chscb

Child E

Case Review

city & hackney safeguarding children board

safeguarding children is everyone's responsibility

Why this Case?

- Home visit by Youth Services
- “Conditions of such squalor that it raised questions about the opportunities for earlier referral/reaction from other involved professionals.”
- The Serious Case Review (SCR) sub-committee agreed to commence a Multi-Agency Case Review.

Why this Case?

- *“The home was shocking. In the hallway, what looked like water was dog urine, there were dog faeces on the wall, junk food litter all over the floor and the dog presented as ill. Child E was off school due to a stomach bug…….*

- *… it was how they lived and functioned. It seemed ongoing and was not a recent downturn. When I sat with the grandmother, she explained this is how they lived. There were drawings/writings on the wall and the grandmother said her son had died and she couldn’t paint over it. There was a presentation of constant grieving in a household, which was stuck.”*

Scope and Focus

- Principles set out in *Working Together to Safeguard Children* 2013.
- Insight into what professionals were thinking at the time, what they knew and why they took the decisions they did.
- **Chronic neglect and abuse across generations and early help**.

Methodology

- Lead Reviewer & Review Team.
- Agency reports / Integrated chronology.
- Conversations with key professionals.
- Conversations with mother.
- Child E engaged at end of review.
- Final report.

Agencies involved

- Children's Social Care
- School
- Charity
- GP Practice
- Housing
- Ambulance Service
- Youth Service
- Health Visiting and School Nursing
- Hospital
- Adult Mental Health Service

The Family

- CHILD E 10 years old
- Adult brother
- Adult sister
- Mother
- Maternal Grandmother

Historical Overview

- Chronic neglect.
- Multiple agencies since 1971.
- School first noted neglect in 2005.
- Neglect also noted by the school, charity, CSC and housing services.
- Between 2007 & 2009 Child E was subject to a Child in Need Plan.

NOVEMBER 2011

- Child E engaged with a charity.
- Pre-existing concerns about neglect not shared with the charity by the school.
- No concerns recorded from initial meeting at family home.
- Child E seen; but away from the family home.

JANUARY 2012

- Child E noted with a sore on her arm by school. States that mum had burnt her with a cigarette whilst asleep.

- After discussing it with Child E, the school determine that it is not a cigarette burn. They note the family owns animals and that the marks could be insect bites.

- No referral to CSC

JANUARY 2012

- The Ambulance Service respond to a 999 call.

- No concerns about the property were noted or any mention made of a child living at the home.

- No referral to CSC

FEBRUARY & MARCH 2012

- Housing operatives visit for repairs.
- Noted that the hallway was covered in urine and dog faeces and that the property needed to be cleaned up before the work could be completed.
- No consideration about whether the matter should be further escalated on welfare grounds.
- No referral to CSC.

APRIL 2012

- School contact CSC - Child E's personal hygiene and persistently unkempt presentation.
- Social worker follows up with the school.
- School felt that the situation had improved.
- CSC decide no further action

MAY 2012

- Charity worker noted that the home, like Child E, was becoming more “smelly” and untidy. Charity worker had access to hallway.

JUNE & JULY 2012

- Concerns of Chairty shared with the school
- School decided against a further referral in the belief that sufficient support arrangements were in place over the summer period.

JULY 2012

- The GP advised the school nurse that the possibility of neglect was highly relevant and recommended that the school escalate concerns.
- GP's observation was not passed onto the school.

- Charity seek clarification from the school about whether a referral to CSC had been made.

SEPTEMBER 2012

- School contacted CSC with further concerns about Child E.
- Not attended the summer school as planned.
- Presentation was a continuing concern.
- CSC advised follow up by Youth Services.

SEPTEMBER 2012

- Child E attends hospital having fallen from a tree.
- Hospital Safeguarding Team contacted due to the delay in presentation although no safeguarding concerns were noted.
- The Safeguarding Team notified the school nurse for follow up.

OCTOBER 2012

- Youth worker visits the home by agreement with family.
- On seeing the conditions of the home, concerns escalated to CSC.
- A Section 47 investigation was initiated and Child E removed to the care of her extended family.

The families' perspective

- Mother accepted responsibility
- Increasingly depressed / didn't ask for help / put on a "front"
- Kept herself to herself on the estate
- Surprised no one had called round
- Did not trust professionals

The families' perspective

- CSC had been explicit with mum about consequences – this helped
- "someone to talk to" would have made a difference
- more confident that if things started to slip again she could access support
- Child E was very "protective" of her family and would do anything to prevent her having to leave them.
- Child E spoken to at conclusion of review – happy at home.

Appraisal of Professional Practice

- *“ A distinguishing characteristic of this case is that the conditions which became plain in October 2012 remained largely* ***beyond the notice of professionals*** *involved with the family and that the presenting issues of which they were aware* ***did not raise concerns to a level which prompted significant concern****.”*

- *“The exception was the school, but they* ***struggled to articulate their continuing concerns*** *about Child E in such a way as to prompt a more assertive approach...”*

Appraisal of Professional Practice

- An insufficient knowledge or understanding of past history and its relevance to present decision making
- a reluctance to go beyond presenting issues
- a feeling that being curious about what lay beyond the threshold of the home was “not my responsibility
- anxiety that escalation might alienate mother
- a lack of common language and understood assessment framework through which professionals could discuss their concerns

Case Review Findings

- Are universal services confident in identifying concerns early and accessing appropriate levels of support for children and families?

- Are professionals confident in recognising what constitutes neglect and are they confident in escalating their concerns appropriately?

- Do professionals routinely and effectively use the past history of families to inform current decision making.

Case Review Findings

- Do professionals and services focus on the presenting issues in families and not see beyond these to other vulnerable family members? Do all professionals “think family”?

- In relation to working with chronic neglect are agencies getting the balance between short term and long term work right?

CHSCB response – Action Plan

- Work programme to provide reassurance to the CHSCB regarding early help.
- Communications focussing on children being seen, heard and helped.
- Multi-agency guidance on information sharing and professionals meetings.
- Housing on the CHSCB
- Assurance from the London Ambulance Service that the “repeat call out “ protocol provides appropriate safeguards to children and young people.

CHSCB response – Action Plan

- A focused period of learning leading to the production of a cross agency strategy focussing on neglect.
- Improve the CHSCB Learning and Improvement Framework's focus on neglect.
- Multi-Agency Audit programme to regularly include cases featuring neglect.
- Improvements to communications and multi-agency training.
- Review and make available the escalation process.

Key Lessons

- Children are Seen, Heard and Helped
- Escalation of concerns
- Information sharing
- Challenges of dealing with neglect

Seen, Heard and Helped

- **Be curious about children**
- **See children in different contexts, including their home.**
- **Listen and hear what children are saying about their experiences.**
- **Act appropriately to help them.**

"Put yourself in their shoes" and ask "what is life like for this child?"

Escalation

- **All staff are aware of and act on their duty to escalate concerns when they consider that a child is not appropriately protected and/or is suffering from neglect.**

- To do this staff MUST be familiar with and use the Hackney Wellbeing Framework / The City Threshold tool

Information Sharing

- **Professionals have a clear understanding of requirements for sharing information and communicate with each other when they are worried about children / young people**
- If you care…share

Questions and Comments

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