DORSET SAFEGUARDING CHILDREN BOARD
SYNOPSIS OF LEARNING FROM SERIOUS CASES
February 2017

Serious Case Audit: Family C20

INTRODUCTION AND BACKGROUND TO THE CASE

The DSCB completed a Serious Case Audit in relation to the harm of four children. An Initial Child Protection Conference was held just before the Christmas period and the children became subject to a Child Protection Plan with considerable concerns voiced by professionals about the safety of the children given an established pattern of neglect.
The situation deteriorated over Christmas with mother's arrest leaving an older sibling (Under 18) caring for the children for a period of several days. Between Christmas and New Year Social Workers attempted to gain access to the property but required Police intervention to check on the children.

At a point over the Christmas period, Police Officers searched the property for stolen items and noted the substandard conditions at the property including dirty and improper sleeping conditions, a strong smell of cannabis and empty alcohol containers. The children's mother was arrested for handling stolen goods and all four children at the property were subject to Police Powers of protection and placed into foster care.

Overall this was a situation of deteriorating neglect over a period of time against a backdrop of a mother who had had multiple problems, and who chose partners who were dangerous for her children. It is a major concern that the risks to these children were not identified and action taken earlier.

EVALUATION OF PRACTICE

This case was responding to the chronic neglect of four children over a period of 2 years in a family where there was disguised compliance. The parents were often (but not always) seen to be doing the right thing in the moment. However a quality chronology would have identified the disguised compliance.

There was no multi-agency overview successfully completed which would have given a picture of the risks and a plan for reducing these; until a Child Protection Conference was held in December 2015 and the Police removed the children following mother's arrest.

The referrals and assessment of this family were seen in isolation to specific incidents and focused on individual children in the family rather than all 4 children as an overview of the family dynamic.

It was recognised that although there were numerous multi–agency opportunities to intervene in a positive way, opportunities were missed and the appropriate escalation policy not followed to allow for challenge.

On another note, the school, along with others, were providing compensatory care for the children such as providing food, washing and caring for them. There are a number of parallels in the learning from this case with the Serious Case Review held in Dorset in 2010 for Family S3 where two girls were severely neglected, along with Case Audit C12. Although this can be seen as a positive intervention to keep children safe and well, it can disguise neglectful care so escalation should be used alongside any support offered to children at the point of contact.

Over the Christmas period following mother's arrest, the children were left in the care of an older sibling who had previously been a child in care in another area. Although there had been allegations of sexual abuse of other children, this was not taken into consideration when leaving siblings in his care.

The concerns around this family escalated over the Christmas period which then impacted on the ability of services to support and protect this family.

LEARNING

- Referrals were being made to Local offices however no feedback to the referring agency was completed. Referral decisions were not always inclusive of historic information. This is now hopefully negated by the burgeoning central point of contact/multi-agency safeguarding hub (MASH) and feedback is offered as a matter of course to professionals who refer children.

- It was highlighted that practitioners were not aware of how much information they could share so were reticent to share. If there is multi-agency engagement, all practitioners should share with consent of the family unless to engage the family would increase the risk to the children. A lack of consent to share information should be a safeguarding concern for all agencies working with children at risk of harm.

- Professionals also found it difficult to gather information about the family, specifically in relation to the adults. Professionals were not clear about the boundaries in sharing parental information with colleagues without consent. If Practitioners are unsure what information can or cannot be shared, they should get in touch with their own Safeguarding leads who will offer advice and guidance as appropriate. This should be escalated using the Pan-Dorset Multi-Agency Escalation Policy where necessary.

- There was limited multi-agency holistic assessment for the family and a lack of joined up thinking/professionals meeting held to support the workers consider the outcome of assessment of the family as a whole. This would have helped manage the outcome where incidents were being responded to in isolation (start again syndrome).

- There was no use of professional tools to assess the cleanliness of the family home. Professionals should be using such tools as the Graded Care Profile and other supported tools in order to consistently measure standards in all areas of work.

- There was limited recognition that often, schools have access to, and have an understanding of children in their care far more than other agencies or even carers. This should be supported by arranging meetings at schools or around school timetables where possible. The 'Team around the School' process should be considered as a form of best practice.

- Where there are concerns about substance or alcohol misuse and antisocial behaviour, professionals should consider liaising with local community teams, an example being local Safer Neighbourhood Teams to support family engagement.

- There is limited evidence that the children in this family were spoken and listened to. There was no attempt to consider the behaviour of the children over a period of time which would have given an indication of the life for them at home. Again this parallels learning from a number of previous Serious Case Reviews including S3, S17 and S23 where the voice of children failed to come through.

- A single point of contact for Dorset Children's Services was not available at the time of this review, however this is now in place in Dorset through the new Multi-Agency Safeguarding Hub (MASH) and can be contacted on: 01202 228866.

ENSURE THIS REPORT MAKES A DIFFERENCE

There are lessons to be learned for anyone who reads this. Please ensure you are listening to children and when you access a home, accurately record the conditions you see.
Think about the learning points above and send us your thoughts via the following survey:
https://www.surveymonkey.co.uk/r/SB6FYZ6

The comments you provide will be consolidated with those made by others and presented to the DSCB in order for them to work to ensure that Serious Case Audits and Reviews can improve service provision in Dorset.

Please complete your survey by 31 March 2017. Thank You