

**Child Y, Child X and Child W  
Serious Case Review Overview  
Report**

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**Jane Wiffin & Kevin Harrington**

**Havering LSCB**

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## 1. INTRODUCTION

## **The Circumstances leading to the Serious Case Review**

- 1.1. In September 2013 three siblings, aged at that time 15, 11 and 6, came into the care of the London Borough of Havering (LBH) under a voluntary arrangement. Care Orders were then sought and subsequently granted.
- 1.2. There was evidence that they had been neglected and that their health and development had been seriously affected. Investigations over subsequent months confirmed that:
  - all three children had failed to thrive in all areas of development
  - all three children had suffered emotional harm
  - all three children had suffered severe neglect, which has resulted in life limiting issues for two of the children
  - there was evidence suggesting that one or more of the children had been sexually abused.
- 1.3. The children had lived originally with their mother in LBWF between 1998 and 2009. Because of concerns about the care she provided, LBWF arranged for them to live with Mr C (their maternal grandfather) and Ms A (their maternal step grandmother) who were then living in the London Borough of Barking and Dagenham (LBBD). In the summer of 2011 the family moved to LBH.

## **Decision to hold a Serious Case Review**

- 1.4. These matters were considered by the Havering Safeguarding Children Board. The Board concluded that there was cause for concern as to the way in which agencies had worked, separately and together, to safeguard the children. In April 2014 the Chair of the Havering Safeguarding Children Board, Mr Brian Boxall, took the decision that a Serious Case Review should be conducted, in line with the government's guidance<sup>1</sup>.
- 1.5. There were discussions between the Safeguarding Boards for each of the localities in which the children had lived. It was agreed that the review would be led by Havering Safeguarding Children Board but arrangements would be made for agencies in all three localities to

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<sup>1</sup> Working Together to Safeguard Children (2013) – referred to in this report as “Working Together” – is a government publication containing statutory guidance on how organisations and individuals should safeguard and promote the welfare of children and young people, in accordance with the Children Act 1989 and the Children Act 2004.

contribute to the Serious Case Review. The findings of the review would duly be reported to all three Boards.

- 1.6 Agencies in all three localities contributed detailed chronologies and analyses of their involvement from the summer of 2007, when Child W was born, to September 2013, when all three children came into the care of LBH.

### **Arrangements for the Serious Case Review**

- 1.7 The Havering Safeguarding Children Board constituted a panel (the Panel) to manage and oversee the conduct of this review. The membership of the Panel and the agencies contributing to the review are listed in Appendix 1. Two independent people, Ms Jane Wiffin and Mr Kevin Harrington, were appointed to lead this review. Both have extensive experience of leading and contributing to Serious Case Reviews. Further details are at Appendix 2.

### **The methodology and structure of the review**

- 1.8 The Havering Safeguarding Children Board determined that the review would use a “hybrid methodology”, drawing from a number of theoretical approaches and techniques. This meant that all involved agencies provided a chronology of their involvement, with some analysis of the key issues. A number of professionals were interviewed. The panel provided critical analysis of the overview report as it developed.

The review has been carried out in keeping with the underlying principles set out in Working Together. The review:

- recognises the complex circumstances in which professionals work together to safeguard children
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight<sup>2</sup>
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

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<sup>2</sup> This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

- 1.9 The government normally requires the publication in full of Overview Reports from Serious Case Reviews. This report has been written in the anticipation that it will be published and a glossary of the professional terms used within the report is provided at Appendix 3. Care has been taken to ensure that the information in the report:
- is appropriately anonymised
  - takes reasonable precautions not to disclose the identity of the children or family
  - protects the right to an appropriate degree of privacy of family members
  - avoids the possibility of heightening any risk of harm to these children or others.
- 1.10 The review has been complex in the sense that three localities have been involved and, for two of those localities (LBWF and LBBB); there has been no local authority involvement for some years. For most of the time under review the children were educated in LBBB but the involvement of the Havering school, once the family moved, was pivotal in bringing to light the causes for concern. Health services have of course remained involved throughout, in all three localities, and issues relating to the health of the children assumed an increasing significance over time. The Metropolitan Police Service had no significant involvement while the children were with Mr C and Ms A, the key period under review.
- 1.11 In that context the report is structured so as to draw out, firstly, learning points specific to the local authority in LBWF and LBBB, and one key theme from that period, the use of “Family and Friends” care. The report then goes on to look at the education of the children in LBBB.
- 1.12 The body of the report then considers the period in Havering before the children came into care, analysing the involvement of all agencies and identifying the most significant cross-cutting themes arising from the review.

## **2. FAMILY COMPOSITION AND FAMILY INVOLVEMENT IN THE REVIEW**

- 2.1 The composition of the family is complex. The mother of all three children is Ms B. The children have different fathers, none of whom played any part in their lives before their admission to care. Shortly after the birth of child W, the children went to live with their maternal grandfather, Mr C, and his partner, Ms A. They were already caring for

a fifteen year old cousin of the children, Ms T, under a Residence Order. After this Ms B had continuing but occasional contact with the children. She went on to have another child, Child V, who, at an early age, was brought into the care of another local authority, where she was living at the time.

The ethnicity of all family members, where known, is believed to be white British		
Anonymised Name	Relationship to subject (if applicable)	Age at September 2013
Child Y	Subject	15
Child X	Subject	11
Child W	Subject	6
Child V	Half-sibling	3
Ms B	Mother to X,Y,W,V	Mid 30s
Ms A	Step-grandmother to X,Y,W,V	Mid 50s
Mr C	Grandfather to X,Y,W,V	60
Mr Q (Deceased)	Father of Child X	n/k
Mr P	Father of Child Y	n/k
Mr O	Father of Child W	n/k
Ms T	Cousin	Early 20s
Mr R	Uncle (maternal uncle )	Mid 30s

### **The family's involvement in the serious case review**

#### **Mr C and Ms A**

- 2.2 Mr C and Ms A agreed to meet with the two Independent Authors. They then cancelled the meeting because of an illness, but a second meeting took place with one of the Independent Author and the Havering Safeguarding Children Board Manager.
- 2.3 Mr C and Ms A said they welcomed the opportunity to contribute to the review because they did not understand why the children had been removed from their care. They were angry that they had given permission for them to come into care temporarily, and had fully expected them to return home once the agreed assessments had been completed. They gave examples of the steps they had taken to redecorate and buy new furniture and spoke of how much they missed the children. They felt professionals had misled them.
- 2.4 Mr C and Ms A did not accept any of the concerns expressed by professionals regarding the children, and suggested some of the disclosures made by Child X since being in care were inaccurate and confused. Their view was that the children had some difficulties that were caused by their early experiences of being cared for by their mother because of her alcohol problems.
- 2.5 They said they had been invited to attend many meetings, and had found many confusing or unclear. They particularly highlighted the case conference and the process of “scoring” using the Signs of Safety<sup>3</sup> approach as “funny” and “silly”. They were dismissive of all the professionals they had been involved with, and suggested that they were all incompetent in one way or another.

## **Ms B**

- 2.6 Ms B expressed interest in contributing to the review, but did not attend two appointments. Her social worker offered support and Ms B agreed to take part in a telephone interview with one of the Independent Authors, but despite a number of messages being left, and the social worker offering to provide further support, there was no further contact.

## **Children Y, X and W**

- 2.7 The Serious Case Review Panel, the Independent Authors and those now responsible for the care of the children all considered that it was not appropriate to speak directly with any of the children for the purposes of this review. This was because of the level and impact of

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<sup>3</sup> This is an increasingly used methodology in child protection work.

change in their lives and their recent contact with a number of new adults, such as foster carers and new social workers.

- 2.8 The views of the children about their circumstances were gathered during the assessment undertaken in LBH. Child W and Child X were also provided with an opportunity to share their views through individual work with a student social worker at school. Child Y was provided with individual support by his school. The information from these contacts is interwoven through the report to give a sense of the children's views about their lives.

### **3. THE PERIOD WHEN THE CASE WAS MANAGED BY WALTHAM FOREST: 1998 TO DECEMBER 2009**

**Child Y – infant – to age 11**

**Child X – not born at the beginning of this timeline – but was known to services here from birth to 7 yrs**

**Child W – not born at the beginning of this timeline – but was known to services from birth to 2 yrs**

#### **Narrative**

- 3.1 Ms B had, by any measure, a traumatic childhood. Her IQ was assessed as borderline in terms of having a defined learning disability and she has epilepsy. There is evidence that she was sexually abused by a relative or relatives from an early age. She has a history of depression, eating disorder, self-harm and suicidal behaviour as a teenager, and was involved with both mental health and substance misuse services in her early adult years.
- 3.2 Ms B's children were conceived with four different men, none of whom offered a continuing relationship. She used alcohol heavily throughout her pregnancies with all the children who are the subjects of this review. She parented her children largely on her own for some years when she was ill equipped to do so.
- 3.3 Ms B's first child, Child Y, was born in 1998 and was the subject of a child protection plan in the early months of his life. This was discontinued, despite continuing evidence that Ms B was struggling with the demands of being a parent. Professionals expressed concerns

about continuing neglect of Child Y in the period leading up to the birth of Child X in 2002 but this did not lead to any safeguarding action.

- 3.4 There are records of a number of injuries to the children between 2002 and 2005 but there were no child protection investigations or medical assessments despite requests from a health visitor and a GP. The case appears to have been defined as one of a family in need of support, and evidence suggesting child protection concerns were repeatedly set aside. Ms B was described as socially isolated and the family lived in a one bedroom flat where Ms B reported being harassed by neighbours.
- 3.5 In late 2005 Child X and Child Y became subjects of child protection plans because of neglect. Reported concerns were an unhygienic, chaotic home environment where the children were inadequately supervised while Ms B was often under the influence of alcohol. The children were described as looking undernourished and it was repeatedly noted that there was little food in the home.
- 3.6 In 2007 Child Y was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and there were continuing concerns that his mother was not administering his medication adequately. Indeed at one point Child Y is described as being a carer for his mother. He was then made the subject of a Statement of Special Educational Needs. Child X is described as “placid” suggesting that Ms B found it easier to care for her. Child W was born in the summer of 2007.
- 3.7 The month after his birth Ms B came to the attention of police, very drunk, with the children in her care. LBWF Children’s Social Care services arranged for the children to be cared for by Mr C and Ms A who lived in LBBB in a two bedroomed flat. They were already caring for a fifteen year old cousin of the children, Ms T, under a Residence Order.
- 3.8 It was known that there were allegations that Mr C had abused Ms B as a child but these were dismissed on the basis that they were not firmly evidenced. Ms B’s mother also contacted LBWF Children’s Social Care (CSC), alleging that Mr C had been extremely violent to her during their relationship and should not be allowed care of the children. Children’s Social Care services and police shared information and Mr C was found to have no criminal record. A CSC manager decided that the children should remain with Mr C and Ms A. LBWF CSC services did not support this arrangement financially. LBBB were notified of these

arrangements and that LBWF would continue to hold responsibility for the case.

- 3.9 LBWF CSC convened a Child Protection Case Conference at which the legal advice was that the threshold for initiating care proceedings had been met. The Chair of that conference recommended to the local authority that this be pursued, but it was not. There were continuing concerns about the nutrition and development of all the children.
- 3.10 In February 2008 the family moved to a larger property in LBBB. The following month the child protection plans were discontinued and the family was provided with “children in need” services by LBWF CSC. Both Child Y and now Child X were said to have learning disabilities and developmental delay, and to be small in stature (during a community paediatric assessment they were all found to be between the 0.4 and 2nd centile for weight and height). Some evidence of brain damage was identified in Child X, possibly caused at birth, but she was not brought for any follow-up appointments. Child Y’s behaviour was of particular concern, strange and uncontrolled, but reportedly improved since leaving his mother’s care.
- 3.11 Ms B’s own situation was not improving; she had become homeless and there was continued evidence of serious misuse of alcohol. Her contact with the children is said to have become erratic. In September 2008 the older children moved to schools in LBBB.
- 3.12 The legal status of the children became more complicated when Mr C and Ms A sought to formalise the arrangements by applying for a Special Guardianship Order, an application which was contested by Ms B. LBWF CSC supported their application in a report to the courts, but instead an Interim Residence Order was made in March 2009.
- 3.13 LBWF social workers continued to visit the children, generally recording that their relationships with Mr C and Ms A were warm but that the adults were unable to cope with the care needs of the three children and provide adequate stimulation for them. There was continuing cause for concern about Child Y’s behaviour and development, Child X’s weight and height, as well as general concerns about her health following the neurological investigations. There were also concerns about lack of weight gain and growth of Child W. Mr C and Ms A were considered not to have followed advice given about how to address the poor nutritional status of all three children. There was consistent evidence that the home conditions were poor and overcrowded.

- 3.14 A referral was made to CAMHS for Child Y and Child X. Ms A was not receptive to this and Child X was taken for two appointments, and Child Y for only one. In mid 2009 it was learned that Ms B was again pregnant. Her fourth child came into the care of another local authority at an early age and was adopted outside the family.
- 3.15 In August 2009 a Core Assessment by LBWF CSC concluded that the needs of the children were not being met and highlighted a number of very concerning aspects of Mr C and Ms A's parenting. These included not meeting the children's educational needs, poor boundary setting and poor home conditions. There were specific additional concerns with regard to Child Y. Ms A was described by a health visitor as looking exhausted and unable to cope. They were said to disregard any advice given by professionals. However, shortly after this a "child in need" review meeting concluded that the local authority should continue to support them in their application to the courts for a Special Guardianship Order.
- 3.16 In late 2009 LBWF CSC sought to transfer the case to LBBB CSC. The letter of referral from LBWF is unclear and inconsistent, suggesting that LBBB CSC should initiate a child protection investigation, not in response to any specific concern but because of the concerns LBWF CSC had been monitoring themselves over several years.
- 3.17 LBBB CSC felt that this request was inappropriate and that LBWF should continue to manage the case, resolving any continuing concerns, until and unless LBBB took case responsibility. There was a dispute between the two authorities but no direct conversation between managers or meeting to try to resolve the situation.
- 3.18 In mid December a teacher from school 1 reported concerns to LBBB CSC that Child X was sometimes brought to school by a man whose own children were subject to child protection plans. LBBB CSC records indicate that the teacher was advised to make contact with LBWF CSC. The account from school 1 is that the response from LBBB CSC was that they "could not get involved". In any event this report from the school did not lead to any further action.
- 3.19 Just before Christmas, LBWF CSC wrote formally notifying LBBB that they were terminating their involvement. LBBB accepted responsibility a few days before LBWF CSC services finally closed the case.

## **Analysis of the case when managed by Waltham Forest: 1998 to December 2009**

### **Concerns for the children when in the care of their mother**

- 3.20 Even with the benefit of hindsight it is difficult to understand the thinking behind the management of this case by LBWF CSC between 1998, when Child Y was born, and January 2010 when the case was transferred to LBBD. As described above the problems experienced by Ms B in her own childhood were substantial and she was largely unsupported in her care of the children. There was, from the outset, evidence that the children's health was not being promoted and that they were being neglected. There were repeated reports of injuries to the children, some of which were not investigated under child protection arrangements.
- 3.21 Yet there is little evidence of alertness to those difficulties and their predictable consequences. Child Y was placed on the Child Protection Register for neglect some six months after his birth but nine months later, those child protection arrangements were discontinued. Ms B was said to have "worked well with professionals" but it is not clear that there was evidence, correspondingly, of improvements in her care of her child or in the child's health and development. There was no evidence of challenge from any other agencies regarding this decision making.
- 3.22 Child protection plans were again introduced in 2005 but seem to have had no impact on the children's situation. The Individual Management Review (IMR) author judges that:  
*"this family were facing substantial difficulties which, if not alleviated, would lead the children to experience significant harm. The outcome of (an) assessment however, seems to have been yet more suggestions for limited support but I could see little evidence that these measures were making much difference".*

### **The arrangement for the children to live with Mr C and Ms A**

- 3.23 The arrangement by LBWF for the children to live with Mr C and Ms A was made in the face of a number of concerns raised at the time. A Child Protection Conference Chair commented in October 2007  
*"The placement is unregulated and not secure as Ms B has parental responsibility and can collect her children at any time. It is better to*

*take the matter before the court to provide security for the children and regular reviewing of their care plans”.*

- 3.24 That officer also noted other worrying aspects of the arrangements;  
*“I am not convinced that Ms B truly understands (these arrangements) and is in agreement ... the department may be exploiting Ms B’s disability by seeing her compliance as agreement (when) in my opinion she does not agree and ... (her) disability is such that she is entitled to representation and such representation would contest arrangements such as supervised contact especially with the baby ... it is fairer to Ms B and the children for the matter to be formalised”.*
- 3.25 In fact the steps taken by LBWF were probably not just unfair but also unlawful. The IMR explains this concisely:  
*“The Court of Appeal had decided earlier in 2007 ... that where a local authority plays a central role in placing a child with relatives that child is formally accommodated under s20, Children Act 1989 and as such is a looked after child”.*
- 3.26 LBWF had undoubtedly arranged for the placement of these children with their relatives and the children should from that point have been seen and treated as children in the care of the local authority. This would have profoundly affected subsequent events. The local authority would have been immediately required to comply with all the statutory requirements in place for children in the public care and would have been directly involved in the legal proceedings arising from the application for a Special Guardianship Order.
- 3.27 The thinking behind the local authority’s management of this situation is not made explicit anywhere. They were right to explore options within the extended family when it appeared that Ms B was no longer able to manage, but the steps taken raise concerns in themselves. Firstly their direct assessment of these adults’ capacity to look after three neglected children, including one with evident special needs and a baby who was weeks old at the time, consisted of one visit. Ms B’s mother contacted them and made explicit allegations that Mr C was a violent man. Ms B herself made explicit allegations about her father’s cruelty. However, the local authority decided to set these concerns aside on the basis that police checks revealed no relevant criminal record.
- 3.28 LBWF also set aside the legal advice that the threshold for initiating proceedings to bring the children into care through the courts had been met. At the next Child Protection Conference the Chair made a detailed

proposal to the local authority that steps be taken to strengthen the local authority's position in these arrangements. Yet this did not lead to any legal action.

- 3.29 LBWF did not financially support these arrangements for the children, or any of the arrangements subsequently made when Ms A and Mr C sought legal orders in respect of the children. It would not have been unusual then, and indeed subsequently, for a local authority to have taken a view that they need not provide financial support in such circumstances. There is extensive evidence over the years of many local authorities being swayed by what they saw as a financial saving arising from a family arrangement that prevented admission to the care system.
- 3.30 There is no reference in case recording to financial support. In fact the absence of any reference to the financial arrangements is in itself of concern. The children's names were on the Child Protection Register and the local authority therefore supervised them. Yet the local authority were content that these two people, who already had the care of another child from their extended family, were taking on a further three children without any additional income except, presumably, child benefit. It is hard to escape the conclusion that the local authority may, at least in part, have seen this arrangement as a way of saving money.

### **Inadequate response to ongoing concerns for the children**

- 3.31 Throughout the rest of the time that LBWF was involved their overarching aim was to support arrangements that would confirm the children remaining with Ms A and Mr C. This was the position taken by LBWF when the courts became involved. The authority told the courts that more could be done to promote the children's well being, especially in respect of stimulation and opportunities for play. However, the overall view from LBWF was that it would be disruptive to move the children, their care was adequate and allegations, which suggested risk of harm, had not been evidenced. In line with that position the child protection plans on the children were discontinued and their situation was being overseen by a social work assistant (not a qualified social worker as would be expected) under "child in need (CiN)" arrangements.
- 3.32 However, running parallel to this, some LBWF officers had serious reservations as to whether these arrangements could meet the needs of the children. Child Y's behaviour was demanding, erratic and sometimes anti-social. Child X's special needs, her lack of resilience

and self-esteem were increasingly emerging. The home was extremely over-crowded, particularly because it contained, as well as too many people,  
*“lots of furniture squashed into the bedrooms (which are) piled high with surplus TVs, computers microwaves, videos and clothes and toys”.*

- 3.33 The capacity of Ms A and Mr C to meet the needs of these children was becoming increasingly questionable and their willingness to “work in partnership” with the local authority was increasingly strained.
- 3.34 The core assessment, at the end of August 2009, highlighted serious concerns about Mr C and Ms A’s parenting. These included not meeting the children’s educational needs, poor boundary setting and a poor home environment. Ms A could not manage Child Y’s behaviour or meet Child X’s needs and was increasingly frustrated by this. The core assessment identified a ‘blame culture’ within the home, likely to have a negative effect on the children’s emotional and behavioural development. The assessment concluded that the children needed:  
*“carers who can recognise signs of their emotional distress and respond appropriately. I am concerned that Mr C and Ms A’s ability to do this is limited and that they have not been willing to take advice on board in respect of this. Overall it is my view that Child Y, Child X and Child W’s needs are not being met whilst in the care of Ms A and Mr C”.*
- 3.35 Ms A and Mr C were informed of these conclusions in late September 2009. A few weeks later LBWF terminated their involvement, transferring the case to LBBB, prompted by a request from the courts for information to assist in considering the application from Mr C and Ms A for a Special Guardianship Order. The family was resident in LBBB, so that, despite the many years of involvement by LBWF, LBBB was asked to complete this court report.
- 3.36 It appears that LBWF knew that the arrangements for the children were unsatisfactory, but were committed to supporting those arrangements before the courts. It was a long-standing plan, it would have avoided a disruption for the children, “Family and Friends care” was seen as having intrinsic benefits, and there were no financial consequences for the local authority. What was lacking was the managerial and supervisory authority to stand back, weigh those factors against the mounting evidence that the standard of care was inadequate, and give staff – who themselves had a range of views about the best way forward – an authoritative lead.

## **The transfer of the case to London Borough of Barking and Dagenham**

- 3.37 In their formal letter of transfer to LBBD, LBWF asked them to carry out a child protection investigation, which would be expected to be addressed as an urgent matter. This was quite inappropriate – LBWF prior to transfer should have dealt with any child protection investigation – and illustrates the confusion running through the management of this case in LBWF.
- 3.38 LBWF had not communicated with LBBD at all since the children moved to live with Mr C and Ms A. The case transfer was opposed but eventually accepted by LBBD. Although the request from LBWF was inappropriate, the response from LBBD was weak. Managers did not directly contact LBWF to discuss the situation and did not formally communicate their view that LBWF should continue to manage the case during an organised transfer process. There was no handover meeting.

The IMR notes that the transfer:

*“was not based on a proper cross-authority and inter-agency safeguarding transfer process in which the children’s needs were the prime consideration and responsibilities agreed accordingly”.*

- 3.39 Legal advice to this review is that the court was correct in requiring that the reports they requested be prepared by LBBD as this is where the children were ordinarily resident. Nonetheless it would have been possible and helpful for LBWF to have maintained an involvement, supported LBBD in preparing the reports and then transferred the case in a more considered way.

## **Service improvements**

- 3.40 In their contribution to this review LBWF have identified a number of key changes in their working practices and service delivery arrangements which they feel would mean that this case would now be managed more appropriately. They have highlighted:
- clearer procedures
  - tighter management oversight and scrutiny
  - the creation of a specialist team dealing with Special Guardianship Orders and friends and families assessments

- Enhanced use of performance and tracking data within the service with greater accountability to senior managers and elected Members
- A regular Quality Assurance Audit programme that considers both thematic monthly audits and regular random selection audits by team managers, which are then re-audited by Heads of Service.

## **Conclusion**

3.41 It is more than four years since the children lived in Barking and Dagenham and some six years since they lived with their mother in Waltham Forest. In those circumstances it is not appropriate to make detailed recommendations to agencies in those localities, nor to the LSCBs for those areas. The review has been informed of changes in practice in both areas which should address the key issues arising in those localities. The review does make one overarching recommendation, as follows:

### **RECOMMENDATION TO THE SAFEGUARDING CHILDREN BOARD FOR THE LONDON BOROUGH OF WALTHAM FOREST**

The Board should satisfy itself that appropriate measures are now in place to identify and tackle the areas of concern identified in this review.

## **4. THE PERIOD WHEN THE CASE WAS MANAGED BY BARKING AND DAGENHAM (JANUARY 2010 TO NOVEMBER 2010)**

**Child Y – 11 yrs old**  
**Child X – 7 yrs old**  
**Child W – 2 yrs old**

### **Narrative**

4.1 In January 2010 the children were allocated to a social worker in LBBD who remained involved until the case was closed in November 2010. The focus of social work involvement was to respond to the matter

before the courts, preparing a Section 37<sup>4</sup> report and meeting the court's timetable. This was achieved: the report concluded that there were concerns about the ability of Mr C and Ms A to meet the ongoing needs of the children, but that the children should remain where they were with support. In June 2010 the children were eventually made subject to Residence Orders, to reside with Mr C and Ms A.

- 4.2 While the discussions about case responsibility were taking place between the two authorities LBBD received a referral from school 1, flagging up concerns that Child X was sometimes brought to school by a man believed to have sexually abused his own children. The subsequent events are not entirely clear but in essence LBBD CSC did not accept the referral and asked the teacher to contact LBWF. In fact ultimately no referral to LBBD was made. School 1 did not follow this up with each Local Authority.
- 4.3 Child W was now under the care of paediatricians for failure to thrive and developmental delay, and Mr C and Ms A had been given advice on how to help him. However, they failed to take him for three follow-up appointments and his next contact with paediatricians was not until February 2011. He was also referred for speech therapy but Mr C and Ms A did not follow this up. Child X was seen by the community paediatrician where her weight and height were noted to have remained very low with little progress having been made - yet she was not taken to see a paediatrician again until 2013. The situations of the other two children remained unchanged and Child Y continued to give particular cause for concern.
- 4.4 In January 2010 Ms B gave birth to her fourth child, who was immediately supervised under child protection arrangements elsewhere in London. Mr C and Ms A were initially approached as potential carers, but withdrew stating that they could not manage the care of another child.
- 4.5 In March 2010 there was one contact with CAMHS. This was as a result of a referral about Child Y's behaviour and specifically about anger he was said to be displaying. Ms B's new baby had now been removed into local authority care and this was said to have caused his behaviour to deteriorate further. However, subsequent appointments with CAMHS were not kept. Child X moved schools in May 2010, to attend the school that had been the family's first choice but had no

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<sup>4</sup> Section 37, Children Act 1989 requires that the courts receive reports when there are welfare concerns about children in the context of private legal proceedings to decide where they live and who should be responsible for them.

places at the point of application. In December Child W started a part-time nursery placement at the same school.

- 4.6 LBBB social workers judged that there was no need for their continuing involvement and closed the case in November 2010.
- 4.7 Child W was taken for a paediatric appointment in February 2011. He was noted to be very small, pale and hyperactive but otherwise presented as well. A number of referrals were made including an “urgent” re-referral to speech and language therapy.

### **Analysis of the period when the case was managed by Barking and Dagenham (January 2010 to November 2010)**

#### **The section 37 assessment**

- 4.8 The point has already been made that LBBB should have contested the proposed transfer of the case. Having accepted it, LBBB’s first responsibility was to conduct the section 37 assessment and report for the court. These assessments are intended to be comprehensive and make recommendations about suitability of the plan. The report/assessment carried out was brief and superficial, and does not reflect the significance and extent of the problems in the family. Despite concerns being raised about the quality of care the children were being provided with, the report recommended that they remain with Mr C and Ms A.
- 4.9 The section 37 report also recommended that a Family Assistance Order be made and the court did so – though there is no explanation as to why such an order was judged necessary, as, on the face of it, the adults were happy to accept professional support. Moreover a Family Assistance Order is time limited for a brief period when it was clear that there were enduring problems in this situation.
- 4.10 It appears that the report was heavily influenced by a view that, because of the length of time the children had lived with Mr C and Ms A, it would be better for them to stay there. This displayed a misunderstanding of the nature and impact of neglect and its impact on attachment relationships – something addressed in Theme 2 at the end of the report. Although the social worker was supervised, the management oversight of this decision was unsatisfactory – there is no evidence of the rationale for the decision.

## **Management of the case by London Borough of Barking and Dagenham Children's Social Care services**

- 4.11 The early concerns raised about the man bringing Child X to school did not lead to an appropriate response. It was right that LBBDCSC should not get directly involved in a case being managed elsewhere. The Head Teacher made the referral in mid December when the family was still allocated to a social worker in LBWF. The case was not eventually closed in LBWF until mid-January.
- 4.12 However, a more helpful response would have been an offer to liaise with LBWF and facilitate a referral from the teacher. It seems that the ongoing dispute about case responsibility prevented a more child-focussed response. We now know of subsequent concerns that Child X had been sexually abused, so this poor management by both authorities becomes even more significant.
- 4.13 The continuing involvement of LBBDCSC was based on a judgment that the children were "children in need" but the IMR tells us that:  
*"There was no child in need plan on records in London Borough of Barking and Dagenham and no evidence that child in need meetings took place over the period of London Borough of Barking and Dagenham's involvement".*
- 4.14 There was no real assessment of the circumstances of these children, each of whom already had significant special needs, nor of the extent to which Ms A and Mr C were meeting those needs.
- 4.15 At the same time it is right to recognise that no concerns were being expressed about the welfare of these children.  
*"Most particularly reports from schools who regularly saw the children were generally positive ... No safeguarding concerns were reported throughout the period of London Borough of Barking and Dagenham Children's Social Care services involvement".*
- 4.16 The Children's Social Care services IMR notes that there is limited evidence of supervision or management oversight of the case. The first recorded supervision follows the conclusion of the court proceedings. Monthly supervision sessions are recorded after that but these reflect that there were no reported concerns and the case is soon to be closed.

## **Service improvements**

- 4.17 The LBBB report for this review highlights the following learning points, and changes in practice which are now in place:
- The use of a formal, explicit process for accepting case responsibility from other authorities
  - An approach to working with “children in need” that reflects statutory obligations towards those children and is based around a continuing process of assessment, service delivery and review
  - Compliance with required standards of staff supervision and case recording.

## **Education Services in Barking and Dagenham**

- 4.18 The family moved home four times during the period when Ms A and Mr C had care of the children, leading to several changes of school for the younger children. While they lived in LBBB the children attended/had contact with four schools, three children centres and the educational psychology service. The Serious Case Review was informed by an extremely comprehensive IMR, considering all those schools and services and containing a great deal of direct evidence from staff who knew the children. The following key issues and learning points emerge.
- 4.19 There was a general assumption that the children’s various problems were a consequence of the neglectful care previously provided by their mother, rather than arising from the care provided by Ms A and Mr C. Some staff were falsely reassured by the fact that there was a legal status to the arrangement, thinking that this must indicate that the adults had been assessed and found to have appropriate parenting skills. In fact, for example, Mr C and Ms A regularly promised to make medical appointments for the children but failed to do so:  
*“important information about the children’s development and general health was not collated or understood by the schools”.*

## **School Records**

- 4.20 The documentation held by the most schools was, in total, substantial but poorly organised. There was, for each school, enough information to indicate that there might be cause for concern about the ongoing care of the children but  
*“busy school staff would have found it very difficult to find the time required to reorganise and make sense of information in the files. This*

*partially explains why the children's vulnerability may not have been well enough understood".*

- 4.21 Relatively straightforward changes could be made to the way in which schools record information about potential vulnerabilities or safeguarding concerns, and present this on children's files, to provide an accessible overview of each child's story.
- 4.22 The secondary school attended by Child Y had no background information except one copy of a child in need meeting minutes, which was misfiled and not accessed by any of the staff who had contact with him. The reasons for this lack of information remain unclear, but are of concern.
- 4.23 Despite not having a full grasp of the nature and extent of the children's vulnerabilities there is evidence that care was taken to engage with the children and to address various issues as they emerged. At Child Y's large comprehensive school 2 his erratic behaviour and limited concentration were well managed and he made good academic progress from a very low base. The school did seek support from appropriate specialist services but were often thwarted in this by a lack of engagement from Mr C and Ms A.
- 4.24 Child Y's school 2 made two referrals to LBH CSC, neither of which was responded to. There is no evidence that the school followed these up.
- 4.25 As a result of a referral by the Police, and the involvement of a LBH Children centre, a Common Assessment Framework was initiated for Child Y, and a plan of action agreed. This plan would have been improved if there had been clearer recording of actions and timescales, and that these were reviewed at subsequent Team around the Child Meetings. This lack of review meant that the non-compliance of Mr C and Ms A was not adequately addressed.
- 4.26 Child X attended two primary schools in LBBD, at both of which she was well supported. As she neared the end of her primary education there was increasing evidence, seen by the school 3, that Mr C had a very negative attitude towards her. This may not have been recognised at the time as indicative of the more general neglect of the children but it is clear that staff took time to support and encourage her.
- 4.27 Generally the schools were not sufficiently alert to issues of concern for the children's growth and development, particularly in respect of Child

Y. He was repeatedly noted to be hungry and to steal food. Indeed, school staff went out of their way to give him extra food and snacks. Had agencies worked together more closely a picture would have emerged, sooner than it did, of a repeated failure by the carers to ensure that the children received appropriate medical input and investigations.

- 4.28 It does appear that, until moving to Havering, the physical presentation of Child X was not exceptional or worrying. Schools noted that she was small but not significantly different from some peers, and one head teacher described her as “well dressed and clean”.
- 4.29 Her relationship with Mr C may also have been particularly significant. He was noticed at school to display a negative and dismissive attitude towards Child X towards the end of their time in LBBB, which may itself have been associated with her physical decline and/or the subsequent concerns that she was sexually abused. The IMR notes evidence of a decline in Child Y’s behaviour at the same time, which *“could also be an indication of changes in home circumstances, or the possible fallout of the ongoing deterioration in Child X’s physical and mental condition”*.
- 4.30 Child X’s school attendance deteriorated around the time of the move to Havering, which may have been linked to a decline in her physical health at that time. Previously the levels of attendance at school by Child Y and Child X had been good. Achieving this level of attendance will at times have taken a good deal of effort from Mr C and Ms A, who had to ensure that the children got to various destinations. This good attendance may have deflected attention from the wider concerns which can now be seen.
- 4.31 This was in line with a more general issue of staff under-estimating the scale of the children’s problems. Child W had very limited communication, wild behaviour and little understanding of boundaries. The IMR judges that this *“might reasonably have been interpreted as showing weaknesses in parenting”*.
- 4.32 Child X wanted to please everyone and did not always provide accurate accounts of things which had happened to her. This might also have pointed to the possibility of difficulties at home. Child Y’s verbal communication skills were limited and he is reported as talking endlessly and spinning illogically from one subject to another. Staff knew him well but did not succeed in getting a picture of his home life.

We have the benefit of hindsight but it may be that staff could have done more to raise concerns about this presentation and what may have caused it.

- 4.33 Overall the potential vulnerability of the children in both LBWF and LBBD might have been more clearly explored, identified, monitored and recorded in schools before the move to Havering. This might reasonably be expected to have led to discussion with children's social care or other specialist services. The IMR report makes a series of detailed and helpful recommendations which address these issues.

## **Conclusion**

- 4.34 It is more than four years since the children lived in Barking and Dagenham and some six years since they lived with their mother in Waltham Forest. In those circumstances it is not appropriate to make detailed recommendations to agencies in those localities, nor to the LSCBs for those areas. The review has been informed of changes in practice in both areas which should address the key issues arising in those localities. The review does make one overarching recommendation, as follows:

### **RECOMMENDATION TO THE SAFEGUARDING CHILDREN BOARD FOR THE LONDON BOROUGH OF BARKING AND DAGENHAM**

The Board should satisfy itself that appropriate measures are now in place to identify and tackle the areas of concern identified in this review.

## **5. THE PERIOD WHEN THE CASE WAS MANAGED BY HAVERING (MAY/JUNE 2011 - OCTOBER 2013)**

**Child Y – 13 yrs old**  
**Child X – 11 yrs old**  
**Child W – 4 yrs old**

- 5.1 Although the family moved to the LBH in May/June of 2011 it was not until March 2012 that any concerns were known. The school attended by Child Y sent a brief referral about bruising to LBH CSC which was not acknowledged and was not followed up by the school.

- 5.2 In June 2012 the police notified LBH CSC that they had visited the family late at night and were concerned about the condition of the home and the distressed state of the children. LBH CSC asked the local children centre to visit and offer the family support. Mr C and Ms A were initially hostile but agreed to a Common Assessment Framework (CAF) being undertaken about Child Y, and this was completed in partnership with his school.
- 5.3 The CAF covered concerns about Child Y's behaviour/achievement at school 2 as well as stealing food and complaining of hunger. Concerns were raised regarding Child Y masturbating and self harming. A plan was formulated, and included a referral to CAMHS to help Child Y with emotional and behavioural difficulties, a review of his ADHD medication and a health assessment regarding low weight gain and poor dental hygiene. There were regular Team around the Child meetings to discuss the ongoing plans, and these were attended by Mr C and Ms A. Mr C and Ms A attended CAMHS once without Child Y and refused further appointments. A health assessment showed that Child Y was considerably below the expected weight and height for a child his age.
- 5.4 LBH CSC received another referral in January 2013 from an anonymous source expressing concerns that the children could be heard crying late into the night. LBH CSC asked the children centre to see if the family needed more support. The children centre contacted school 4 to which the younger children had recently moved and were told that there were concerns that Child X was underweight, looking unkempt, and seemed very emotionally fragile and that Child W was also underweight and developmentally delayed. Ms A agreed that a Common Assessment Framework could be completed about Child X and Child Y.
- 5.5 The CAF was a comprehensive overview of the academic, physical and emotional concerns about both of the younger children. A clear plan of action was formulated including health checks for all three children and a referral to the Eating Disorder Service for Child X. It was agreed that the historic records would be reviewed and Child X would be provided with individual support from a social work student on placement at the school. Progress of the plan was reviewed in Team around the Child meetings (TAC) and this enabled concerns to be considered regarding Child X telling the student social worker she was unhappy at home, worried about being taken into "care" and making herself sick. The health checks for the children showed that they were all considerably below the weight and height expected for their age, and had not attended routine paediatric appointments for some time;

the Eating Disorder Clinic reported that Child X needed an urgent referral to a Paediatrician because her weight and height was so low - representing 68% of what it should have been. The children centre became aware that there had been a further referral to LBH CSC regarding bruising to Child Y, which had not been responded to because there was a CAF process in place.

- 5.6 The TAC agreed that a referral should be made to LBH CSC and this was completed in May 2013 by school and children centre, but it was not acknowledged. This referral was comprehensive and based on the issues raised within CAF and the TAC. LBH CSC asked the children centre to visit the family. Ms A was angry that social workers were involved and she refused to allow the children centre to visit or to share information with other professionals, which meant they had to withdraw from work with the family.
- 5.7 The referral was evaluated by Multiagency Safeguarding Hub (MASH) who initially questioned the central focus on health issues, when no concerns had been raised by health agencies. It was agreed that a child in need assessment would be undertaken. School 4 and the children centre were not informed of this outcome and because they were so concerned they sought further information from a LBH CSC Senior Manager.
- 5.8 The assessment was commenced quickly and Child X and Child W were interviewed at school by a social worker and the student social worker on placement at school 4. Child X said that she was not happy at home, partly because of her older brother's behaviour which she described as "playing with himself"; she also reported that she had been in trouble with Ms A for being sick. The social worker recorded that she was surprised when Child X hugged her at the end, because she had been quite reserved in the interview; the student social worker said that they school had been concerned that Child X often hugged strangers. Child W was described as "friendly and chatty" and he also raised the same concerns about Child Y.
- 5.9 During this time Child X attended her planned paediatric appointment and because of significant concerns about her weight loss and failure to thrive she was admitted to hospital. On admission her clothes were described as smelly and dirty and nursing staff noted that Ms A was aggressive towards them. Child X was to remain in hospital for nearly two weeks, with the primary aim of trying to establish the cause of her small stature and weight loss. She was monitored closely and was

seen at times to conceal food. The ward and hospital school staff were concerned about her vulnerability and emotional fragility, the negative attitude of Mr C and Ms A towards her and that she was being neglected. On the ward she was noted to hug women who she had not met before. The hospital could find no medical cause for Child X's low weight and attitude to food, and they considered that the cause might be her relationship with Mr C and Ms A and the poor quality care she received. Consequently they made a referral to LBH CSC asking for a strategy meeting to be convened.

- 5.10 This was held at the hospital and attended by all relevant professionals. Information was shared about all three children, and the senior social worker concluded that "*everyone has shared concerns regarding historic and ongoing neglect which these children have to endure*". It was agreed that the assessment that had already been started would continue under child protection processes, and there would be an Initial Child Protection Case Conference (ICPCC). The strategy meeting finished, but professionals asked to see the social worker before she left and a further informal meeting took place. Professionals expressed concerns about Child X returning home to the care of Mr C and Ms A, as she was due to be discharged the next day. The social worker explained that there was insufficient evidence for emergency action. It was agreed that health and education professionals would provide chronologies, and these were received a month later. After the meeting a number of agencies contacted senior managers in LBH CSC to express concerns about the wellbeing of the children and to seek reassurance that action was being taken. Child X remained hospitalised for three more days. There was no formal discharge planning meeting, but the discharge plan was discussed with LBH CSC via telephone.
- 5.11 The assessment was completed in July in readiness for the Initial Child Protection Case Conference. It was shared with Mr C and Ms A and all other professionals at the start of the ICPC and reports were also provided by the schools and the hospital. This conference was carried out using the Signs of Safety approach and this was explained to Mr C and Ms A by the Independent Chair of the Conference, leaving all professionals 30 minutes to read the reports. A 12 point plan was agreed, which included support for Ms A and Mr C regarding the management of Child Y's behaviour, general support to meet the needs of the children, a requirement that the children's medical and nutritional needs were met and that Mr C and Ms A would work positively and openly with all agencies.

- 5.12 A core group meeting was held the following week to discuss the child protection plan. Ms A said she disagreed with the focus of the current plan because the children's difficulties were due to historic issues related to the care they received from their mother. At the conclusion of the core group, professionals asked to see the social worker. This led to an informal meeting where professionals expressed concerns about the current plan, the lack of attention paid within it to the emotional well being of the children and the lack of acknowledgment that many of the current concerns and actions replicated those raised many years earlier with Mr C and Ms A and which they had not historically complied with. There was a further professionals meeting a few weeks later, because of continued concern from professionals about the progress of the child protection plan and the wellbeing of the children. A new plan was formulated which included seeking background information, a more comprehensive health chronology and further assessment of the family routines.
- 5.13 Intensive support was provided by LBH CSC and focused on establishing routines, clearing the flat (there was a large amount of old furniture as well as many animals) and ensuring the children were provided with appropriate food. This continued for a few weeks and some progress was made. The children centre was asked to continue this work. Mr C and Ms A agreed to this plan but almost immediately undermined it. They were increasingly hostile to professionals, Ms A was observed to be unnecessarily critical towards Child X, suggesting that she was being sick to gain attention and to get the family into trouble, and individual work with Child Y was sabotaged.
- 5.14 There were a number of further meetings over the following weeks, where the same concerns were discussed. At the beginning of September the consultant child and family psychiatrist wrote to a senior manager in LBH CSC expressing "grave concerns" for the children because of significant neglect and emotional abuse, and asking that all three be removed from the care of Mr C and Ms A. A legal planning meeting was convened and it was agreed that legal proceedings would be pursued; Mr C, Ms A and Ms B were all formally notified of this. Mr C and Ms A were asked to agree to the children coming into care on a voluntary basis so further assessments could be undertaken regarding their individual needs. They agreed to this but declined an offer to attend a parenting course.

- 5.15 After discussions between all parties, informed by specialist medical advice, Child X had a further planned admission to hospital for failure to thrive, feeding issues and concerns about neglect. Child X was also seen on a number of occasions by specialist medical teams at Great Ormond Street Hospital who made an assessment of Child X's difficulties and continued to support her. In October the two boys were placed together with foster carers and Child X went to a separate foster-placement. They were able to remain at their schools and Child X talked to the student social worker about aspects of her home life which led to a joint investigation by police and social workers. Child X disclosed having been sexually abused by a maternal uncle. Mr C was said to be aware of this as Child Y had told him. Further disclosures were subsequently made leading to continuing investigations into concerns about sexual abuse in the family.
- 5.16 The children were made the subjects of Care Orders to the local authority and are currently placed with foster carers.

### **Analysis of the Period when the case was managed by Havering (May/June 2011 - October 2013)**

- 5.17 The three children who are subject of this review came to the attention of agencies in LBH when they had already experienced long term, chronic abuse and neglect and non organic failure to thrive; this information was not initially known, but emerged over a 17 month period, in which there were a number of referrals to LBH CSC and early help response from the children centre and schools. The time from the comprehensive referral made by the school/children centre about failure to thrive and neglect to the children coming into foster care was a period of 14 weeks. On the face of it this was appropriate decision making. It is evident that all professionals were concerned about these children, but there was significant multiagency professional disagreement about what could be done and how quickly. This was in part because of the different roles professionals play in the context of addressing neglect. These differences of professional opinion are explored in Theme 5 in the next section of this report. The analysis which follows tracks the children's journey through services and reflects on the multiagency professional response to these children.

### **Making Referrals to Children's Social Care**

- 5.18 Research, policy and practice<sup>i</sup> <sup>ii</sup>have identified the importance of offering help to agencies in making referrals. National guidance<sup>iii</sup> <sup>iv</sup>makes it clear that all professionals who have contact with children have a role to play in recognising concerns, sharing information and taking prompt action regarding those concerns. This is particularly important in the context of neglect, where research suggests that professionals are often uncertain about when to make a referral. There was little concern expressed regarding these children from 2010 – 2012 but once the children moved to LBH there were six CSC referrals in a 15 month period.
- 5.19 Those referrals from school 2 did not provide sufficient information to make a decision about next steps. It is the responsibility of the referring agency to ensure that they provide clear information to enable the agency receiving referral to make a decision about next steps. This includes being explicit about what the concerns are, why they are of concern, what is known about the child's development, information about parental and family circumstances, a brief chronology of the agency's involvement and any actions already taken.
- 5.20 When a referral is made regarding the wellbeing of a child it is expected that Children's Social Care will respond regarding actions and next steps within 24 hours and guidance requires that if an agency has not received feedback within three days the referring agencies should seek information about the progress of their referral. Four of the referrals made by agencies about these children received no contact or feedback. This had the potential to leave children at risk of continued harm. In this case concerns about bruising to Child Y and glimpses of underlying chaos at home were left unassessed.
- 5.21 The lack of feedback regarding the referral made by the children centre and the school (4) of Child X and Child W marked the start of tensions across the multiagency network, and caused agencies to feel that their concerns were not being taken seriously. Feedback regarding referrals is an important opportunity to clarify agency concerns if they are not clear. The MASH team who screened the referral from the children centre and the school were concerned that the focus was on health issues, and there had been no contact from health agencies. In reality the referral was underpinned by work undertaken by the school nurse. The information should have been checked directly with the referrer and feedback given about the concerns regarding the basis of the referral. This would both have fostered effective multiagency relationships but been a forum for early sharing of the very significant concerns held.

5.22 There is little information provided about the extent to which Mr C and Ms A were informed about any of these referrals being made. It is an expectation that parents/carers are informed about referrals and their permission sought for information to be shared, unless to do so would put a child at risk of significant harm. The intention is that parents are clear both about agency concerns and actions to be taken. In the context of addressing the early signs of neglect this is important; it gives families a chance to address concerns and enables agencies to see if changes can be made. Since the time under review action has been taken by the LBH Multi Agency Safeguarding Hub service to ensure that all agencies and relevant individuals are provided with feedback in a timely way.

### **Early Help Response**

5.23 Research, policy and practice<sup>v vi</sup> have identified the importance of offering help at an early stage to children and their families to improve outcomes and to prevent problems becoming entrenched. Responding early and in a focussed way is particularly important during the early identification of neglect. It is good practice that all three children were offered an early help response, initiated because of referrals to LBH CSC and brokered by the children centre. It would have been appropriate for school 2 to have considered undertaking an early help assessment when Mr C and Ms A sought help regarding Child Y's self harming, and subsequently did not follow through with the support offered to him by CAHMS.

5.24 The first CAF was undertaken with the children centre and school 2 focussed on Child Y. This appears to be because at this time the schools for the younger children had no concerns and they were not in contact with any other agencies. The information in the CAF for Child Y was comprehensive and this was the first time in a number of years that there had been any professional reflection regarding his circumstances. However, the CAF lacked a clear plan, with stated objectives and timescales, which could be reviewed in subsequent TAC meetings. This meant that the lack of compliance with agreed tasks by Mr C and Ms A got lost. There was also no mention of the lead professional, or the role they could play as a link to Mr C and Ms A or as a point of contact for Child Y, who was now 14, and whose views about the plan are not recorded.

5.25 The second CAF was instigated for Child X and Child W as a result of an anonymous referral to CSC. There were growing concerns from the

school, who had been considering an early help response, having known the children for only about 10 weeks. School 2 and the children centre worked together and the second CAF was comprehensive, and clear objectives were set for each child. The CAF and subsequent TAC meetings would have been enhanced by clearer goals and timescales, and more information about the role of the lead professional. At this point the CAFs for the siblings were connected, and an appropriate decision was made to escalate the concerns to LBH CSC. It was notable that none of the CAFs made explicit reference to concerns that the children were being neglected – or that this might be attributable to the care provided by Mr C or Ms A. Addressing neglect requires professionals to be clear about persistence – making comment about its longevity in the context of a child’s developmental needs. This requires all agencies to name neglect. Since the time under review work is underway to enhance the early help response in LBH.

## **Assessment**

- 5.26 Assessment is critical to addressing neglect and emotional abuse; it provides an opportunity to establish detail, which can either aid intervention, or start to “evidence” the need for further action to safeguard children. In LBH CSC single assessment was undertaken under the auspices of child protection. Appropriately, this process started with all three children being seen individually, two with support from the student social worker at school 2 and Child Y was seen alone at home. They were enabled to talk about their lives, and this was recorded clearly in the assessment record. In the actual written record there were times when Ms A was quoted in some of the sections meant for the children’s views; where the children’s view were not known this should have been recorded rather than allowing Ms A to speak for them. The assessment brought together a lot of information, from the past and the present, but overall it lacked analysis and the risk assessment section did not reflect the many concerns about these children or the quality of care they were being provided with. The assessment did not acknowledge that it had not been possible to make contact with biological mother, because Mr C and Ms A could not provide contact details nor that there were significant concerns about the negative way that both Mr C and Ms A spoke about Ms B – their mother - to the children.
- 5.27 Overall the assessment was too tentative in its conclusions, and lacked a full analysis of the children’s present circumstances. There was considerable evidence that these children were being neglected by Mr C and Ms A. The assessment concluded that all the children were likely

to continue to suffer harm, without making clear the nature of the harm or who was responsible for it. This was despite the multiagency group being clear about issues of neglect, alongside concerns about emotional abuse and worries about issues of sexual abuse which were never recorded. The Single Assessment is intended to be a multiagency document. A number of agencies did provide information as part of the assessment process, but this information was missing from the final analysis, particularly the concerns of health agencies regarding the cause of Child X's poor weight gain and difficulties with food which was attributed to the care provided by Ms A.

### **Recommendation to the Havering Safeguarding Children Board**

The Board should review and improve as necessary the arrangements under which other agencies contribute to formal assessments led by Children's Social Care services

### **Professional Meetings**

- 5.28 The formal meetings that bring professionals together to evaluate, plan and review actions are an important part of the response to vulnerable children and their families. These are particularly important in the context of neglect and emotional abuse. In this case there were many professional meetings. Some were the formal processes in the context of safeguarding – Strategy Meetings and Core Groups - others were informal meetings called at short notice, which were a response to multiagency disagreements about proposed plans and actions and often lacked clear purpose.
- 5.29 The strategy meeting took place in a timely way and there was high level multiagency attendance. The meeting was chaired by a senior social worker as would be expected. The minutes show that a lot of information was shared, but these minutes lack a clear structure or analysis, and do not give a clear overview of the risk and strengths for each child, and do not cover the issue of parenting capacity or the family context. This meeting should have considered a safe discharge plan for Child X.
- 5.30 A core group took place as would be expected a week after the case conference. This meeting should have focused on the child protection plan. However, Ms A was said to dominate, refuting all concerns and the need for the plan. There is no evidence that this disruption was challenged or that there was any discussion about the likelihood of the

plan working if Ms A disagreed with its contents. This meeting was followed by a professionals meeting, called because of professional concerns about the appropriateness of the current plan and the robustness of the formal meetings. Since the time under review work is underway to enhance strategy meetings and core groups in LBH but, in view of the significance of this issue for all agencies, it is recommended that the Board review the progress of that work.

#### **RECOMMENDATION TO THE HAVERING SAFEGUARDING CHILDREN BOARD**

The Board should evaluate and promote the progress of the work in hand to enhance the effectiveness of strategy meetings and core groups

#### **Case Conference and Signs of Safety**

- 5.31 The Case conference was held in a timely way, using the Signs of Safety methodology. There was good multiagency attendance. The reports for the conference were not provided either to the Chair of the conference or other professionals beforehand. The London Child Protection procedures make it clear that all reports should be provided to the chair of the conference two working days before the conference. It is important that all reports for conferences are provided in a timely way, enabling professionals to be able to contribute to the task of the conference.
- 5.32 Mr C and Ms A attended, and the Chair of the Conference explained the signs of safety methodology to them and the process of the conference. They reported that they did not understand the process, and found it a perplexing meeting. Research<sup>vii</sup> suggest that parents and carers have been very positive nationally about case conferences undertaken using the signs of safety methodology. It is the role of the Chair to ensure that the case conference process is explained in a way that is understandable, and to debrief after to clarify concerns and address any confusion or misunderstanding. Mr C and Ms A were then also not provided with a copy of the report before the conference. It is expected that parents/carers are provided with a copy of the report for conference two days before the conference takes place.
- 5.33 The conference minutes highlight that there were many concerns about the children, some aspects of their lives which were not well understood, and very few strengths, none of which related to the care

or commitment of Mr C or Ms A. The conclusion of the conference did not reflect the level of complexity or concern, and there was insufficient recognition of the views of the multiagency group. This highlights the important role of the Chair of the conference, which can be undermined if reports are not provided to them before the conference.

#### **RECOMMENDATION TO THE HAVERING SAFEGUARDING CHILDREN BOARD**

The Board should make arrangements which ensure that

- 1) All agencies provide reports for Case Conferences in a timely way
- 2) Reports and assessments are provided to and discussed with parents and, where appropriate, young people in a timely way before a conference

5.34 All present were asked to score their concerns to give an indication of the degree of safety or risk (this is an integral part of the Signs of Safety methodology) but the differences across the professional group were not discussed, so an opportunity to explore the multiagency disagreements about the risks to these children was lost. A twelve point plan was outlined, but as there was no discussion of what was causing the level of harm to the children, it is hard to see how this plan could have effected any change. The plans were written in a way that assumed compliance from Mr C and Ms A and there was no outline of the implications for the children's outcomes if the plans were not implemented as had been evident during the CAF process. It has not been possible to establish why the conference process did not accurately reflect the seriousness or complexity of the children's lives. This appears to have been caused in part by the Chair not having sight of any of the conference reports before the meeting (see recommendation above) and that Signs of Safety approach had only recently been implemented. Since the time under review, work has been undertaken to develop the use of the Signs of Safety to ensure that it is a robust process.

#### **Child focused practice**

5.35 Child focussed practice lies at the heart of any effective safeguarding system. In LBH there was much evidence of child focussed practice.

- 5.36 School 2 immediately recognised the vulnerability of Child X and Child W and put plans in to address their educational needs, but also provided them with individual support. This gave the children a voice.
- 5.37 When Child X was hospitalised she was provided with individual support by the ward teacher, who made sure that Child X's views were heard by other professionals. Overall the ward staff were good advocates for Child X.
- 5.38 The assessment that was undertaken by LBH CSC social worker clearly highlighted the voice of the child throughout, and all the children were given the opportunity to share their views individually.
- 5.39 Individual support for all three children was organised by LBH CSC from after the case conference, and despite Mr C and Ms A trying to sabotage it, the children centre continued to ensure that this support was provided.

### **Complexity and Professional disagreement**

- 5.40 This was a difficult case and complex case, which stretched the professional knowledge and experience of all those involved; it caused great concern and anxiety. This case highlights the importance of all professionals receiving high quality safeguarding supervision.
- 5.41 When the children moved to the LBH concerns were acted upon and action taken to ensure their safety and wellbeing and this was as a result of the resilience and persistence of many professionals. There was no multi-agency forum in which to consider the complexity and think about whether a different response or approach would be helpful.

### **RECOMMENDATION TO THE HAVERING SAFEGUARDING CHILDREN BOARD**

The Board should develop a multiagency complex case review and planning process for individual cases

## **6. CONCLUSION AND THEMES**

### **Conclusion**

- 6.1 This serious case review covers the circumstances of Child Y, Child X and Child W over a significant period of their lives, and their house moves across three London Boroughs, Waltham Forest, Barking and Dagenham and Havering. It is clear that they experienced neglect and emotional abuse from their earliest years, and this continued when they were placed with their maternal grandfather (Mr C) and maternal step grandmother (Ms A), despite the intention that this was a safe placement. This is addressed in Theme 1.
- 6.2 The neglect led to significant non organic failure to thrive, an issue that was not addressed. This is addressed in Theme 3. Over the time of the review it is clear that both Mr C and Ms A did not accept the concerns of professionals, were unwilling to accept help offered, and were obstructive of plans made. These difficulties meant that at times professionals were overly optimistic when small changes were made, or services partially engaged in. This is addressed in Theme 4. It is apparent across the whole review that there was a variable professional response to addressing the neglect and emotional abuse of these children and this is addressed in Theme 2. There were considerable professional disputes about the right course of action across the whole period of this review and this is addressed in Theme 5.

### **Theme 1: Appropriate Assessment, Planning and Support when Placing Children with Relatives – Family and Friends Care**

- 6.3 The Children Act 1989, 25 years ago, introduced the policy imperative that where children could not live safely with their parents, placements with relatives should be sought wherever possible and appropriate. Practice was slow to develop in this area and guidance regarding Family and Friends Care was only formally introduced in 2011.
- 6.4 Research<sup>viii</sup> has shown that children do well in these types of placements when there are robust and appropriate assessment processes in place, the placements are monitored appropriately, there is good overall support for carers and that a permanent, legal order is established quickly to ensure that children feel secure. These were all areas of concern in the placement of Child Y, Child X and Child W.

### **Assessment**

- 6.5 The assessment of Mr C and Ms A was cursory. This was despite the following concerns:

- Ms B had made allegations that she herself had been abused within her family as a child
- Ms B's mother had made allegations of violence against Mr C
- Ms A had never been a parent to young children
- They lived in a two bedroomed flat and were already caring for a cousin of the children
- Child X and Child Y were known to have significant health, emotional and behavioural needs.

6.6 These matters should have led to a full and considered assessment. The passage of time has meant it has not been possible to establish why the early assessment process was so poor, except for the general observation that practice developments in this area were in their early stages at this time.

6.7 An assessment was carried out when the children had been living with Mr C and Ms A for two years, and concluded that alternative carers should be sought. This never happened and the reasons are again unclear.

### **Monitoring and support**

6.8 When children with significant physical, emotional and educational needs are placed in Family and Friends placements, it is essential that a plan of support is put in place, and where necessary there are appropriate monitoring arrangements. Neither of these things happened in this case. The children were initially subject to child protection plans, and at this point there were considerable concerns both about how Mr C and Ms A were coping, and the wellbeing of all three children.

6.9 These plans were discontinued – a social work assistant took over the case and the children were seen as “children in need”. There is evidence that child in need meetings took place, but not that a robust plan of support was developed or implemented. Mr C and Ms A received no financial support during this time. Despite the concerns arising from the assessment in June 2009, LBWF transferred the children's case to LBBB. When they did so a child protection assessment was recommended by LBWF with little evidence of why this was necessary, or of why they had not themselves addressed the concerns.

### **Legal Permanency**

- 6.10 It is particularly important to ensure that, when children cannot live with their parents, swift decisions are made about where they can live permanently and that these arrangements are made secure by appropriate legal orders. The exact basis for the placement of the children in the summer of 2007 remains unclear, but it appears in the early days this was wrongly considered to be an informal placement, made by LBWF but with no legal basis, with Ms B maintaining legal responsibility for the children.
- 6.11 A case conference held when the children were removed recommended that care proceedings be initiated – without it being entirely clear what that would mean for where the children lived – but this decision was not followed through. There is no evidence of any further action by LBWF to seek any legal security for the children, other than supporting the application for Special Guardianship despite their own reservations about the care provided.
- 6.12 LBWF transferred the case to LBBD hurriedly and therefore left the responsibility for ensuring legal permanency to professionals who had no previous contact with the children. It was not until June 2010 that a Residence Order was granted - three years after the children had moved to live with Mr C and Ms A. Setting aside the concerns about the care provided by Mr C and Ms A, this was an unacceptable delay in ensuring legal certainty for these children.

## **Theme 2: Addressing the Neglect and Emotional Abuse of Children**

### **Neglect**

- 6.13 Research suggest that the neglect of children has the potential to significantly compromise development and wellbeing in all areas<sup>ix</sup>, but that paradoxically professionals<sup>x</sup> often find it hard to respond appropriately. There is evidence that these issues were at play for these three children.
- 6.14 It is evident that the neglect of the three children was longstanding and that in their early year's insufficient action was taken to address it. When they moved to LBH neglect was immediately recognised, but there was dispute about what action could be taken and how quickly. The reasons for this appear to be concerns about the evidence to escalate to legal action, and that "*neglect was difficult to evidence*". It is clear that there is considerable pressure from the courts regarding the

quality of evidence required to take legal proceedings in the context of concerns about neglect. This raises the importance of clear tools and frameworks to assess and analyses neglect.

- 6.15 Significant and chronic neglect is a serious and complex issue, which requires good assessment and analysis. It is defined in the statutory guidance for England in *Working Together 2010*<sup>xi</sup> (and all subsequent revisions) as follows:

*'Neglect is the persistent failure to meet a child's basic physical and /or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance misuse. Once a child is born, neglect may involve a parent or carer failing to:*

- *Provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
  - *Protect a child from physical and emotional harm or danger;*
  - *Ensure adequate supervision (including the use of inadequate caregivers); or*
  - *Ensure access to appropriate medical care or treatment.*
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs'.*

- 6.16 This definition requires all professionals to consider five questions in order to analyse neglect effectively – these were all relevant to the children under review but were not consistently addressed:

1. Persistence and pervasiveness
2. Type of neglect
  - a. Physical
  - b. Emotional
  - c. Medical
  - d. Supervisory
  - e. Educational
  - f. If all areas affected – is it global neglect?
3. Impact on child outcomes and wellbeing/the child's lived experience
4. Causal factors – which will aid appropriate interventions
5. Whether the neglect is intentional or not.

### **Persistence and pervasiveness**

- 6.17 There was considerable evidence that these children had experienced long term neglect, which was not addressed in their early years. Their

moves across boroughs meant that this important information was partially lost. There is a real danger for children when agencies feel they have to start the process of assessing the persistence of neglect from scratch when they move, leading to the possibility of the “start again syndrome” and causing delay in taking action. Historical concerns must form part of the assessment and analysis of risk.

### **Type of neglect**

6.18 There was considerable evidence that all five developmental areas of all three children’s lives were being impacted on:

- There were concerns about the **physical care** of the children and the home.
- There were issues regarding **the relationships** with Ms C and her negative attitude to Child Y and Child X.
- All three children had **unmet medical needs** – Child X was not seen by a community Paediatrician for a number of years, despite issues regarding weight and possible brain damage; Child Y’s ADHD medication was not consistently administered and Child W had poor weight gain and concerns about his hearing which were not responded to.
- Poor supervision was an issue for Child Y both in terms of some unexplained injuries, his access to the internet and inappropriate sexual behaviour; Child W was reported to be allowed to be disruptive at home and cause his siblings harm.
- All three children had unmet educational needs.

### **Impact on children’s outcomes/ their lived experience**

6.19 There was also significant evidence that all three children were experiencing significant developmental and educational delay. They all had low weight and height, and although this had been a consistent issue from their birth, there had been no improvement during the time they lived with Mr C and Ms A – and for Child X her weight and height had decreased.

### **Causal factors**

6.20 If neglect is to be addressed the causal factors need to be established. This requires moving beyond “poor parenting” as an explanatory framework – to an understanding of what causes parents to provide poor parenting. Without this information it is hard to know what intervention is required. For these three children it is hard to say what

caused this level of significant neglect, because it was not addressed historically. This absence meant it was hard to see how appropriate interventions to address the cause could be put in place.

### **Intentional or unintentional**

6.21 This is a particularly important question, because it has an impact on how children feel about themselves and the extent to which they may see themselves as being to blame for what is happening to them. It is clear that Ms A often blamed Child X for being sick, and there was concern that Child X would constantly apologise to hospital staff and teachers. This required further analysis. Mr C also had a negative attitude to Child Y.

### **Sexual Abuse**

6.22 Neglect can allow other kinds of abuse to be masked, or hidden. In this case there were growing concerns over a number of years about Child Y and self harming behaviour with a sexual element. This was commented upon, and addressed through a referral to CAMHS. Mr C and Ms A did not facilitate attendance at these meetings. Child X and Child W talked about being worried about this behaviour during the assessment undertaken by the LBH CSC. This was noted, but the behaviour was not sufficiently analysed.

6.23 There were many concerns held by professionals regarding Child X's behaviour, and underneath this was a concern regarding sexual abuse, for which evidence did emerge, which went unacknowledged in a multiagency context and unrecorded. The reasons for this are unclear.

### **Emotional abuse**

6.24 Emotional abuse, like neglect, is a significant issue about which there is growing concern<sup>xii</sup>. Emotional abuse can have a significant impact on children's lives and severely damage their sense of self-worth. It can impair psychological and social development, and may result in an impaired ability to perceive, feel, understand and express emotions. Evidence suggests that the impact on children's development and social functioning can be both longstanding and serious.

6.25 Through interviews with professionals as part of this review, it became clear that there had been considerable concern about the possible emotional abuse of Child X and possibly Child Y. What is perplexing is that this concern was not recorded or analysed in the context of either

the common assessment records, or the assessment completed for the conference or the strategy meeting minutes. It does feature in the minutes of the case conference as an area of risk, but was not addressed in the plan produced. The hospital reported as part of their information to conference that they considered that Child X's poor weight gain and attitude to food was caused by the poor emotional relationship with Ms C, but this was given insufficient weight in the LBH assessment. These issues were not discussed again until the legal planning meeting in September 2013.

- 6.26 Overall, professionals in LBH recognised that these children were experiencing long term, chronic neglect and emotional abuse. There was a reluctance to name the emotional abuse, perhaps because this was an area where there was emerging information. The issues regarding neglect became an area of conflict for the multiagency group, and through interview it became apparent that one of the key issues was a lack of a shared understanding of what neglect is, how it should be assessed, and what could be done about it. LBH CSC staff became particularly concerned about pressures from the courts regarding the need for evidence; this led them to take a more cautious approach.

**RECOMMENDATION TO THE HAVERING SAFEGUARDING CHILDREN BOARD**

The Board should draw up and implement a strategy for improving agencies' identification of and response to the neglect of children. This strategy should reflect the extent to which neglect can mask emotional and sexual abuse.

**Theme 3: Recognising and addressing non-organic failure to thrive/weight faltering**

- 6.30 There were concerns about failure to thrive/weight faltering of all three children from their earliest years, and these concerns were prominent in the early days of living with Mr C and Ms A. Over the years they attended a number of community paediatric appointments where issues of failure to thrive were discussed, and remedies such as protein shakes were prescribed. There was no analysis of whether these remedies were successful, largely because the children were not consistently brought to follow-up appointments.

- 6.31 Weight faltering/failure to thrive is not uncommon amongst very young children<sup>xiii</sup> but is much less common in older children. The fact that this was a long term problem for all these children should have prompted more concern and assessment.
- 6.32 Research<sup>xiv</sup> also suggests that there are rarely medical or genetic causes for failure to thrive it and it is therefore important to be clear whether weight faltering/failure to thrive is organic (caused by medical/genetic issues) or is non-organic – and therefore requires a more psychosocial assessment.
- 6.33 The cause of non-organic failure to thrive/weight faltering is often complex, but in its early manifestation is often a lack of nutrition/not enough food to meet the physical needs of young children. However, where the issues are of long standing, more thought needs to be given to an assessment of children’s emotional development, attachment relationships and parent child relationships, which are likely to be causal factors, rather than a focus on issue of food and food intake<sup>xv</sup>. There was a focus on medical issues, rather than on relationships and emotional issues, reinforced Mr C and Ms A’s view that this was genetic and the fault of Ms B. They remain convinced of this, and when interviewed as part of the review asserted that this was what they had been told. Certainly Ms A expressed these views forcefully at the Core group in July 2013, and there is no evidence that this was challenged.
- 6.34 Overall the management of the failure to thrive/weight faltering was not well managed by most agencies. This was due in part to a lack of knowledge regarding the assessment and management of failure to thrive across a number of agencies. Failure to thrive in its chronic form is impaired growth in the long term and damage to cognitive development, and causes difficulties with behaviour and self esteem. These issues were seen in all the children, and it is impossible to confirm a causal link, but more analysis of this should have been part of the assessment, planning and intervention process integral to the child protection plan. There were many meetings to discuss the circumstances of these children, but these became about professional disputes, which is addressed as the next theme. The process lost sight of the children at the heart.

**RECOMMENDATION TO THE HAVERING SAFEGUARDING CHILDREN BOARD**

The Board should develop a multiagency pathway for identifying and responding to weight faltering / failure to thrive

#### **Theme 4: Parental Motivation to change – assessing and addressing false compliance**

- 6.35 Mr C and Ms A took on a parenting role of Child Y, Child X and Child W for a period of six years. During this time, there was evidence that they struggled to meet the physical, emotional, educational and medical needs of the children. These deficits in parenting capacity were highlighted on a number of occasions, but led to little positive change. There were concerns historically that Mr C and Ms A were reluctant to accept professional advice, and it is unclear during the early years of their parenting the extent to which this was challenged in a child-focussed way.
- 6.36 Children require parents who are able to perceive, understand and respond appropriately to their needs – this is what promotes healthy psychological, physical and intellectual development. Alongside this, it is necessary for parents to recognise when their actions or inactions impact on the wellbeing of children, be willing to accept responsibility for this and accept help and support for themselves and their children. If parents do not accept that they need to change, and facilitate change for their children, there is considerable evidence<sup>xvi</sup> to suggest that children’s wellbeing and developmental outcomes will be significantly compromised.
- 6.37 The biennial review of serious case reviews<sup>xvii</sup> has highlighted the concept of “false compliance” which refers to the process whereby parents or family members present as engaged with services, they attend meetings, etc., but their engagement is superficial without a genuine commitment to, or acceptance of, the need for change. Morrison and Howarth<sup>xviii</sup> have referred to this as the extent to which parents are motivated to change to improve their children’s circumstances, and put their own feelings of being under scrutiny, or subject to criticism, to one side, and work with professionals. Professionals have a responsibility to help parents understand the issues, set goals and plans in place, and provide appropriate support and interventions. Parents need to engage in these help-seeking activities.

- 6.38 The children centre visited Mr C and Ms C in June 2012 because of concerns raised by the police regarding all three children. They were initially hostile and denied there were any problems. This was to be their stance over the rest of professional contact.
- 6.39 What made the increasing level of false compliance more difficult to address or challenge was the lack of clear plans, which outlined tasks and timescales, and which were regularly reviewed. There was a plan from the conference, but this was changed as a result of two further meetings. Mr C and Ms A were also never provided with a clear outline the professionals' expectations of them, and what might happen if they did not comply, for example a written agreement or contract of work. This means that they now believe that professionals were not honest with them, and that they did not know what was expected of them.

#### **RECOMMENDATION TO THE HAVERING SAFEGUARDING CHILDREN BOARD**

The Havering Safeguarding Children Board should promote the capacity of agencies to recognise and respond to issues of disguised and partial compliance.

#### **Theme 5: Disputes between agencies**

- 6.40 One of the more concerning aspects of this case is that the accumulating evidence of neglect of the children was tolerated across the agencies for so long. In LBWF, towards the end of the family's residence there, there was disagreement within the local authority about the scale of the problems but concerns were not raised by other agencies. Similarly the family generally remained "below the radar" while they lived in LBBB.
- 6.41 It was following the move to Havering that concerns became increasingly clearly defined and that evidence began to emerge of agencies taking different views about the scale of the problems and how they should be tackled. Those differences came to a head when Child X had been admitted to hospital in the summer of 2013 and a polarised position developed between the local authority and the other agencies. This caused tension and frustration across the multiagency network which remained evident even during the process of this review over a year later.

- 6.42 A recent judgment by the President of the Family Division<sup>xix</sup> has emphasised the nature and scale of evidence that courts will expect local authorities to provide in care proceedings. The judgment stresses the importance of reliable evidence of cause for concern and a demonstrable link between that evidence and evidence of significant harm. The judgment goes on to say this:  
*“It is vital always to bear in mind in these cases, and too often they are overlooked, the wise and powerful words of Hedley J in Re L (Care: Threshold Criteria) [2007]*  
*‘society must be willing to tolerate very diverse standards of parenting, including the eccentric, the barely adequate and the inconsistent. It follows too that children will inevitably have both very different experiences of parenting and very unequal consequences flowing from it. It means that some children will experience disadvantage and harm, while others flourish in atmospheres of loving security and emotional stability. These are the consequences of our fallible humanity and it is not the provenance of the state to spare children all the consequences of defective parenting. In any event, it simply could not be done.’*”
- 6.43 It is not easy to draw a line between what is “barely adequate (or) inconsistent” and what is inadequate, and to accept the requirement to tolerate “diverse standards of parenting”. One can see how staff may take different views and how those disagreements will be heightened by the emotionally charged context in which they emerge. In those situations staff and agencies may need to rely on formal arrangements within and between agencies to ensure that there is progress in the management of the case.
- 6.44 The review identified some confusion among staff about what escalation means – that it is not just complaining to another agency or to a more senior colleague about another agency. Staff may feel that they have appropriately raised concerns but are often not clear about what they expect to happen as a consequence, or about what to do if their concerns persist.
- 6.45 When concerns are passed to managers, those managers must be clear about what processes they are following. Their task can be about managing anxieties within their own organisation as well as raising concerns with partners. Problems may be resolved by discussions with managers from other agencies but they may not. Managers then need to be clear and to make it clear that disagreements have been moved or escalated into a more formal process.

- 6.46 In fact this review has offered an opportunity to bring agencies and their staff together in a way that has helped them to appreciate their differing positions and the reasons for them. Agencies have commented positively on that. BHRUT have written to the Safeguarding Board to acknowledge that:  
*“a more formal escalation process could have been followed”*  
and proposes changes to their internal guidance to support that. However, escalation by definition is an inter-agency issue and there is accordingly a recommendation to the Board from this review.

#### **RECOMMENDATION TO THE HAVERING SAFEGUARDING CHILDREN BOARD**

The Board should

- 1) Require all agencies to remind staff in the light of the matters arising from this review of the established arrangements for escalating concerns to senior managers
- 2) Develop an audit programme across all agencies to evaluate the use and effectiveness of these arrangements

### **ALL RECOMMENDATIONS**

#### **RECOMMENDATION TO THE SAFEGUARDING CHILDREN BOARD FOR THE LONDON BOROUGH OF WALTHAM FOREST**

The Board should satisfy itself that appropriate measures are now in place to identify and tackle the areas of concern identified in this review.

#### **RECOMMENDATION TO THE SAFEGUARDING CHILDREN BOARD FOR THE LONDON BOROUGH OF BARKING AND DAGENHAM**

The Board should satisfy itself that appropriate measures are now in place to identify and tackle the areas of concern identified in this review.

#### **RECOMMENDATIONS TO THE HAVERING SAFEGUARDING CHILDREN BOARD**

The Board should review and improve as necessary the arrangements under which other agencies contribute to formal assessments led by Children's Social Care services

The Board should evaluate and promote the progress of the work in hand to enhance the effectiveness of strategy meetings and core groups

The Board should make arrangements which ensure that

- 1) All agencies provide reports for Case Conferences in a timely way
- 2) Reports and assessments are provided to and discussed with parents and, where appropriate, young people in a timely way before a conference

The Board should develop a multi-agency case review and planning process for individual highly complex cases

The Board should draw up and implement a strategy for improving agencies' identification of and response to the neglect of children. This strategy should reflect the extent to which neglect can mask emotional and sexual abuse.

The Board should develop a multi-agency pathway for identifying and responding to children who may have weight faltering / failure to thrive.

The Board should promote the capacity of agencies to recognise and respond to issues of disguised and partial compliance.

The Board should

- 1) Require all agencies to remind staff in the light of the matters arising from this review of the established arrangements for escalating concerns to senior managers
- 2) Develop an audit programme across all agencies to evaluate the use and effectiveness of these arrangements

## **Appendix 1: Panel Members and the agencies contributing to the review**

## **Appendix 2: The Lead Reviewers**

### **Jane Wiffin**

Jane Wiffin is a social worker by profession and has extensive experience of working in safeguarding. She is an experienced Serious Case Review Author and Chair, having undertaken 35 reviews. She is an accredited SCIE Learning Together Reviewer and has undertaken a number of reviews using this methodology.

### **Kevin Harrington**

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on more than 50 SCRs in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile SCR reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

### Appendix 3: Glossary

<b>ADHD</b>	Attention deficit hyperactivity disorder (ADHD) is a form of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.
<b>Child and Adolescent Mental Health Services CAMHS</b>	CAMHS are specialist services that offer assessment and help when children and young people have emotional, behavioural or mental health difficulties.
<b>Care Orders</b>	This is a court order which places a child in the care of Children's Social Services. In these circumstances children's services share the legal responsibility of being a parent (parental responsibility).
<b>Care proceedings</b>	A care proceeding is the name for the court process when Children's Social Services go to court because they are concerned that a child is not safe and want a legal order to protect the child.
<b>Child in Need</b>	A child is in need if s/he is under 18 and either s/he needs extra help from Children's Social Services to be safe and healthy or to develop properly; or s/he is disabled. Children's Services decide if a child is <i>in need</i> by undertaking an assessment of their and their family's needs. A child in need plan is put in place where the child has been identified as needing extra support.
<b>Child in Need review meeting</b>	If children's Social Services decide the child is <i>in need</i> they will draw up a plan setting out what extra help they will provide to the child and their family. This is called a child in need plan. The plan should say when and how the plan will be reviewed.
<b>Child protection investigation/Child Protection enquiries</b>	Children's Social Services have a legal duty to look into a child's situation if they have information that a child may be at risk of significant harm. This is called a child protection enquiry or investigation. Sometimes it is called a "Section 47" after the section of the Children Act 1989 which sets out this duty.
<b>Child Protection Case Conference</b>	This is a meeting which takes place between local authority Children's Social Services, other professionals who are in contact with the child, and family members. It happens within 15 days of the strategy discussion if a child is considered to be at risk of significant harm. Those at the meeting

	(conference) discuss the risk to the child and decide what needs to happen, if anything, to make sure they are kept safe.
<b>Chair of the Child Protection Conference</b>	The Chair of a child protection conference is a senior social worker whose job it is to run the conference. They will be independent of the child's case and will not be involved in managing the child's social worker or their manager.
<b>Child Protection Plan</b>	A child protection plan is drawn up at the initial child protection conference. It says what support and monitoring will be put in place when a child is considered to be at risk of significant harm because they have been physically, emotionally or sexually abused or neglected in some way. When there is a child protection plan, the child will be given a social worker who should meet regularly with the child and the parents to discuss the child's progress. The child's situation and the plan will be reviewed after three months and then every six months.
<b>Child Protection Register</b>	The child protection register was a confidential list of all children in an area who have been identified at a child protection conference as being at significant risk of harm. This was replaced by a child protection plan which is drawn up at a child protection conference. It says what support and monitoring will be put in place when a child is considered to be at risk of harm.
<b>Common Assessment Framework (CAF)</b>	The Common Assessment Framework was established by the former Department for Children, Schools and Families. It is described as <i>"a standardised approach to conducting assessments of children's additional needs and deciding how these should be met ... The Common Assessment Framework promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development"</i> .
<b>Community Order</b>	A community order, sometimes referred to as community sentences, allows judges or magistrates to tailor a sentence to meet the needs

	of the offender. The sentence is served in the community under the supervision of a Probation Trust and should be considered a punishment, in that it may restrict an offender's movements and activity, as well as encouraging attendance at activities or treatment-based interventions that are rehabilitative in nature.
<b>Core Assessment</b>	The Core Assessment Record provides a structured framework for social workers to record information gathered from a variety of sources to provide evidence for their professional judgements, facilitate analysis, decision making and planning. A core assessment should be completed within 35 working days of its commencement. A completed Core Assessment Record is then used to develop the plan for the child or young person.
<b>Core Group Meeting</b>	This is a small group of professionals and family members who meet together after a child protection conference to decide how best to implement the outline child protection plan, drawn up at the child protection conference. The core group fills out the details of the plan, what exactly will be done, by whom and by when. It will also make sure that the plan is carried out.
<b>Family Assistance Order</b>	Section 16, Children Act 1989 enables a court to make an order requiring a Cafcass officer or an officer from a local authority to advise, assist (and where appropriate) befriend any person named in the order
<b>Family and Friends care</b>	A family and friends carer is a relative, friend or other connected person who is looking after a child that cannot live with his/her parents. Sometimes they are known as kinship carers. If the social worker was involved in arranging for the child to live with the family and friends carer, the child is likely to be looked after. If they were not, then it is likely to be a private arrangement.
<b>Lead Professional</b>	Sometimes professionals from several different agencies are involved in a child's life, for example Children's Services, Health, Education. Usually in those situations, one person is named as the lead professional. The lead professional can come from any of the different agencies working with the child,

	depending on the child's needs. It's their job to be the main contact person for the child and their family and to coordinate all the help the family is getting under the Common Assessment Framework.
<b>Legal Planning Meeting</b>	If work with the family cannot keep a child safe, a legal planning meeting should be called. This is sometimes called a legal strategy meeting or a legal gateway meeting. The purpose of this meeting is to obtain advice as to whether a care order under section 31 Children Act 1989 is necessary. The legal planning meeting is usually attended by the child's social worker, manager and a legal adviser. The meeting also considers whether there is sufficient evidence for the proposed plan. Notes should be kept of the process whereby the decision was reached.
<b>Single Assessment</b>	This is the name for the detailed assessment of the child and their family's circumstances, to see if they need any help. It is prepared by a social worker. It looks at the child's needs, the parents' ability to meet those needs and the family's general situation. An assessment is usually carried out as a part of Child Protection enquiries or as a part of a Child in Need plan. It should be done in time to meet the child's needs and always within 45 working days of the referral.
<b>Individual Management Review (IMR)</b>	A report produced by individual agencies as part of the Serious Case Review
<b>Professional meeting</b>	These are meeting which are held when a group of professionals work together with and for a family and their children, but need to meet discuss plans made.
<b>Multiagency referrals (MARF)</b>	This is a form which is used by all agencies when referring children about whom there are concerns. The more information available at the first point of contact, the more likely it is that appropriate service will be delivered at the earliest opportunity to help children and their families.
<b>Multiagency Safeguarding Hub (MASH)</b>	Many local authorities have set up multiagency safeguarding models where a hub of key agencies (which can include children's services, police,

	<p>health, education, probation and youth offending) are co-located or have an agreed protocol in place to promote better information-sharing, decision-making and communication in relation to concerns about children. The aim is that referrals are responded to in a coordinated, appropriate and timely way. This should also mean that early intervention can be offered to prevent crisis or risks increasing.</p>
<p><b>Signs of Safety approach</b></p>	<p>The Signs of Safety is based on the use of Strength Based interview techniques, and draws upon techniques from Solution Focused brief therapy. It aims to work collaboratively and in partnership with families and children to conduct risk assessments and produce action plans for increasing safety, and reducing risk and danger by focusing on strengths, resources and networks that the family have.</p>
<p><b>Section 37 report</b></p>	<p>If a Court has cause to feel concern for the welfare of a child during the course of proceedings in a private law application then it can ask an Independent Social Worker to conduct a Section 37 investigation. The information gathered during the Section 37 investigation will assist in the decision making and care planning for a child, determining whether a child needs to be made subject to a Care or Supervision Order in accordance with the Children Act 1989 significant harm criteria.</p>
<p><b>Strategy meeting/discussion</b></p>	<p>This is a meeting/discussion which takes place between Children's Services, the police and possibly other child care agencies at the beginning of child protection enquiries. The purpose of the discussion is to decide whether and how the child protection enquiries should be carried out; and whether any immediate steps need to be taken to keep the child safe while the child protection investigation is underway, for example, if someone should be asked not to have contact with the child for the time being.</p>
<p><b>Team around the Child (TAC)</b></p>	<p>This is a way of working with children and families which usually follows the Common Assessment Framework process. The lead professional will bring together people from different agencies who are involved with the child and family to develop a</p>

	<p>plan of action/support that will help with whatever difficulties the family may have. Each Team around the Child will be different and will come together to meet the particular needs of the particular child/family. By working very cooperatively with the family and with good information sharing, the Team around the Child tries to make sure the family get the right help.</p>
<p><b>Residence Order/ Interim Residence Order</b></p>	<p>A Residence Order is a legal order which says who a child should live with and gives that person parental responsibility for the child. It does not take away parental responsibility from the child's parents. A Residence Order can last until the age of 18, or can be ended earlier by the court.</p>
<p><b>Special Guardianship Order</b></p>	<p>A Special Guardianship Order is a legal order which says that a child will live with someone who is not their parent on a long-term basis.</p>
<p><b>Statement of Special Educational Needs</b></p>	<p>This is a formal document detailing a child's learning difficulties and the help that will be given.</p>
<p><b>Voluntary care</b></p>	<p>This is the part of the law (Section 20 of the Children act 1989) that gives Children's Services the power to look after a child when there is no-one with parental responsibility for the child or when the person caring for the child is prevented from caring for them, for whatever reason. This is also called voluntary Accommodation.</p>

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<sup>i</sup> Munro (2011) The Munro Review of Child Protection Interim Report: The Child's Journey:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/175391/Munro-Review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf)

<sup>ii</sup> Working Together to Safeguard Children (2013) – referred to in this report as “Working Together” – is a government publication containing statutory guidance on how organisations and individuals should safeguard and promote the welfare of children and young people, in accordance with the Children Act 1989 and the Children Act 2004. It has now been superseded by the 2015 publication <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

<sup>iii</sup> Ibid

<sup>iv</sup> **DfE (2006)** [What to do if you're worried a child is being abused](https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused)

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<sup>v</sup> Munro (2011) The Munro Review of Child Protection Interim Report: The Child's Journey:

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<sup>vi</sup> Working Together to Safeguard Children (2013)

<http://media.education.gov.uk/assets/files/pdf/w/working%20together.pdf>

<sup>vii</sup> NSPCC (2013)

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<sup>ix</sup> NCH (2014) impact, causes and responses to child neglect in the UK:

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<sup>xi</sup> Working Together to Safeguard Children (2010)

[http://www.workingtogetheronline.co.uk/documents/wt\\_2010.PDF](http://www.workingtogetheronline.co.uk/documents/wt_2010.PDF)

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- <sup>xii</sup> Radford et al (2011) Research into the prevalence of child maltreatment in the United Kingdom: NSPCC <http://www.nspcc.org.uk/preventing-abuse/research-and-resources/child-abuse-and-neglect-in-the-uk-today/>
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*BMJ* 2012; 345 doi: <http://dx.doi.org/10.1136/bmj.e5931> (Published 25 September 2012) <http://www.bmj.com/content/345/bmj.e5931>
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