings	Mikey	Boy	10 years
	Rosie	Girl	9 years
	Marty	Girl	8 years
	Bobby	Girl	5 years
	Holly	Girl	4 years
	Jude	Boy	2 years
	Jamie	**Boy**	**5 months at death (4 months at fatal injury) Main Subject of this review**
Lodger	Female		36 years Relative of Mother's Partner
Father	33 years		Father to all the children, except Mikey; but had co-parented Mikey for several years and they had a strong emotional bond. Lived in the household until summer 2015.

An older half-sibling, an adolescent at the time of the work in this review, had been taken into care as an infant when the Mother was herself an adolescent. This half-sibling is not included in this Review.
All the family and household are described as White British. It is understood that they did not practice a faith.

Genogram



Background

4.1 Mother's childhood is reported (by her) to have included domestic abuse and parental alcohol abuse. As an adolescent, she was reported to have experienced sexual exploitation and drug misuse (although she denies the latter).

4.2 As an adult, Mother experienced domestic violence from partners, including Jamie's Father and was also herself, on occasions, a perpetrator. Mother's first child did not grow up in this household. Mother came to the attention of Police on several occasions for theft, drugs (dependency), violence and public disorder.

4.3 There appears to be no complete history of the Birth Father, his background or upbringing in the reports or assessments. He was described as unemployed and of a traveller background.

4.4 Mother's Partner had a prior conviction for common assault as part of an affray in 2011. In the period of this Review, he became known to the police for being drunk and disorderly.

4.5 From 2005, the family had periods of being open to SCS under **Child in Need** and **Child Protection Plan**, with support provided to the family in respect of home conditions, parenting skills, routines, domestic abuse, drug and alcohol misuse, budgeting and benefit issues, and financial support for paying bills. The family were stepped down or closed when it was felt that good progress was being made.

4.6 There were concerns expressed and referred to SCS by the School around the children's development and appearance, (unkempt, unclean, head lice infestations). The School put in support, including a Play and Learning Scheme and Speech and Language Therapy.

4.7 A number of referrals to SCS were made by the Police relating to poor home conditions, the state of the children, suspected drug use by the parents and continued domestic abuse.

4.8 Child and Family Assessments undertaken by SCS showed neglect, parental failure to follow up immunisations, and failure to follow up developmental checks and specialist health assessments; the home was overcrowded and filthy and the children were dirty.

4.9 At the end of 2013, the children were stepped down from a Child in Need Plan to a multi-agency Team Around the Child service, led by the Kent Troubled Families Service. Concerns at that time were poor school attendance, cramped housing (a two-bedroom house for two adults and 5 children), anti-social

behaviour and not keeping medical appointments for the children. There were ongoing concerns of neglect and injuries to the children.

4.10 In February 2014, following concerns being expressed by the School, SCS gave advice, but did not re-open the case; saying that a re-referral could be made, if necessary. The School was supporting the older children to compensate for the poor parenting.

4.11 By March 2014, school attendance and nursery attendance had improved, and work was being done with Mother to advise her on managing the children at home. There were concerns about dental hygiene of the older children, but the neglect was not assessed by SCS as serious enough to warrant calling a Child Protection Conference.

4.12 SCS became involved again in May 2014, after a further incident of domestic violence. A further Child and Family Assessment was undertaken and a written agreement was drawn up with the Parents that the Father would not drink in front of the children, the parents would not fight or argue in front of the children and the children were to be appropriately dressed and clean for school. The case was closed to SCS and was 'stepped-down' back to Team Around the Child, despite a further domestic abuse incident.

4.13 In October 2014, a member of the public expressed concern to the Police about the home, the children and parenting. The Police assessed that the state of the home did not warrant taking immediate action to protect the children, by removing them or making a referral to SCS.

4.14 The School and Troubled Families Project were increasingly worried because of the lack of progress, domestic violence, concerns about alcohol use, the state of the children, overcrowding in the small home, (including a dog), and missed medical appointments. These problems persisted despite extensive support from agencies. The family was referred to SCS for another further Child and Family Assessment. Concerns continued while the assessment was being done and included injuries and health needs not being attended to.

4.15 A multi-agency strategy meeting held in December 2014 and another Child and Family Assessment showed: injuries not being properly addressed, poor home conditions, chronic head-lice infestations, unmonitored health and safety hazards, over-crowding, missed medical appointments, a chaotic life-style, denial by parents of the concerns, lack of stimulation of the children by the parents, and concerns that the children were poorly dressed and often hungry. There were 14 reports of domestic incidents to the Police from 2007 to October 2014, some witnessed by the children, some allegedly involving alcohol. At times, the home was damaged. When there had been grounds for a possible prosecution of Father, Mother had not supported this. Father appeared to have left the home or been excluded on several occasions, but in 2014, Father was resident in the home.

4.16 This resulted in the convening of a multi-agency Child Protection Conference, in early January 2015. This detailed review of the multi-agency work starts at this point, prior to Jamie's conception and birth.

5 Timeline of key events and actions to support Jamie and his family:

January 2015 – April 2016

5.1 The SCR Panel was provided with detailed chronologies by the agencies which worked with Jamie and his family; these chronologies showed significant contacts over the period under review.

5.2 The SCR Panel has summarised and analysed these in the timeline below, setting out key phases of family life and agency and multi-agency involvement.

January – June 2015

5.3 The **Child Protection Conference** was held. The following was highlighted: cramped and dirty conditions,

with safety issues in the home, there was evidence of neglect, poor hygiene, anti-social behaviour and missed health appointments for the children, whose immunisations were not up to date. There was concern that the Parents lacked capacity to change and that, over time, there had been insufficient progress. Parents were reluctant to work with professionals to improve the parenting. The Parents did not see or accept the concerns. Father often avoided workers when they visited, unfortunately, he was not then fully assessed as a parent. A history of alleged drug misuse and domestic abuse was noted. Mother denied that there was any current drug use. All six siblings were made subjects of Child Protection Plans for Neglect. The contingency plan was: "that if there was insufficient improvement, SCS would call a multi-agency strategy meeting or consider Care Proceedings."

5.4 In this period, the Police continued to be called to incidents of domestic abuse, with both Mother and father being victims as well as perpetrators. Although the Police recognised the poor conditions of the home, (poor bedding, children sleeping in school uniform) and the distress shown by the children, no further action was taken. When challenged, both Parents continued to deny the domestic abuse, saying that they only argued when the children were asleep. At one visit when the Social Worker challenged mother about the domestic abuse, the worker was asked to leave.

5.5 The non-attendance and cancellation of appointments was a recurring theme, with Mother also not attending the Domestic Abuse programme that she had been referred in to.

5.6 When challenged, Mother continued to deny neglect and the impact of the domestic abuse. At the first Review Child Protection Conference, she claimed that Police and School had lied and that the Social Worker's report was wrong. She did not accept the risks described. The Group questioned about whether Mother was being honest with workers. A third-party allegation was made that Mother had admitted to drug use and dealing, but she denied this, saying that it was 'malicious'. The Social Worker noted that there appeared to be little capacity and willingness for change.

5.7 Mother was advised that the children's care was not yet good enough and that, if there was no improvement, a **Public Law Outline** (PLO)[3] process would be considered at the next Core Group Meeting (to initiate possible court action to safeguard the children). Managers within SCS reviewed the case at the request of the Social Worker who was concerned about lack of progress and agreed that there should be a **Legal Planning Meeting**[4] to consider court action.

5.8 The School continued to report concerns about the cleanliness of the children and untreated head lice. All the children were described as smelling. The children were seen as guarded and possibly advised not to talk about home. However, the children were worried about the Parents arguing.

5.9 Issues were identified about the home. It was overcrowded, and conditions were noted to be poor, with additional concern about safety hazards in the garden. The children mentioned an 'Auntie' who was staying in the house on the sofa. SCS had not been told about this by the Parents, for appropriate checks to be done. This person later became a Lodger in the home.

5.10 There were several reports of the children having injuries. These concerns, together with those about the older children's appearance and hygiene were not accepted by the parents. Marty was noted to have a bruise on her arm; professionals questioned if it was a 'grab mark'. Mother's explanation of 'a fall' was doubted. Marty was seen by the GP who asked for the child to be taken to hospital, concerned about the possibility of Non-Accidental Injury. Father was reluctant to take the child to hospital. Following a welfare

3 The Public Law Outline is statutory guidance following the Children Act 1989 which sets out the steps to be taken when legal action is being considered to protect children from significant harm through the Family Proceedings Court by seeking a care order or supervision order. https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12a

4 A Legal Planning Meeting is a meeting internal to Children's Social Care to obtain legal advice on a case where it is considered that the threshold for legal action may be met and whether the Public Law Outline should be initiated or what other steps should be taken.

check by the Police that evening, and after discussion with the out of hours' Social Worker, Father took Marty to the Emergency Department because of the injuries to her arm and leg. Marty and Father stayed overnight in the hospital. Non-Accidental Injury could not be confirmed as the cause. The following morning it was agreed that SCS would lead a 'single-agency' Section 47 child protection enquiry and that the Police would take no further action at that point. SCS agreed to seek Legal Advice on safeguarding the children. The following week, Mother was angry with the School for reporting the bruise on Marty. Several children were kept off school for several days with 'medical issues' or 'fear of attending school'.

5.11 The single agency Section 47 enquiry was completed. As a result, Parenting Assessments were to be done on both Parents, singly and jointly, unannounced and planned home visits were to continue and Parents were to work on the poor home environment, hygiene and the children's self-care. Direct work was to be started with the children to help them understand their daily life experience better.

June to October 2015

5.12 By mid-June, it was known that Mother was pregnant with Jamie; the due-date was not known. From mid-July, Mother started attending ante-natal clinics at the Children's Centre and continued to the end of October. Mother provided some misleading information and was seen as evasive. The Social Worker liaised with the Midwifery Service to advise them of the safeguarding concerns. The Social Worker also referred Mother and Father to a service for alcohol abuse.

5.13 SCS met with Mother and her solicitor in the Pre-Proceedings Meeting as part of the PLO as a precursor to possible court proceedings to protect the children. Father (and his legal advisor) did not attend. Mother denied using drugs or alcohol, claiming that the incident in March was a 'one-off'. A Written Agreement was signed with the Mother on the actions to be taken. Father was not a party to this agreement. In carrying out the agreed work with Mother, the Social Work Assistant noted that Mother's involvement was only superficial and that she avoided key areas of the Child Protection Plan and did not accept the need for change; Mother saw the problems as only a housing issue.

5.14 A Family Group Conference (FGC)[5] was held to seek assistance from the wider family because of the concerns attended by fewer family members than were expected. They agreed practical support with child care, baby sitting and housework, when they could, about once a week. It was recognised that the family did provide support, but that this was not sustained.

5.15 The previous concerns on parental engagement continued, as did the Parent's response. The Health Visitor and Children's Centre Worker visited the home; despite the visit being arranged in advance, they were not expected. They were not able to see all the children. On another occasion, when following up on a report of Marty having a bruise, the Parents avoided the Social Work Assistant and Social Worker by cancelling appointments and going out quickly when the Social Worker arrived. Father also avoided a planned Parenting Assessment session.

5.16 There were numerous reports and concerns about unexplained injuries to the children and the Parent's response in addressing these medical concerns. Mikey was off school, unwell with a persistent illness, but was noted to have gone fishing with his Father, Marty had a cut on the elbow, which was not attended to medically by the Parents. On a home visit, the Social Worker found the children unkempt and parts of the home were dirty.

5.17 A Strategy Discussion was held at the SCS District local office attended by the Social Worker, Team Manager and Police. The decision was to convene an Initial Child Protection Conference in respect of the

5 In Kent. a family group conference is a process led by family members to plan and make decisions for a child who is at risk of coming in to care. Children and young people are normally involved in their own family group conference, although sometimes with support from an advocate. It is a voluntary process and families cannot be forced to have a family group conference."

unborn baby.

5.18 At the beginning of September, Mother advised the Health Visitor that the Father had 'left home' and that she had started a new relationship with her Partner. Father informed SCS that Mother 'threw him out' and that he was worried about the Mother's Partner, (cousin to the Lodger) having contact with his children.

5.19 Mother attended a Parenting Assessment session, leaving the children in the care of her Partner. The Social Worker stopped the session and went to the home to meet Mother's Partner. Mother was seen to have lied about her Partner living in the house, but the children said he was living there and that he had been there for a week. Mother's Partner agreed to police checks and not to be alone with the children. The Social Worker followed this up with an unannounced home visit and found the home conditions to be good, including the garden, which had been a worry before. Mother was showing signs of wishing to change.

5.20 The Child Protection Review Conference was held for the older siblings with a parallel Pre-birth Child Protection Conference for Jamie. The older siblings were to remain subject to Child Protection Plans at risk of neglect and Jamie was to be made the subject of a Child Protection Plan from birth. Concerns continued to be poor basic care and Mother's inability to sustain changes. Some improvements to the home were noted, but it was too soon to confirm that these would be sustained. There was also concern about the rapid change in the Parental relationship. Because of this, it had not been possible to complete the Parenting Assessment. Due to a change in the parents' circumstances, the Social Worker was to liaise with the Legal Team for a new deadline to complete the Parenting Assessment. The **Pre-Proceedings Meeting**[6] took place in the second week of October. No consideration was given to including Mother's Partner in the Assessment.

5.21 At School, Bobby mentioned possible sexualised behaviour relating to one of her siblings, at home. It was Mother's claim that it was a dream or the dog. This was not followed up and there was no Strategy Meeting/Discussion to consider how to respond to this possible disclosure. A week later, the Mother said that 'the dog had licked Bobby's vagina' and this was accepted. Bobby was later seen by the GP and diagnosed with a urinary tract infection, vaginal soreness and a discharge.

5.22 A Core Group was held at the beginning of October. Positive progress was noted with Mother; Mother's Partner had also attended one Parenting course session, (although Mother had dropped out of the course after this). Holly was reported to be scratching her vagina; sexual abuse was not considered, and as before, Mother's explanation of the dog licking Bobby's vagina appears to have been accepted. Mother's Partner was seen as a positive influence. There were no concerns about unborn Jamie; the plan was for the baby to go home after birth.

5.23 A follow-up Pre-Proceedings Planning Meeting was held as part of the PLO. Mother and her solicitor attended; the Father did not. Following better engagement by Mother and reported improvements in the basic care of the children, SCS decided to end the Pre-Proceedings, but it was agreed that more work was to be done on parenting and work was to be done with the children on safe touching. Mother's Partner's presence was noted, but it was said that he was not staying at night, in the week. Family members were no longer offering so much help, but a friend was assisting. The friend later became the Lodger in the house.

6 The Pre-Proceedings Meeting is part of the Public Law Outline process. It is a formal meeting between the SCS the family and their respective legal advisors to set out the concerns about possible significant harm which may result in legal proceedings if not addressed, and it agrees the actions to be taken, support to be given and how progress will be reviewed. See: https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12a

October to November 2015

5.24 Mother reported that Father was being abusive to her; this was impacting on his contacts with the children. Father met with the Social Worker to discuss contact and he signed a Written Agreement which addressed these issues. Father said the children cried when he returned them after contact and did not want him to leave. Mother stated that since the written agreement was signed, contact had been okay and there had been no further problems.

5.25 Mother was offered a move to a larger property locally.

5.26 In late October, direct work was done with some of the older children on good and bad touching. (A few days later, Jude was noted to be kissing inappropriately).

5.27 During home visits, it was noted that the home conditions were said to have improved. It was noted that the Lodger, had moved in and that Police checks would be required on her. It was noted to be a concern that Mother had introduced another adult to the over-crowded home without agreement.

5.28 In the second week of November, the family moved to a larger home. The Lodger took up a room meant to ease the overcrowding for the children. She also brought two additional dogs, meaning that there were then three dogs in the house. The Housing Provider Officer later expressed their concern that the Lodger was resident as she had been excluded from another property because of domestic violence against her own partner. It was thought that Mother's Partner was now permanently resident, but Mother denied this.

5.29 The children were seen at School, as Mother would not let the Social Worker visit at home. The children reported that things were fine at home, but there was a suspicion that they were being coached in what to say.

5.30 The Social Work Assistant visited the home and found Mother's Partner alone with Jude who had bruising; the explanation given was that Jude hurts his head banging when he has tantrums.

5.31 The Review Child Protection Conference was held in the last week of November. Improvements were noted, but it was decided by agencies present, that the children should remain subject to Child Protection Plans for a further three months to ensure that changes noted were sustained. School was not represented in this meeting, but provided a positive report noting improvements in the children's appearance and attendance at school. Mother was still attending ante-natal care. The presence of the Lodger and her history of perpetrating domestic violence were noted; the presence of three dogs in the overcrowded home were a worry. It was thought that the move of home, change of school and the birth of a new baby in a few days may present challenges to the good progress noted. There was no discussion about Bobby's disclosure of possible sexualised behaviour by one of the other children and Mother's claim that it was a dream or the dog. Also, there was no discussion of the information that Jude sometimes hurts his head when he banged it having tantrums.

5.32 Three days later Jamie was born.

December 2015 – February 2016

5.33 In early December, background information was received from the Police about the Lodger, including information about domestic abuse and drug usage, however, she was not assessed as a risk to the children.

5.34 The Social Worker visited the home. A strong smell, suspected to be cannabis, was noted outside the house. Mother denied that the Lodger used cannabis in the home. She was advised that the Lodger should not be using one of the children's bedrooms. The house was clean and tidy, and the children were seen to be clean and appropriately dressed, but there were more bruises to Jude; Mother was advised to supervise Jude more closely.

5.35 A few days later, Mother's Partner was seen at the house with Jamie and Jude. Jude had fresh cuts to his face. It was alleged that the cuts were caused by the other children and Mother's Partner was advised of the need for better supervision.

5.36 The Core Group met in the week before Christmas. Mother did not attend. The continued bruising to Jude was noted and thought to be increasing; it was seen as Jude not being properly supervised. It was also noted that there were complaints about the dogs and that the Lodger could be very aggressive. When these matters were put to Mother, she denied them.

5.37 The Social Worker and her Supervisor met to review the case. It was thought that the improvements were probably due to Mother's friend's presence. It was questioned whether Mother could sustain the improvements. The concerns about the children's appearance and poor supervision were seen to be less serious. Mother had co-operated with what was required. It was understood that the Lodger was due to move out soon.

5.38 The Health Visitor visited the home; Jamie was putting on weight, but Mother was concerned about him vomiting and was advised to take him to the GP, however, he was not yet registered with the GP. Jude was seen with a scratch to his forehead. Holly's speech was not clear. The Lodger was to stay in the house for a further month as the Order against her was still in place. The Health Visitor re-enforced the concern about this to Mother. The house was not yet properly furnished as there were financial issues.

5.39 In the first week of January, four of the children started at a new School. Mikey remained at his old School.

5.40 The School noticed an increase in the number of injuries sustained by the children. Marty had bruising to her leg and said that she had 'fallen over' outside, her Mother confirmed this. This was followed by the School noticing a bruise and lump to Marty's head, said to have been caused when the Lodger dropped her from a piggy back. It was also thought that Marty was sleeping in her clothes at night as she was cold. Two days later, Rosie brought herself to School and her Mother was unaware. The School also reported that Bobby was filthy and crawling with headlice. Mother claimed that it was difficult to care for so many children and the baby.

5.41 The Social Worker visited the home. The children were said to be happy at school and at home. Bobby had head lice, which Mother agreed to treat. Mother was challenged about not seeming to play/relate with Jamie, but she maintained that she did. Mother appeared to be sustaining changes in the household. The Lodger and Mother's Partner were at home, but were not part of the session**.** The same day, the Mother declined to take part in a session on domestic abuse with the Social Work Assistant on the grounds of being unwell.

5.42 The following day, Housing staff expressed concern about the state of the garden and rubbish. Bruises were seen on Jude and reported to the Social Worker who thought that they resulted from poor supervision. Housing sent a breach of tenancy letter the following week because of the state of the garden.

5.43 In the last week of January, the Core Group met. It was agreed that Mother should take Jamie to the GP for a development review and immunisations. Jude was to be registered at Nursery. Jude's bruising was discussed. It was noted that he was clumsy, but there was no detailed discussion about accumulation of bruising. The Lodger was to move out of the children's bedroom. A friend, who had not been police-checked, was said to be taking Holly to School. Mikey was grubby and not appropriately dressed, but was thought to be better than previously. Professionals thought there had been a change in the children's behaviour over the last week; they appeared more clingy; Mother said that she had not seen such changes and that there was nothing wrong at home.

5.44 At the end of January, there was an anti-social behaviour report relating to the home, four dogs and abusive behaviour by the Lodger.

5.45 At the beginning of February, the Health Visitor visited and noted improvements in the home. Jamie

appeared to be developing and was alert and responsive. Jude had a cut on his forehead and a graze to his chin; Mother's Partner said that he only had injuries to his head. Mother said that she had spoken to the GP about Jude falling over often and had wanted a referral to a paediatrician.

5.46 On his first day at Nursery, staff noticed bruising to Jude's face and body and suspected non-accidental injury. The Lodger picked Jude up from the nursery in her pyjamas. The Social Worker discussed the injuries with the Lodger and later with the Mother by phone. Mother maintained that the injuries were caused by clumsiness and falling and that she had asked the Health Visitor to refer Jude to a Paediatrician, (which was not the case). Mother was defensive and said that no-one helped her with seven children.

5.47 The following day, the scheduled Review Child Protection Conference was held. All the children, except Jude were removed from Child Protection Plans and 'stepped-down' to Children in Need. A Strategy Meeting was to be held for Jude, who was to be seen by a Paediatrician urgently. The Lodger was to be out of the property by 1 March. There were disagreements between the professionals about whether all the children's names should be removed from Child Protection Plans. Overall, the view was that there had been improvements, however, the Independent Child Protection Conference Chair Person used their authority to retain Jude on a Child Protection Plan. The Contingency Plan noted that if the current progress was not maintained or there were any new incidents of significant harm to the children the local authority should seek legal advice.

5.48 The following day, Jude was assessed by a Paediatrician. Several bruises and healing grazes were noted. The Doctor said there was no evidence of Non-Accidental Injury, apart from bruising around the face, but there was a clear history from Mother that he bumped into a door a few days previously. Jude was noted to be very active. The Social Worker attended the examination and gave the Paediatrician the relevant history.

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5.49 In the third week of February, Mother went to a neighbour in the early hours, four of the children were with her, she was shouting that Mother's Partner was in the neighbour's house. Mother had been drinking and kicked her Partner on his return.

5.50 Two days later, the Social Worker visited, unaware of this incident when Mother had been noted drunk with the children in the early hours. The home was satisfactory. The children were fine, but Jamie was not being supervised properly.

5.51 That evening, Police were called to the house at 10pm. Mother's Partner was drunk and disorderly. Mother and Mother's Partner were shouting at each other and fighting. The children witnessed the fighting and were unkempt and crying. Mother's Partner was asked to leave by the Police. The Lodger was also drunk and agreed to move out. There were whisky bottles and evidence of cannabis having been smoked. One of the children later told the School that the children had been told not to talk about the domestic abuse, but reported that the Lodger had tried to strangle the Mother. When questioned, later by the Social Worker, the Mother denied that the incident happened in the way that the Police had described it.

5.52 A few days later, the Social Work Assistant visited and found the home conditions to be good, new beds had been provided for the children, the Lodger had moved out and Mother's Partner was back in the house.

5.53 A Core Group for Jude, was held in the second week of March. Improvements were noted in all the children, Mother was engaging in the Domestic Violence Programme. There had been no further arguments between adults in the home.

5.54 The Social Worker met with Mother's Partner who claimed that the drunken incident was a one-off and that he did not drink around the children; although one of the children said that this was not so. Mother's Partner was observed to have a good relationship with the children. No new bruising to Jude was seen.

5.55 Mother cancelled a visit by the Social Work Assistant in which it had been planned to do further work on domestic abuse, this was the second cancelled visit; she was advised of the consequences of further cancelling.

5.56 The Social Work Assistant visited in the third week of March and noted appropriate care and stimulation of Jamie; lack of stimulation had previously been a concern. Work was done on domestic abuse and Mother was said to be shocked about how sexual abuse and emotional control were features of domestic violence.

5.57 A week later, in a further session with the Social Work Assistant, Mother continued to show greater insight into the impact of domestic violence. On that visit, Jamie was described as babbling to himself and happy.

5.58 At the end of March, Jude was noted, at Nursery, to have bruising to his forehead, right eye and a cut behind his ear. Mother and Mother's Partner said that this was because of Jude falling to the floor in a tantrum. An email was sent to the Social Worker, who was on leave. This was not picked up until her return the following week.

5.59 On her return, the Social Worker saw the fading injuries to Jude and discussed them with a Manager. Mother had said the cause was a tantrum, the cause of the injury behind the ear was unknown, but possibly caused by climbing on bunk bed. It was decided not to hold a **Strategy Discussion**. Mother had not sought medical advice as previously advised. Jude was known to have tantrums.

5.60 Overall, professionals were reporting improvements in respect of the children and Mother's parenting and the home and safety. Observations were that Mother's Partner interacted well with the children and they had not shown any concerns about him. It was agreed that the Nursery should be asked to keep a log of any injuries to Jude and report them to the Team Manager if the Social Worker was not available. Jude was to be seen as soon as possible following any further injuries being reported and Mother was to be reminded that any injury that Jude sustained to his face/head should be seen by the GP, at least. The issue of unexplained injuries was to be reviewed in four weeks.

5.61 Four days later, Jude was seen at Nursery with a split nose. Mother's Partner said that Jude had fallen out of bed on to a toy and had been taken to hospital. The Social Worker was informed. There was no evidence that Jude was taken to hospital.

5.62 Four days after this, an ambulance was called to the house as Jamie had 'stopped breathing'. He was taken to the local hospital and assessed to have significant brain injury; from there he was transferred to specialist care in a London hospital, where he did not recover, and life support ceased two weeks later. Jamie's siblings were removed in to Interim Care.

6 Practitioners' and Managers' Perspectives

Lessons arising from the Practitioners' Learning Event

6.1 As part of the methodology of this Review, a Practice Learning Workshop was convened, led by the Lead Reviewer (with some of the SCR Panel Members). The purpose of the Workshop was two-fold: to seek the views and experiences of the practitioners and line-managers who had been directly involved in the case to see whether lessons applied to this case only, or more widely as possible 'systems issues' and, finally, to consider what was known at the time and what was learning from retrospective reflection.

6.2 Key priority messages from the Learning Event are included in this section. The practitioners' views are also incorporated into the analysis and evaluation of the work and wider systems in Section 8.

Practitioners' views:

6.3 The case was time-consuming and required a high number of visits and co-ordination. There was no overall planning of the contacts from different agencies to the family, this meant that sometimes, Mother had or was being asked to have several contacts in one day or week.

6.4 The case was not seen as a complex case by many of the practitioners; it was seen to be like other cases in the locality, which shared common themes of overcrowding, possible drug use, neglect and violence.

6.5 Workers did not feel competent in working with **'disguised compliance'**[7]. This may have been a lesson from hindsight, rather than an insight concurrent with the work.

6.6 The number of children meant it was harder to ensure one-to-one contacts with the children to get to know them well, observe them, assess all aspects of their development and ascertain their wishes and feelings. This was a big task for a single key-worker.

6.7 In terms of assessing safeguarding risk, multi-agency partners felt they lacked the knowledge and skills to assess significant harm on a 'balance of probability' and what this meant and how it should be judged. This may have influenced decision-making, especially the decision to remove the children's names from the Child Protection Plan in February 2016. The Panel's view was that the introduction of Signs of Safety had led to a greater understanding about assessing risk and that at the February Child Protection Conference there was agreement between agencies about the scorings for each child and that there had been improvement. A question arises, however, about the possibility of 'group think' influencing practitioners who feel less confident; and of the need to assist practitioners to have the confidence to say either 'I don't know' or I don't agree'.

6.8 Some staff outside SCS felt that it was hard to have the confidence to challenge decisions and thinking in multi-agency meetings where they felt there was no parity of voice. A similar view was also expressed with some workers feeling uncomfortable sharing their concerns about a family with the family in the same room. This may also have been a lesson from hindsight, rather than an insight concurrent with the work. It was recognised that staff attending meetings should receive appropriate support from their manager and safeguarding leads.

6.9 Practitioners from several agencies felt that information sharing was 'jealously protected' by Agencies, for fear of breaching the Data Protection Act.

6.10 Practitioners believed from this case and others more widely, that more energy needs to be put into ensuring that Core Groups work well and are chaired efficiently.

6.11 Practitioners outside SCS were unfamiliar with the PLO processes and did not feel that legal advice on cases was shared with them.

6.12 There was a question about the availability, quality and quantity of 'supervision', (sometimes called management or advice), across all agencies to support front-line workers in different services thinking about and managing the child protection work.

7 'Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions and allay concerns. Published (serious) case reviews highlight that professionals sometimes delay or avoid interventions due to parental disguised compliance.'

https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/disguised-compliance/

7 Family Perspectives on the Services offered to them

7.1 Mother and Father were informed that this SCR was being undertaken and invited to make representation and to seek legal advice, given the criminal investigation of Mother and Mother's Partner.

7.2 The Chair and Independent Reviewer of the SCR Panel met with Mother and Mother's Partner in their new home in March 2017.

7.3 Father said that he would write a letter to the SCR Panel setting out his views, but no letter has been received.

7.4 The views of the Mother and Mother's Partner which follow should be read in the context that they were made to the Reviewers after they were charged, but before the trial.

Mother's and Mother's Partner's View of the Services Offered

7.5 The purpose of the discussion was to ascertain Mother's and Mother's Partner's views on the services and assistance provided to the family up to Jamie's death. Because of the impending trial, they were advised that they would not be allowed to discuss the events of Jamie's collapse and subsequent death, or the agency actions which followed it. At the time of the meeting, they were both facing the criminal trial and for Mother, there were also Care Proceedings for all of the children. Despite these stresses, they were both open and ready to share their thoughts. They were surrounded by photographs of the children with whom Mother was having supervised contact. They spoke about them with warmth and love. Mother spoke mostly, and Mother's Partner confirmed some of what she said, when she invited him to do so.

7.6 What follows is a summary of the key points of Mother's perspective and views on the issues and the services. They clearly differ from the perspectives of the Professionals who worked with her. She was advised in the discussion that Practitioners had a different view to that which she was putting forward, but that this was her chance to put her own point of view. Her account is not challenged here.

7.7 For Mother, the most important issue over ten years had been the problem of housing; two adults and up to six children in a two-bedroom property. She felt that this was the main problem which needed to be resolved. She accepted concerns about the house being cluttered at times. She also appreciated when she was given practical help, such as when Troubled Families staff assisted her with obtaining a skip to tidy up the garden and provided a fridge and tumble dryer. After the move to the new house, she would have liked more practical help and more time to get it sorted.

7.8 Mother found the insights gained through the work on the Freedom Programme (on domestic violence), undertaken with the Social Work Assistance helpful. She said that she understood more about abusive men and their attitude to themselves and to women. In her view, some of the problems were attributable to Father who caused damage in the home, breaking doors through anger and being the cause of Police being called to the home.

7.9 After Jude's and Jamie's births, Mother found the Health Visitor helpful. There was good advice and the Health Visitor was always there when needed. The problem with the immunisations was that Mother did not want to see the babies cry and so she would not go. She did not think that there had been delays with immunisations.

7.10 In terms of health services, Mother did not feel that she had had enough help with Mikey, who she thought had ADHD and Autism, from being a very little boy. He would not eat properly. She said that she was not offered any help or treatment for him and that, at times she rang Services (Local Hospitals) but got no service. On this issue, she was complimentary about the School, which worked well with Mikey and got him to talk.

7.11 The Midwife who supported her with Jamie was helpful.

7.12 The Parenting Course at the Children's Centre was, in Mother's view, helpful. She thought it would have been better if Mother and Father or later Mother's Partner had done it together.

7.13 She had a different view of the School, which she thought 'pinpointed' her unfairly, drawing attention to the way the children were dressed, or claiming that they were dirty or smelly, which she denied. The children regularly got headlice at School and she would always treat all the children and the adults each time, but then they would go back to School and get them again. She did accept that sometimes the care of the children did 'slide'. As noted earlier the School helped Mikey and the other children liked School; Holly liked the Nursery. The children made friends at School and were not picked on or bullied. Mother was pleased that the School helped her with bidding for a new property.

7.14 Mother had a positive view of the longer term Social Worker and Social Work Assistant from the first Child Protection Conference. She was happy with them and the support they gave her, especially after Jamie's birth when they thought she was caring for the children better. The work on the Freedom Programme with the Social Work Assistant was helpful.

7.15 In terms of the Meetings that she was asked to attend, (Child Protection Conferences and Core Groups), Mother thought that these could be draining and make you depressed. She saw reports in advance and concerns were explained there. She understood the 'Scaling' that was used to rate the concerns as part of the Signs of Safety approach. She did feel able to give her point of view in the meetings, but did not always agree with others' scaling. However, she thought that the way of raising concerns should be 'lighter' so as not to 'break' parents and make them depressed and that more advice should be given in advance on parenting.

7.16 The Legal Meeting was 'awful', she was pregnant and felt on her own. Father had refused to attend. She was told what progress had to be made and she felt that the finger was being pointed at her and that she was offered no help.

7.17 Father never went to the Meetings as he had to stay at home and look after the children, but he wasn't very good, in her view, with these things and would 'kick off'. She did not want to separate from Father. He did at times help in the house and kept things tidy, cooked and helped with bathing the children. He was often at home all day and occasionally played with the children. He did not bring any income into the home. Mother said that she had been given advice to get Father out of the home rather than go to a Refuge. She knew she had to put the children first and so in the end, felt that she had to tell Father to leave.

7.18 On specific issues and concerns, Mother said 'all children say things', as if these had been taken too seriously. She said that when necessary the children were taken to hospital or the doctor. She had been worried about Jude and his balance, falling and his boisterousness and clumsiness, and had asked for help with this. She said that the Children's Centre had witnessed this. When he cut his nose, he was taken to the Walk In Clinic for assessment. When Holly had thrush, she had got cream for her.

7.19 Mother did not say why it had taken so long to evict the Lodger, but she 'kicked her out' after a 'falling out'.

7.20 She admitted to occasionally smoking cannabis, but only at night and only in the garden or at a friend's house, and an occasional drink. Mother and Mother's Partner were both adamant that he did not smoke cannabis.

7.21 She was clear that she loved the children and that 'you always have to think kids first and put the children first' and maintained that that was what she had done.

8 Analysis and Evaluation

Good Practice:

8.1 It was appropriate that the services working with the family in 2014, assessed that the family needed more than Early Intervention or Troubled Families Services and that the threshold for social care intervention had been met and referred the case back to SCS, which undertook a Child and Family Assessment and convened the Child Protection Conference at the start of the period under review in this SCR.

8.2 The decision to make the children subject of Child Protection Plans was appropriate given the levels of concern.

8.3 When it became known that Mother was pregnant, it was appropriate to initiate a Pre-Birth Child Protection Assessment Process and consider that the baby should also be considered for a Child Protection Plan.

8.4 As the concerns about the children's welfare and the quality of parenting continued, it was right to initiate Pre-Court actions under the PLO and to convene a FGC. There is evidence that practitioners monitored the children's welfare, particularly through School and Nursery, up to the move of the family home.

8.5 At times, as new concerns were identified or where there was a deterioration in care, the Parents, (mainly Mother), were challenged to improve.

8.6 Supporting the family to move home meant that there would be better chances of the children's needs being met.

8.7 The work with Mother on understanding domestic violence, even though incomplete, was positive and appears to have given her a greater understanding of how some other people have taken advantage of her in her life. Mother certainly saw this work as a positive.

Was this a Complex Case, a Complicated Case or a High-Volume Case?

8.8 This was a big family with several children with different needs, and at-times, a volatile parental relationship and later, the addition of new, unassessed adults. The SCR Panel formed the view that this was not a complex case, in that it had the common features of usual child protection work, but perhaps it was a complicated case, in that it that had many (changing) dynamics and a high volume of work was required. Such families and dynamics are not unusual, which raises the question about whether practitioners or the local child protection system can become desensitised, (or perhaps overwhelmed), particularly in a case of ongoing neglect where there appears to be no clear triggers for action.

8.9 The question was raised, of when it is appropriate to allocate a larger family where there is chronic neglect, such as this one, to a single key worker, (even with appropriate adjustment of overall caseload), as seven children and four adults, plus their networks and agencies supporting them were a lot to be held in mind by one worker. Who is also responsible for leading the multi-agency team?

8.10 The caseload management and allocation system in use in SCS allowed for the number of children, ensuring a balance across the whole of the Worker's caseload.

The Children: Were practitioners able to see the world through the eyes of <u>each</u> child?

8.11 This was a large family to monitor and support, to collate information and make assessments for each of the children according to her or his own needs, development and functioning. At times, they appeared to be seen as a group, not as individuals.

8.12 The Social Worker's composite reports to Child Protection Conferences, drawing on other practitioners' observations, as well as the Social Worker's own, sought to provide a pen picture for each child, collating

and addressing the key concerns about learning, attendance and clothing, but these do not include a thorough-enough assessment of each child's overall emotional and general development.

8.13 All the children were seen to 'idolise' their Mother and to feel loved by her. In the Initial Child Protection Conference, it was considered whether this may be the children 'normalising' their lives. It was thought that the children were emotionally attached to their Mother. A question to be considered, however, was whether the children were, in fact, showing signs of chronic emotional neglect and insecure or **disorganised emotional attachment**[8]. This appears not to have been explored. Research into **chronic neglect**[9] shows the importance of recognising emotional neglect as well as more physical aspects of neglect.

8.14 More attention appears to have been paid to practical matters, such as health appointments, head lice, immunisations, physical safety within the home, clothing, etc. than to the consistent emotional needs. The Assessments did not consider whether Mother, Father or any of the other adults caring for the children had the capacity to hold the children's emotional needs in mind. Assessing the parental capacity to respond to the children's emotional needs was the responsibility of the whole team of practitioners working to support the children. It was noted that the theme of focusing on the more practical and tangible actions at the expense of the child's emotional world, had been a theme in other SCRs.

8.15 This raises systems questions of how well-equipped practitioners are in this area and how local Agencies and multi-agency processes work to ensure that the child's emotional world and needs are fully assessed and supported, when necessary.

8.16 Some good one to one work was done by the Social Worker and Social Work Assistant; it must be noted that direct work with six siblings, individually was a very big task, in addition to the work on Parenting, report writing, new safeguarding assessments and coordinating the network.

8.17 At times, the children spoke out to draw attention to what was happening to them and at times they appeared to communicate through acting out. They were unhappy at the arguments between their parents, but these were minimised by Mother and Father. The practitioners' view was that the children had been told by the Adults not to talk with practitioners about what happened at home.

Assessing and working with Parenting and Parental Relationships:

8.18 **Mother:** Mother was known to have a difficult history from her own childhood. Her first child was brought up by relatives. She was described as having a chaotic lifestyle as a young person, involving acting out, drugs and alcohol. She would, now, be seen as a victim of exploitation and perhaps sexual exploitation, but that was not the view at the time, and not one that Mother herself shared, then. It is known that she had some volatile and abusive intimate partner relationships, including with the children's Father. There were also historic reports, recent reports and current allegations of drug use and alcohol use, which were vehemently denied, despite strong suspicion and probable evidence.

8.19 It is not clear how much thought was given to Mother's own history of attachments and negative relationships to know whether her own inherent attachment-style was disorganised. The information provided for this Review suggests that this could and should have been considered as it would affect her

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8 Understanding disorganized attachment; Theory and Practice for Working with Children and Adults; David Shemmings and Yvonne Shemmings; Jessica Kingsley Publishers; 2011. Or The Place of Attachment in Children's Development; by Aldgate and Jones in (Chapter 4) in The Developing Work of the Child; Jane Aldgate, David Jones, Wendy Rose and Carol Jeffery; Jessica Kingsley Publishers; 2006; and Attachment across the Lifecourse; David Howe, 2011 Chapter 4 Patterns of Attachment

9 Safeguarding children across services, Messages from research: Davies and Ward; Jessica Kingsley Publishers; 2011 These messages from research summarise a range of evidence-based research studies commissioned by the Government after the Victoria Climbie Inquiry.

own ability to enter into healthy and trusting relationships with others, including practitioners. It would also have been an indicator of her ability to hold her children's emotional needs in mind, including the need for consistency.

8.20 Given this history, there was not enough challenge and skepticism about her capacity to change and sustain change. She was challenged and made occasional improvements, but these were often short-lived and appeared more as reluctant compliance than insight-based change based in realising the impact of the neglect and domestic violence on the children. At times, she had control and refused workers entry to the home. There was a view by workers that Mother knew how to keep workers at bay and what to say to please them. Disguised compliance was thought about, but not tested out or robustly challenged.

8.21 **Father:** Mother and Father had been together a long time. He was the Father of Jamie's five older siblings and had accepted Mikey as a 'step-son'. The history showed that the parental relationship was volatile; over nine years there were several Police notifications of arguments or violence, at times fueled by alcohol.

8.22 There was no understanding of Father's own history and the quality of his own attachments as a base of how he could offer security and affection to Mother or the children. He does not appear to have supported the home financially. He did provide some physical care for the children, taking the older ones to school, occasionally cooking for, or bathing them, but he was said to be reluctant to undertake the tidying up or the repairs to the property which were required to support a move to a larger home, which was needed. The children, some more than others, showed a fondness for him. There is no doubt that he had a role in some of the parenting and without him, Mother's task of caring for the children, especially when pregnant with Jamie would have been greater and more challenging.

8.23 Research in child protection has shown the importance of the 'absent men' and the difficulties that practitioners can have seeking to engage and work with male parents. This Father was far from absent until he was asked to leave by Mother in the summer of 2015. However, he absented himself from the child protection assessments and work to improve the parenting. He was regularly asked to attend meetings, but did not do so. He avoided the Social Worker and Social Work Assistant on visits when he could or would go out. He only attended the second Child Protection Conference and the FGC and even with the threat of Care Proceedings, did not attend Core Groups or the Legal Planning Meeting when SCS were considering taking action to remove his children. He did sign a written agreement with Mother and SCS in October 2015, after he had left the home, agreeing to 'no arguments between parents at time of contact visits, no further domestic abuse and not to abuse alcohol or any substances during contact with the children'. This appears to be reluctant compliance.

8.24 His avoidance meant that no real work could be done with him to help him change his own behaviour or parenting. It was only possible to tell him what had to change with no work being possible with him to help him change or work with Mother towards them both changing.

8.25 **Mother's Partner:** Mother's wish to conceal the relationship with the man who would become like a step-father to the children, meant it was initially, difficult to establish who he was and what his role was. Mother's Partner came to attention because Father complained about him and expressed concerns about him, but there is no evidence that Father was asked what he was worried about in this young man. The children talked about him and seemed to like him, and it seemed evident that despite Mother's denials, he was resident in the home.

8.26 A Police check was undertaken on Mother's Partner which showed a historic assault in an affray; nothing indicated that he was a risk to children. Although Mother agreed that he would not be left alone with the children, there was evidence that he was and that he very quickly played quite a big role in their care, and certainly did in the latter months of the pregnancy with Jamie.

8.27 There was, in fact, evidence to show that his presence brought some stability and improvement in the

conditions of the home and the parenting, yet, he was not assessed as someone who, not having any Parental Responsibility was, in fact, playing a significant co-parenting role. He was an unknown quantity and should have been joined to the pre-birth parenting assessment being undertaken for unborn Jamie and the ongoing child protection reviews for the older children, with whom he had significant contact and emotional impact. There was no separate assessment of his intellectual capacity, his personal motivation or his views about entering a relationship with Mother and ostensibly taking on a role of caring for seven children. His presence was accepted.

8.28 **The Lodger:** Another adult joined the over-crowded house in the summer of 2015**.** She was an older friend to Mother and a relative of Mother's Partner. It is not fully clear when she joined the household; the children referred to an auntie staying but this was denied initially. Police checks were undertaken, but the information known about her was not fully analysed. There was also a misrepresentation about her being the victim of domestic abuse when in fact there was an order against her preventing her living in the home with her own partner on the grounds of her own violence. When this was later corrected by another agency, it was not fully assessed and her inappropriate presence in the home was not properly dealt with. No real attempt was made to remove her, apart from advising Mother that the Lodger should go.

8.29 No assessment was undertaken of the Lodger or of the prior relationship between Mother and Lodger, or Lodger and Mother's Partner; explanations were taken at face value. The Lodger was known to be a strong and intimidating woman; her influence or possible control over Mother was not considered. No direct work was done with the Lodger.

8.30 She moved to the new home after Jamie's birth and occupied one of the rooms meant to ease the overcrowding for the children. Although this was challenged, Mother allowed it to continue. More could, (and should), have been done by the Core Group to move this person out of the home, given that the children were subject to Child Protection Plans.

8.31 As with Mother's Partner, the apparent improvement in the home and the care of the children in the Autumn of 2015 up to Jamie's birth, was probably partly because of the Lodger's presence and assistance.

Domestic Abuse and Drug and Alcohol use:

8.32 Within the history of this family, there were known incidences of domestic abuse, with both Mother and Father as victims and perpetrators. Some of the incidents of domestic abuse appear to have alcohol, and drug use as a significant dynamic within them.

8.33 Mother was encouraged to undertake work on understanding domestic abuse and its impact on the children, which she regularly denied, despite evidence that the children were unhappy when the Parents fought. It was reported that when she finally did some work in the incomplete **Freedom Programme**[10] that her insight into abusive relationships and the impact they had had on her increased. However, her own behaviour could also be volatile and there were suggestions that she had also assaulted Father or initiated rows, sometimes when she appeared to be under the influence of substances or alcohol herself.

8.34 The Police assessed the severity of incidents of domestic abuse and as none were rated as High, the continued incidences of domestic violence between Mother and Father were not referred to the Multi-Agency Review and Assessment Conference, MARAC. When visiting the home in response to allegations of domestic abuse, the Police did not discover any evidence of substantive violence or any crime. At the time, Police policy was to assess the new information against previously held information and give advice to the couple, as necessary. If there was insufficient risk to warrant referral to MARAC and children were present, the concern was referred to Children's Services.

8.35 Throughout 2016, Kent Police made significant changes to the way in which they respond to allegations

10 The Freedom Programme www.freedomprogramme.co.uk

of domestic abuse, making it a priority for the Force. Actions included ensuring that where Police attend domestic abuse incidents, regardless of whether the incident is assessed as High, Medium or Standard risk, a Domestic Abuse Notification (DAN) is sent to the Central Referral Unit where they will be reviewed and where there are children in the household, appropriate child safeguarding procedures will be followed.

8.36 There were strong, but denied concerns about drug and alcohol use**.** These dynamics were recognised in the early assessments and attempts to tackle them were built in to the Child Protection Plans. As the suspected drug and alcohol use were denied, practitioners felt that they could not do more to tackle this, apart from advise against its use. At a later stage of legal proceedings, it may have been possible to involve testing and treatment programmes as part of court agreements or orders. Drug usage should *probably* have been considered more robustly in the Legal Planning Meeting and the Written Agreement with Mother.

8.37 This case and others where 'soft use' such as cannabis or intermittent alcohol use are common in a family, raise questions for child protection practitioners and Services about knowledge and skill where there is no agreed 'addiction' or mandate to test and treat; yet the use is likely to be impacting on judgement, parenting and, in pregnancy, on the developing foetus.

The Effectiveness of Agency and Multi-Agency Local Safeguarding Systems as seen in this case:

8.38 **Recognition and referral of safeguarding concerns:** It was appropriate for the early intervention and Troubled Families Services to refer this case to SCS in late 2014; placing six children on Child Protection Plans confirms this. A question arises, however, given what was found, as to why this had not been done sooner. The SCR Panel was advised that agencies had been reluctant to refer the case sooner as they felt that it would not meet the local threshold for action as either a child in need or for child protection. This was clearly in late 2014, but local services and the KSCB need to be assured that there is an understanding of the thresholds and that where there is doubt or disagreement about them that any service can seek advice, challenge this or escalate their concern.

8.39 **New concerns and safeguarding incidents:** Between January 2015 to Jamie's death in April 2016, whilst all or at least one of the children were subject to a child protection plan and all the children were children in need, a number of instances of neglect, new injuries, failure by parents to respond to injuries and domestic incidents occurred. Although most of these were followed up, they were not followed up with the robustness of a multi-agency Section 47 enquiry. Not all were subject of a Strategy Discussion or followed up at the Core Group when they should have been. Some were not seen as child protection issues.

8.40 There seems to be a confusion in the phrase 'single agency assessment' and its meaning to practitioners. In one incident, the Police were informed of an injury to Marty, a discussion was held between the Police and SCS where following a decision that the Police would not be taking any further action, it was agreed that SCS would lead a 'single-agency' Section 47 child protection enquiry involving other appropriate agencies. In this case, health partners or school were not always involved in the Strategy Discussions about new concerns, even when they had been the agency raising the concern.

8.41 **Assessments:** The Child and Family Assessment is the responsibility of all agencies, led by a Social Worker. The Assessment provided to the Initial Child Protection Conference was fairly robust, however, it lacked a proper chronology of family history which would have enabled a picture of the Family, Parents' own histories and parenting over time. This would have given a better assessment of the Parents' understanding of concerns and what interventions or support had been used previously as a way of assessing their ability and capacity to change and care for and protect the children. There was no separate Pre-Birth Assessment for Jamie.

8.42 Ongoing 'assessment' was provided to the Child Protection Conferences through updating what had happened, rather than revised full assessments.

8.43 When there were new concerns of physical injury which were suspicious, or not wholly consistent with explanation, or suggestive of neglect or when there was a possible disclosure of sexual behaviour by the children or a dog, which possibly met the child protection thresholds, there was no separate multi-agency strategy and assessment process.

8.44 More attention should have been paid to repeated suspicion of injuries with Jude, even if it was thought that they may be self-inflicted through clumsiness. This lack of a multi-agency approach led to inappropriate response and delays.

8.45 The disclosure about possible inappropriate sexual activity petered out, and the Mother's suggestion of the dog licking Holly, appears to have been accepted without Holly being interviewed. Local procedures were not followed. The information shared at a Core Group and Mother's explanation was accepted. This may have contributed to a more optimistic picture in the consideration of whether the children could be removed from the Child Protection Plan.

8.46 **Child Protection Conferences:** There were five Child Protection Conferences relating to children in the family during the period under review. In Kent, during the period under review, the **Signs of Safety**[11] methodology was being introduced in a programme which trained the Chair Persons and Social Workers first.

8.47 Mother attended all of Child Protection Conferences, including one just a few days before Jamie was born. Father only participated in the first Review Conference. He did go to the office for one other meeting, but was excluded on the grounds of his aggressive behaviour prior to the meeting. The Lodger attended the September Conference but was appropriately excluded from participating by the Chair Person as she was not seen as impartial as she was expressing greater concern about the risk of her own homelessness rather than the needs of the children. Mother's Partner did not attend any of the meetings.

8.48 The Review Conference in September was also a parallel Initial Pre-Birth Conference for unborn Jamie. The baby's name was to be placed on a Child Protection Plan at birth, based on the continuing concerns and lack of progress in protecting the older siblings. There were differing views of the scaling of risk held by the multiagency practitioners, some of whom thought that there were signs of improvement. The Social Worker and Independent Chair thought that the risks were, in fact, greater than noted in March and that it was too soon to say that there was sufficient improvement or that it would be sustained. Mother's Partner had just moved in, (denied by Mother), and was an unknown. The decisions to retain the older children's names on a Plan and to make the expected baby subject to a Plan from birth were correct.

8.49 A further Review Conference was required within three months for the baby, who had not yet been born. The meeting was held a few days before Jamie's birth in late November. SCS had reviewed and ceased the Pre-Legal Proceedings between the two conferences on the basis that there had been improvement and that there was no longer a need to consider Care Proceedings for the children. The family had just moved home and some improvements were noted; the children's appearance had improved, school attendance was good and there were no concerns about the pregnancy, Mother was engaging with the Social Worker and Social Work Assistant, there was a new and larger home. There was a concern about the Lodger still being present in the home and that the children would face a change of school and children's centre. There was no discussion about Holly's recent disclosure of inappropriate touching, nor of Jude's bruising by banging his head in tantrums.

8.50 The professionals present at the Review Conference thought the risks should be scaled lower, but that the children should remain subject to Child Protection Plans for a further three-month period in order to

11 Signs of Safety http://www.signsofsafety.net/signs-of-safety-2/

See also the NSPCC Review of the Methodology and its use in England 2013

https://www.nspcc.org.uk/services-and-resources/research-and-resources/2013/signs-of-safety-model-england/

see that the improvements were sustained. The SCR Panel's view is that the Review Conference view was the correct decision

8.51 A further Review Child Protection Conference was held in February 2016. Although continued improved home conditions were reported, with the children being seen as happy and their basic needs were being met, it was also noted that there were hygiene issues for the girls. At times, the children were not supervised well enough and new and unexplained bruising had been noticed on Jude at his new nursery which had not yet been investigated. In addition, a complicating factor was the relationships between the four adults, two of whom had not been assessed. Mother was given an ultimatum to ask the Lodger to leave by the beginning of March. Mother's Partner was to be included in final work with Mother on the Freedom Programme on domestic violence.

8.52 The overwhelming view presented to the Chair of the Conference by professionals present was that the scale of risk was lower and that improvements had been sustained and that the children should no longer be subject of child protection plans. The Chair felt that there were still some uncertainties and would not agree to the removal of Jude's name until there was clarity about the cause of the repeated bruising. There was also the matter that the Lodger was still resident, and little was known about Mother's Partner, who had not been assessed. Jamie and the five oldest children ceased to be subject to Child Protection Plans and were designated as Children in Need. As Jude remained the subject of a Child Protection Plan, the other children would automatically be considered at the next Child Protection Conference and at Core Group Meetings.

8.53 The SCR Panel's view is that the decision to remove the older children and Jamie from Child Protection Plans and to retain Jude was not appropriate. Despite the apparent improvement in care for the older children, if one sibling is sustaining unexplained bruising, (even if thought to be self-caused, but from neglect of care), it was premature to remove the other children until expert advice had been given about the causes of the bruising and there was a resolution to the problem. However, it is unlikely that this was a key factor in Jamie's' death.

8.54 **Child Protection Plans, their creation and monitoring through Core Groups and Review Conferences:** Child Protection Plans are at the centre of the multi-agency safeguarding process. It is the actions agreed as a result of the assessments, interventions and monitoring which will protect children and improve their lives. The Plan is also an opportunity to make clear, in writing, to Parents and any advisors they may have, what the concerns are and what must be done to remove those concerns and by whom, including by the Parents.

8.55 Throughout the programme of Conferences, Review Conferences and Core Groups, Child Protection Plans were produced and shared with the Parents and with attending professionals. The Plans considered the key issues identified for the Parents and professional and contingency plans were also put in place.

8.56 A theme that continued in the reviewing of the Plan was that the family were showing limited improvements, however, these improvements were short term and not being sustained. The Parents continued to be in denial in relation to the identified concerns. Evidence was provided that demonstrated that the Plans were clearly not working. On one occasion, the Social Worker was appropriately concerned about the lack of progress and she warned Mother of the possibility of legal action and, after the Core Group, asked Managers to agree to Legal Advice being sought.

8.57 The Plans were reviewed when it was known that Mother was pregnant with Jamie.

8.58 Towards the end of 2015, the Core Group noted good progress against the Plan, however, it did not properly review the need to plan for the assessment of the involvement of the Lodger or the Mother's Partner. The latter was being seen as a positive influence. SCS ended the Pre-Proceedings under the PLO, given the improvements noted by the Core Group, which agreed with this decision.

8.59 The family moved to a larger home, however, this brought problems, (the Lodger had moved in to one of the rooms meant for the children), which required changes to the Child Protection Plan which were made.

The Contingency Plan was a repeat of the previous contingency; to convene an early Core Group if necessary or to rely on the PLO process, which was no longer in place. This was clearly inadequate.

8.60 It is to be noted that tasks in the various versions of the Plans, were agreed for Father, but he did not attend the Conferences, was no longer engaged with services and had not been responding to the Social Worker's attempts to contact him; there must be a question, therefore, about the realism of ascribing tasks to him in absentia.

8.61 Overall, it appears as if some small improvements led to an 'optimism' by the network that Mother had turned around the long history of concerns. Also, reviews of the Plans failed to take into account some of the newer concerns, e.g. Holly's recent disclosure of inappropriate touching, Jude's bruising by banging his head in tantrums, supervision of the older children in the community, (perhaps being left to supervise each other or to their own devices).

8.62 This review of the Child Protection Plans overall raises the question of how KSCB and Partner agencies ensure that Child Protection Plans properly reflect changes in family circumstances, including assessment of new risks and the use of contingency planning as part of the safeguarding process. The only two contingency plans noted before the children, except Jude, were removed from Plans, were 'to convene a Core Group earlier if that would be useful'. The final contingency plan, when the children were taken off a Child Protection Plan, was to seek legal advice if there were any new incidents of significant harm. What is of concern here is that when there were new concerns and / or insufficient progress or insufficient compliance, no consideration was given to convening Core Groups earlier, or even having a new strategy discussion, or seeking legal advice. It is not clear why Partner Agencies did not query or challenge that the contingency plans had not been triggered, when they should have been.

8.63 **Written agreements:** These are helpful to put in writing to Parents what the concerns are and what actions they, and Agencies need to take to improve parenting and lessen risk. There is little research into the efficacy of such **written agreements**[12]. There were three written agreements with Parents during the review period.

8.64 The written agreements were in plain English and the actions addressed the key concerns at the time. They related to expectations from both Parents. The final written agreement was drawn up between Mother, Father, (who had left the home), and SCS in October 2015. It clearly set out the concerns and the expectations on each Parent and on SCS, but no other agencies. It is signed by all three parties and stated that it may be used as evidence in court.

8.65 The SCR Panel questioned how much partner agencies within a Core Group are aware of, or party to written agreements, in order to be able to support them and monitor them, including being able to challenge parents who are not compliant with 'agreed' actions.

8.66 **Family Group Conference (FGC):** These aim to engage the wider family in finding solutions to concerns put by Safeguarding Agencies (usually SCS) about the welfare or safety of the children. An independent facilitator supports the family in a confidential discussion to seek their own solutions.

8.67 A FGC was held in June 2015 with Mother, Father, the two Grandmothers and a Great Aunt to the

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12 It is usual policy and practice to include a written agreement as part of child protection plans in order to spell out to the parents the concerns and what actions must be taken by whom, and possibly what the consequences will be of non-compliance. There is not a base of research into the efficacy of such agreements and how best they should be constructed. It could be argued that they provide a clear statement about what is expected and so meet a form of fairness with parents. But there are questions about how they are negotiated and whether they are realistic. See Community Care Survey published September 2017: http://www.communitycare.co.uk/2017/09/21/written-agreements-still-common-part-child-protection-practice/

children. It was clear that the meeting was in the context that the Local Authority was considering legal action to protect the children. Extended family members offered to provide support to Mother and Father. The family agreed to monitor the plan. The Plan was produced but it is not clear if copies of the agreement were given to the family and, unlike a written agreement, it is not signed by any party. It did not agree what would happen if the family support did not happen in the way agreed, which was the case. Information given to Core Groups later in the year, suggested that the wider family was assisting, which was no longer the case, perhaps leading to a false positive view.

8.68 **Public Law Outline (PLO) and Consideration of Legal Action:** Given the long history of neglect and poor parenting, and the lack of progress from January 2015 when the children were made subject of Child Protection Plans, it was appropriate to consider legal action. It was noted by the SCR Panel that Partner Practitioners can feel optimistic when a case gets into PLO and they can sometimes feel that they can stand back, but many do not understand the process and are rarely involved in any court proceedings.

8.69 Multi-agency staff need to understand the PLO process and the agreed actions to support parents and challenge any lack of progress. It is also important that they understand that Pre-Proceedings are not court action, but a warning and a formal attempt to bring about change and make it clear that lack of the required change will lead to consideration of an application to a family proceedings court. However, such an application is not a guarantee that children will be removed.

8.70 Practitioners need to understand that ceasing a PLO process does not mean that there are no risks but may be an indicator that risks have reduced sufficiently to mean that there may not be grounds for a care or supervision order, which have a higher threshold than child protection plans.

8.71 With the benefit of hindsight but using information that was readily available at the time and therefore knowable, the SCR Panel questioned why the Pre-Proceedings were stood down when they were. It appears to have been that there were some minimal improvements, noted by the professional network, and that Mother had co-operated when in fact she had not done so fully, and the changes in the family structure were not fully assessed. Was the ceasing of the PLO was a false positive, and was there unwarranted **optimism[13].**

8.72 Later, when there were new concerns, it is not clear why the legal processes were not re-considered as required by the final Contingency Plan.

8.73 **Multi-Agency Work:** Several agencies were involved in the case and sought to work together to improve the children's care and reduce neglect. Overall, there was commitment in the network. Inevitably, however, there is a systems issue in that when children become subject of Child Protection Plans and Pre-Legal Proceedings, the leadership of the network rests with SCS, and some agencies are not so involved in the direct work, such as FGC and legal meetings.

8.74 At the Practitioners' Learning Event, non-social work Practitioners spoke of 'lack of parity of voice' and that they felt that their voices were not given weight or that they deferred to SCS colleagues' views; an issue not just in this case.

8.75 This raises questions about how the local agencies' supervisory systems prepare and support Practitioners from the wide network of services in advance of attending meetings where they will be required to give their professional views about child protection and the need for and content of plans with the parents present.

8.76 The introduction of the Signs of Safety Model in Kent over the period of this case enables each Practitioner's views and reasons for it to be heard. It was noted by the SCR Panel that the training provided in Kent on the role and processes of child protection conferences was not well-attended. The

13 Revisiting the Rule of Optimism; British Journal of Social Work, Vol47, Issue 6; Sept 2017 pages 1624-1640

https:doi.org/10.1093/bjsw/bcx090

training and advisory role of Agency-based Safeguarding Advisors/Leads, (in schools known as Designated Leads) is important in this.

8.77 A key role of the network is to hold the child's experience, (including emotional experience), in mind and to act as a balance to ensure that this does not get lost in the demands of parents. The network saw minimal improvements, which were not being consistently maintained, but did not pro-actively ask 'is this good enough?'. There is a question from the SCR Panel about whether the minimal improvements and the departure of the Father led to 'fixed thinking'[14] which prevented relapse or new concerns being fully assessed. The possible 'normalisation' and acceptance of levels of chronic neglect in some geographic areas is also a kind of 'fixed thinking' and may have acted to prevent the network seeing that the inconsistent care of the children was not good enough.

8.78 The SCR Panel's view was that differing systems, busy workloads, larger sibling groups and parental needs or behaviours could easily get in the way of seeing the individual child's experience. A fundamental question in every meeting should be, 'What is this child's experience and is it good enough?'

8.79 At the time of this case, KSCB had not introduced some of the research into the impact of neglect[15] across the sectors. Subsequently the KSCB has implemented a multi-agency 'Neglect' strategy accompanied by an associated training programme. This has been followed up by neglect focused multi-agency audits.

8.80 **Use of supervision and professional oversight of complicated and distracting cases:** It is well known that safeguarding practice needs critical and reflective thought to understand and work with the dynamics in families. Workers can get caught up in processes, such as fixed thinking, disguised compliance, false positives, or optimism and may be easily distracted by uncooperative parents. Professional curiosity and respectful scepticism are important.

8.81 Personal responsibility is important to understand role and tasks, but Agencies' have a responsibility to support the frontline staff in thinking through, and perhaps challenging the workers themselves, about what may be happening, assessments and plans. Supervisors must be curious and challenging and seek evidence for real change in long-term cases.

8.82 In relation to the support and reflective supervision of the Social Worker, (the Key Worker), and Assistant Social Worker, there were supervisory arrangements in place. SCS review of the quality of supervision in this case has noted the following: the formal supervision for both workers did not happen with the frequency expected, but there was also ad hoc supervision. This was not in line with policy. The two workers were supervised by different senior staff and at no point in the management of the case was there joint-supervision to co-ordinate and plan the work that they were doing in parallel. It is noted that the two workers did have regular conversations and shared information about their progress. This does not, however, replace reflective questioning and advice by a third party as a 'critical friend' to challenge and inform the continual re-assessment and proposed actions. For both practitioners, the standard of recording of supervision was not met. The social work supervisor did, appropriately, take into consideration pressures on the worker from outside the case which may have had an impact on the Social Worker's capacity and competence.

8.83 There was inconsistent social work case supervision.

8.84 It is known that such formal case supervision is not routinely used by other Agencies as in social work.

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14 Thematic Reviews of previous SCRs have noted previously that flexible thinking rather than fixed thinking is required. Once a view had been formed there is often a reluctance to revise a judgement about the family, or about individual family members. **Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009;** Brandon, Bailey and Belderson; DfE 2011

15 Safeguarding children across services: messages from research; Davies and Ward, 2011

8.85 In Health, 'clinical supervision' is expected. The Kent Community Health Foundation Trust (KCHFT) has a Safeguarding Supervision Policy which sets out mandatory Safeguarding Supervision for all safeguarding cases, which cases must be brought for supervision and the minimum frequency of safeguarding supervision meetings. This case was not discussed with the Health Visitor. Previously, practitioners chose which cases to discuss with supervisors, but now the practitioner and their manager regularly review which cases will be discussed in Safeguarding Supervision. The Trust has now introduced a system to track how child protection cases are being monitored and supervised.

8.86 The Education and Early Help analysis undertaken for this Review noted that 'professional supervision in schools remains something of a concern'. **Keeping Children Safe in Education 2016** refers to 'support and training' rather than supervision and is aimed at the school's Designated Safeguarding Lead. Safeguarding consultation or supervision, (which are different processes), are available to schools through the Kent Education Safeguarding Team, but the resourcing of such a service is down to the school and its governing body. A question remains, therefore, in complicated or complex cases, how are school staff (in Kent) supported and challenged to think about child protection and the needs of the children in their school who are subject of child protection processes? In the absence of a clear internal supervisory process or access to a well-trained Designated Safeguarding Lead or Safeguarding Governor, School Heads are likely to rely on the leadership and guidance of the Social Worker or the Child Protection Conference chair, who will not necessarily hold the required perspective or specialism of the school setting.

8.87 This case underlines the importance of good quality supervision, particularly where there is long term neglect and/or parental denial and avoidance, so that workers are helped to think through what is happening and if it is 'good enough' for the children. Supervision has a role to challenge assumptions, question evidence, help workers think about possible blind spots, monitor professional standards and provide constructive advice.

8.88 **Health Agencies involvement with the Family:** The Health economy is a vast and complex structure in both the commissioning and provider arrangements. Within Kent, healthcare services can be commissioned by National Health Service England (NHSE), Public Health or Clinical Commissioning Groups (CCGs) and the delivery of healthcare can vary across Kent as services may be commissioned differently by one or all of the seven CCGs.

8.89 Health visitors and GP services are probably the most common services that are readily accessible to families and professionals. However, in complex cases it would be beneficial for specialist services, like Community Paediatricians, who have the expertise in providing an overview of development in children, to be involved in giving a comprehensive overview of children's health and development to be involved. Additional information which can influence the safeguarding plans for these children and the attendance of Community Paediatricians/ Paediatricians at targeted case conferences would allow a comprehensive overview of the health and development of these children. In this case there was no overview of each child's health and development.

8.90 It was evident in this case that the children 'Did Not Attend' (DNA) a number of health appointments. The issue of DNA and how to manage them in the context of safeguarding concerns have been addressed in **research**[16]. It is more pertinent to say that 'X' 'Was Not Brought', which then shifts the responsibility to the parent or carer. This hopefully then focuses the mind of professionals in dealing with frequent

16 Lisa Arai, Terence Stephenson & Helen Roberts; **The unseen child and safeguarding: 'Did not attend' guidelines in the NHS; Archives of Disease in Childhood,** March 2015 http://adc.bmj.com/content/early/2015/03/16/archdischild-2014-307294 and Munro, Eileen (2012) ***Review: Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' - a review of the evidence for practice.*** Journal of Research in Nursing, 17 (2). pp. 193-194. ISSN 1744-9871

non-attendances to appointments as possible neglectful behaviour.

Encouraging and responding to community concerns about child neglect and maltreatment:

8.91 After the Trial the Kent Safeguarding Children Board received representation from the local Community that concerns about these children had been raised to public agencies from within the Community over several years. The Board agreed that the Panel should look into how local services had responded to community concern about the children from the period before the children were made subject of Child Protection Plans. The Panel Chair and the Independent Reviewer met with one representative of the community.

8.92 People in the local community had been worried about the children as they perceived very poor hygiene, untreated head-lice, lack of food, lack of supervision, unsafe garden conditions, and parental domestic violence and regular drug use (including anti-social behaviour relating to visits to the home by others seeking to use drugs and possibly obtain drugs). As more children were born the seeming neglect appeared to be become worse; older children being expected to care for the younger children. At times improvements were noted in the children's care, particularly after Agency intervention and in the months up to Jamie's birth.

8.93 These direct referrals from community members were taken seriously and followed up at the time, assessed and appropriately shared with SCS. When different Agencies received information from the community, they did respond and did find that some of the observations and concerns of community members were founded and yet accepted the parents' denials or did not see the neglect to be serious enough to use child protection procedures.

8.94 Where wider family, friends or community members repeatedly make referrals about a family, and these are credible, these should not be seen as one-offs but should be seen and tested as a possible true pattern of family life, rather than the life represented by parents in denial to officials. There needs to be curiosity in assessments about what additional supports community members may provide in a family's life.

8.95 Reports of child abuse or neglect from the wider community must be encouraged and taken seriously but there are challenges about confidentiality and assessing motivation. The national 'Together we can tackle child abuse' campaign raises these issues.[17]

9 Key Lessons

In summary, this case highlights the following key lessons:

9.1 The need to keep an open mind in neglectful families of the possibility that any injuries may not be as a result of neglect or caused by children themselves, but may result from physical abuse or mishandling by adults, especially for babies and toddlers;

9.2 The importance of undertaking full assessments of all new adults in the household, regardless of their standing of 'Parental Responsibility';

9.3 The importance of engaging Parents and other adults, especially new adults who join households where children are already subject to safeguarding concerns;

9.4 The need for the continuing assessing the Parents' capacity to change and sustain change in cases of chronic neglect;

9.5 The need to engage with men and consider gender dynamics in households;

17 Together we can tackle child abuse: Department for Education https://tacklechildabuse.campaign.gov.uk/

9.6 The importance of focussing on the child's experience and life, including their emotional experience;

9.7 Ongoing assessing for emotional neglect and insecure or disorganised attachment as part of assessing neglect in 'chaotic' families;

9.8 Working with adults who may be domestically abusive and confronting the reality of the impact on children of living in a violent world;

9.9 Working with drug and alcohol using parents, including where the level of use does not evidence dependency;

9.10 The importance of analysing history, new concerns, assessing new injuries or disclosures for children who are already subject for CP Plans;

9.11 Recognising how the term 'single agency assessments' might exclude other partners from contributing to the assessment process;

9.12 The need to develop confidence in multi-agency staff to undertake appropriate inter-disciplinary challenge and escalation;

9.13 The need for critical thought and Reflective Supervision;

9.14 The adequacy of a child's physical home circumstances is an important factor in neglect and this must be fully considered within a safeguarding assessment.

9.15 Ensuring that holistic assessments of children who have experienced long-term neglect, include emotional neglect;

9.16 The understanding of the implications for children missing health appointments/assessments or specialist services assessments as 'Did Not Attends' and how this term puts the focus on the child as opposed to the Parent/carer;

9.17 The need to encourage and respond to community concerns about child neglect and maltreatment.

10 Conclusion

10.1 It is known that Jamie died as a result of injuries inflicted on him by his Mother and her Partner. Given the timing of the injuries and his tragic death, there is no evidence to suggest that any professional working with the family saw or could have seen any indication of the violence experienced by Jamie.

10.2 At the time of his death, Jamie was known to SCS as a child in need, as were his elder siblings, except for Jude, who was under a Child Protection Plan. Partner agencies had been working with the family for a significant period. The level of this support varied according to the assessed needs at the time, from Public Law Outline to child in need.

10.3 There was a history of domestic abuse and drug and alcohol use by the adults in this family. The impact of this on the children was not assessed. Physical neglect was recognised, and despite being considered for legal proceedings, due to limited and sometimes disguised compliance, was never really addressed; emotional neglect was not assessed.

10.4 On occasions, there were signs of improvement in how the children were cared for, however, these improvements were never sustained despite continued support from professionals working with the family. There was evidence of workers being overly optimistic with the observed improvements and the parents were rarely challenged when the improvements were not sustained.

10.5 The known history of the family and negative parental behaviour was not fully explored or used to assist in the undertaking of more detailed assessments. In general. incidents and concerns were dealt with in isolation and not viewed as part of an ongoing pattern of behaviour, nor was their impact on the children fully assessed, including the emotional impact.

10.6 Father's history was unknown and later when Mother's Partner and the Lodger moved in with the family, although this was initially denied by Mother, full assessments of them, including motivation and caring capacity, were not undertaken.

10.7 During involvement with this family, and especially when Mother's Partner and the Lodger were resident in the family home, there were occasions where new concerns came to light, e.g. Jude sustaining unexplained bruises and Holly's disclosure of inappropriate touching. Mother's explanation as to the causes was accepted without challenge and these did not result in more detailed multi-agency investigation.

10.8 There was a history of behaviour in the family, that if fully explored and challenged, may have resulted in agencies being more aware of the potential implications of how these children were being raised.

11 Recommendations

Considering the findings from this report and in response to the key lessons identified the following recommendations were made to KSCB and its Partner Agencies which agreed them and will implement an Action Plan to manage them:

Recommendation 1

The KSCB will review policies, procedures and training of relevant practitioners in the recognition of assessment of physical injuries to young children to require that consideration must always be given to whether unexplained or repeated injuries in babies and toddlers should be assessed as physical abuse.

- *As part of that consideration, attention should be paid to the assessment of the parental handling of babies. Paediatricians undertaking such assessments must be aware of the history and context of any prior child protection concerns.*

Recommendation 2

The KSCB will regularly review and seek evidence through a programme of case-audits that SCS and Partner Agencies, when assessing risk to children and leading multi-agency child protection plans, that there is a thorough assessment of parents' or carers' capacity to change and maintain change, using on evidence-based processes, including previous work with them.

- *These audits will include review of multi-disciplinary assessments of new adults who join or regularly visit the household.*
- *The programme of multi-agency audits will also review that any new incidents, disclosures or injuries to children already subject of child protection plans are subject of a strategy discussion with the relevant agencies, as per procedure.* (*This should include a longer-term view of the history of the incidents and concerns as a whole and not just an assessment of single incidents as they occur.)*
- *Within this the SCS should review how written agreements are used.*

Recommendation 3

The KSCB and its Partner Agencies will strengthen, through Learning and Development, the arrangements in place to consider the child's experience and emotional development, as well as the child's voice, within safeguarding assessments and multi-agency procedures.

- *This should include consideration of any barriers within systems and processes which are inhibiting the child's needs as being seen as central.*

- *Such assessments should include assessments of the child's emotional state and attachment, which should be considered at Child Protection Conferences.*

Recommendation 4

The KSCB and its Partner Agencies will review how they equip and support frontline practitioners and supervisors/managers in engaging with challenging parents and carers, including fathers and other resident adults, to assess their capacity to change and sustain change in cases of domestic abuse.

- *In reviewing the effectiveness of the new arrangements for assessing domestic (abuse) incidents, Kent Police and SCS should ensure that the impact on children over repeated incidents is considered fully and prioritised according to any pattern identified, not just by single incident or by parental behaviour.*
- *The KSCB will ask the Central Referral Unit Strategic Board to provide an Annual Report on the oversight and management of the Domestic Abuse notifications and processes, including data and outcomes.*

Recommendation 5

The KSCB will ask its Partners to jointly review the multi-agency and single agency guidance and training for frontline staff and their managers on understanding and working with drug and alcohol use.

- *The purpose of the review would be to ensure that practitioners are aware of the possible impacts of different types of parental alcohol and substance use on children and how to raise this with parents. This should include Drug and Alcohol Abuse services roles, including where the level of use may not have been assessed as 'problematic'. This should include guidance on thresholds of when to seek or require testing of adults as part of an assessment if alcohol and/or drug use as part of child protection procedures and when there are grounds to believe that there is misuse which is impacting on children's welfare.*

Recommendation 6

The KSCB will require its Partners to confirm the effectiveness of the arrangements for frontline practitioners to have informed and constructive reflective supervision or consultation, including group supervision for joint workers.

- *The KSCB should consider that, in the commissioning of regular audits of the quality of frontline safeguarding practice (as at Recommendation 2), the provision and quality of advice, consultation or supervision is also reviewed.*

Recommendation 7

The KSCB will ask the Kent Housing Group and the Joint Policy and Planning Board (Housing) with Children and Young People's Services to review the arrangements in the Kent Agency Assessment process for (priority) nomination to housing.

- *The purpose of this review would be to ensure that the housing needs of children subject of child protection plans, where the housing circumstances contribute to ongoing neglect, can be properly considered.*

Recommendation 8

The KSCB will ask the Commissioners and Providers of Health Services to review and report back on the policies for children who are not brought for medical appointments, health assessments or required treatment, with clarity about when the failure to bring a child may be considered to be neglect.

Recommendation 9

The KSCB, with the responsible Partnerships, will review how communities in Kent are made aware of the impact of child abuse and neglect, including how domestic abuse and drug misuse can impact on children, and how members of communities can report these.

Recommendation 10

Kent Police and SCS should review their guidance on communication with non-family members who refer safeguarding concerns about children or who support families to ensure that concerns are assessed over time and so that community members who support families can be appropriately involved in child protection assessments and plans for family support, subject to confidentiality and consent.