SERIOUS CASE REVIEW

FAMILY L

OCT 2014

Lead Reviewers:
Sally Trench
Sian Griffiths
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A. Introduction

1. Why this case is being reviewed

1.1 Four children were removed from their family home, after it was determined that their mother was unable to offer adequate care and keep them safe from harm. The children’s needs had been neglected for several years, with damaging consequences for their physical, emotional and cognitive development. The second and third siblings (Child 2 and Child 3) were assessed as having suffered permanent harm, attributable to neglectful parenting.

The oldest sibling, now an adult, remained with her mother.

1.2 Norfolk Safeguarding Children Board (NSCB) decided to conduct a Serious Case Review (SCR), judging that the harm suffered by these children met the current criteria set out in Working Together to Safeguard Children:

(a) abuse or neglect of a child is known or suspected; and
(b) (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. (Working Together to Safeguard Children, 2013:68)

The NSCB definition for serious harm, laid out in previous guidance, is when:

'a child has suffered potentially life threatening injury, serious sexual abuse, or sustained serious and permanent impairment of physical and/or mental health or development' (WT, 2010:169)

In this case, the chronic neglect resulted in serious harm to at least two of the children’s long-term emotional health and development.

2. Succinct summary of case

2.1 This case concerns a socially isolated and chaotic family where the parents had been in conflict for several years, and there were periodic recorded incidents of domestic abuse (DA). Father was not part of the household, but regularly spent time there in order to see his children. The three oldest siblings had emotional and behavioural difficulties, and two were severely delayed in their learning and development. Mother struggled to meet the children’s basic needs, including keeping them safely supervised and taken to school consistently and on time; she relied on the help of her oldest child, herself a very vulnerable young person, as an extra carer.
Various services had been involved in trying to support the family, generally at
the 'universal' or Tier 2\(^1\) levels. There had been occasional involvement from
Norfolk Children’s Social Care (CSC), but this had been minimal.

2.2 CSC received a referral in March 2011, expressing concerns about the
children’s care; this came from a women’s refuge, at some considerable
distance away, where the family had just spent two weeks. This referral was
not deemed to meet the threshold for an assessment by CSC, who instead
recommended that a Common Assessment Framework (CAF)\(^2\) should be
started. The family’s Health Visitor (HV) set up and led the CAF initially, until
the family moved out of her area later in 2011.

2.3 The children’s experiences at home and the full extent of their neglectful
parenting remained largely unrecognised by the professionals who were trying
to work with Mother via the CAF process. Little meaningful progress was
made, and over time Mother’s engagement declined. Late in 2012, CSC
accepted a re-referral, this time from his school, following concerns raised
about Child 3 by a new member of staff. A Core Assessment was completed
for all the children, which led to an Initial Child Protection (CP) Conference
(March 2013), and the adoption of CP Plans designed to improve the
children’s circumstances as quickly as possible. In the next few weeks, there
was growing and concrete evidence that the children were not safe in the
home, and they were accommodated (S20 of the Children Act 1989\(^3\)) and
placed in foster care in late April 2013. At this point, the children were
assessed by Paediatricians as suffering significant developmental delays and
emotional difficulties.

3. **Family Composition**

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<tr>
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<tbody>
<tr>
<td><strong>Mother</strong></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>(not resident with the family)</td>
</tr>
<tr>
<td>Child 1</td>
<td>(Mother's first child, with a previous partner)</td>
</tr>
<tr>
<td>Child 2</td>
<td></td>
</tr>
<tr>
<td>Child 3</td>
<td></td>
</tr>
<tr>
<td>Child 4</td>
<td></td>
</tr>
<tr>
<td>Child 5</td>
<td></td>
</tr>
<tr>
<td>Maternal Grandparents</td>
<td>(not resident with the family)</td>
</tr>
</tbody>
</table>

All members of the family are White British.

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1 Tier 2 services are those which offer the first level of early or specialist help to children or adults with additional needs.

2 The Common Assessment Framework (CAF) was introduced as a national programme in England in 2003, as a key tool in the early identification of children and young people and families who may experience problems or who are vulnerable to poor outcomes. The aim is to identify children’s ‘additional needs’ and make a multi-agency plan for services to be offered which will meet these needs. The CAF is a consent-led process, with parents retaining the right to withdraw or to limit the level of information shared among agencies.

3 S20 (1) (c) gives local authorities the duty to look after a child in circumstances where his carers ‘have been prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care’. It is undertaken as a voluntary arrangement with the child’s normal carers.
4. Time Frame for Review

The Learning Together model, in line with systems models generally, works best when reviewing in detail a period of no more than two years, in order to discover how systems are currently (or recently) operating. Scrutinising the work of agencies further back in time is unlikely to achieve useful systems learning, given the inevitable changes in personnel, local arrangements, and national guidance, regulations and legislation.

The L Family had been known to various agencies in the past, especially at times when Mother appeared to be struggling with looking after her growing number of children. At the beginning of March 2011, however, it was largely 'universal' services who were involved. A natural beginning point of this review, therefore, was when the family again came to the notice of the district Housing Service, a women’s refuge, and Children’s Social Care. These events triggered CSC and other agency involvement over the next two years.

This SCR examines professional practice from all agencies with the L children and their parents between **March 2011**, when the first referral to CSC was made, and **April 2013**, when the four youngest children were removed from home and placed in foster care.

5. Key Dates Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tr>
<td>Early March 2011</td>
<td>Mother approaches her district Housing Service about the need to move away from home – relating to domestic abuse (DA) from her partner (unclear whether past or current). She and her 4 children go to a women’s refuge some distance away. (Child 5 not born until later in 2011)</td>
</tr>
<tr>
<td>15.03.11</td>
<td>Referral received in Children’s Social Care from the Health Visitor linked to the women’s refuge. The family were about to return to Norfolk, and there was concern about the level of DA, witnessed by the children – who were said to be ‘scared to return’. The refuge staff noted other evidence of neglect and the role of eldest child as carer to her half-siblings. The case was not accepted for an Initial Assessment.</td>
</tr>
<tr>
<td>05.04.11</td>
<td>The family’s Health Visitor made a follow-up enquiry with CSC, after she had telephone contact with the Health Visitor for the refuge. She had known the family for some time, and had concerns about DA. CSC again did not accept the referral, stating there was no new information, and they were ‘already aware of the concerns’. CSC suggested a CAF should be commenced instead.</td>
</tr>
<tr>
<td>27.04.11</td>
<td>Health Visitor home visit. Both parents present. (Two previous attempts to visit were not successful.)</td>
</tr>
<tr>
<td>28.04.11</td>
<td>Child 2 seen in ADHD Clinic. Said he 'doesn't like Dad.'</td>
</tr>
<tr>
<td>10.05.11</td>
<td>Health Visitor completed CAF application form with Mother and made arrangements for the first Team around the Family (TAF) meeting.</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>06.06.11</td>
<td>First TAF meeting; Mother attended, not Father. The originating HV was named as the Lead Professional.</td>
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| 18.07.11   | Second TAF meeting  
Some progress in the plans noted by the schools.                                                                                                                                                        |
| 12.09.11   | Third TAF meeting  
‘Positive feedback reported from all attendees’, according to school records.                                                                                                                              |
| 26.09.11   | Family were allocated a larger property in a different area – though appear not to have moved for a further few weeks.                                                                                              |
| October 2011 | Child 5 born; family moved house about this time.                                                                                                                                                                |
| 07.11.11   | Fourth TAF meeting  
Mother did not attend. Positive progress reported (school records). The move to a larger property was seen as helpful for all the children.                                                                    |
| 14.03.12   | Children’s Centre (Early Years) – first letter to try to commence involvement with the family, and re-start the CAF. Family did not respond.                                                                     |
| 31.05.12   | TAF meeting (CAF process recommenced after gap of 7 months)                                                                                                                                                      |
| July 2012  | TAF meeting planned (but no records of this meeting – so unclear whether it took place)                                                                                                                          |
| 19.09.12   | TAF meeting  
November 2012 CAF ceased, when Mother appeared to be disengaging from the process.                                                                                                                        |
| 26.11.12   | Referral received in CSC from Child 3’s infant school, expressing concerns about his wellbeing, lack of boundaries in the home, parental neglect of the children, and DA between parents. The case was allocated for assessment. |
| 14.12.12   | Initial Assessment completed, and decision to complete a full Core Assessment. Case transferred to a Safeguarding Team.                                                                                           |
| 26.02.13   | Strategy discussion between police and CSC. Based on a considerable number of concerns about the care of the children, including  
- Children living in a climate of DA  
- Physical chastisement of children  
- Very poor/dangerous home environment  
- Low school attendance  
- Physical and emotional neglect of the children (who have special needs)  
- Poor supervision of the children, who have not always been kept safe  
Agreed need for Initial Child Protection Conference (ICPC) |
ICPC held.
Four youngest children made subject of CP Plans, category of neglect (Child 1 was now an adult.)

Home-based Support Worker noticed bruise to Child 5’s nose. Mother did not know how this happened, as Father was said to have been caring for the child at the time. Further incident of Child 5 found with adult medication in his mouth (belonging to Child 1).

CP Medical for Child 5. Not possible to determine whether bruise was accidental or non-accidental injury (NAI). Poor interaction between child and Mother noted by doctor.

CSC notified of incident: fight between Child 2 and Child 3, with slight injuries to both.

Strategy discussion followed by joint action between police and CSC. Assessment that children were at risk of physical harm and neglect. All children accommodated under S S20 (Children Act 1989) and placed in foster care.

6. Organisational Learning and Improvement

6.1 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including SCRs states:

‘Reviews are not ends in themselves. The purpose of these reviews is to identify improvements that are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.’ (Working Together, 2013:66)

6.2 Norfolk Safeguarding Children Board (NSCB) identified that this SCR held the potential for learning in particular areas of practice, and hoped to explore the following questions:

- Is there a generally shared understanding by professionals in Norfolk of the indicators of neglect and of the threshold for taking safeguarding action?
- How effective is the CAF/Family Support Process system within Norfolk in supporting the needs of children?
- How effectively are families in Norfolk being helped to make long term changes to their parenting where this is necessary to ensure their children’s needs are met, and therefore enable children to stay within their family of origin?
How well do professionals in Norfolk recognise the impact of domestic abuse on children’s emotional and physical wellbeing, so that they can take appropriate action?

6.3 The Board was also keen to respond to the new *Working Together* learning and improvement guidance, in the following ways:

- by developing a systems approach and involving those working with the family;
- by being pro-active regarding learning, in the context of the issues facing Norfolk as a county; and,
- by improving the way the Board implements and embeds the messages and recommendations from case reviews.

7. Methodology

7.1 Statutory guidance in *Working Together* (2013) requires SCRs to be conducted in a way which:

- 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;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings. (2013: 67)

It also stipulates that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- there should be a culture of continuous *learning and improvement* across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be *proportionate* according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are *independent* of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process. (2013: 66-67)
In addition, SCR reports should

“…be written in plain English and in a way that can be easily understood by professionals and the public alike” (2013: 70)

To help all readers, a glossary (of acronyms and terminology) is provided as Appendix 1 of this report.

7.2 In order to comply with these requirements, the NSCB has chosen to use for this SCR the Learning Together systems model (Fish, Munro & Bairstow, 2009), developed within the Social Care Institute for Excellence (SCIE). A Learning Together review process is based on several key principles:

1. **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time. In particular, explore what sense they were making of the case, and the contributory factors which were influencing their practice at the time.

2. **Provide adequate explanations** – appraise and explain decisions, actions and inactions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it.

3. **Move from individual instance to the general significance** – provide a ‘window on the system’ that illuminates what supports and what hinders the reliability of the multi-agency CP system.

4. **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult issues.

5. **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

Details of the model and this process are contained in Appendix 2 of this report.

8. **Reviewing expertise and independence**

8.1 **Lead Reviewers**
The SCR has been led by two people independent of the case under review and of the organisations whose actions are being reviewed. Sally Trench and Sian Griffiths are both independent consultants, accredited to carry out SCIE Learning Together reviews, and with extensive experience of writing SCRs/IMRs under the previous ‘Chapter 8’ framework in *Working Together* (1989, 1999, 2006, and 2010). Neither had any knowledge of or involvement with this case prior to the review.
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Sally Trench has been commissioned by the NSCB to act as independent reviewer for three previous Multi-Agency Reviews (MARs). Sian Griffiths undertakes occasional training on behalf of Barnardos, which has been commissioned by the NSCB to provide multi-agency safeguarding training to Norfolk agencies.

The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

8.2 Review Team
This was comprised of 8 senior managers or senior professional leads from the multi-agency services involved with the family. Their role was to provide a source of high-level strategic information about their own agencies, as well as professional expertise in their fields. Together with the Lead Reviewers, they collected data about this case, including a review of agencies' records, and produced and agreed the content of this report.

8.3 Case Group
The second important group taking part in the case review was 20 front-line professionals and first-line managers who had worked with the L family in different capacities. They provided a detailed picture of what happened in the individual case; in addition to their work with the family, they brought their wider experience of working within local systems, through a range of cases. To elicit their involvement in this case, members of the Review Team held individual conversations with the Case Group professionals. The Case Group also attended a full-day Workshop to respond to the analysis and emerging findings from the Review Team and Lead Reviewers.

9. Methodological comment and limitations

9.1 Key member of Case Group missing
The professional who had known the family longest, going back to when Child 1 was small, was the Health Visitor who commenced the CAF in May 2011, and who before that had tried to persuade CSC to accept the referral from the refuge in March 2011. She had a number of concerns about the family, and wanted an assessment to be undertaken so that both children and Mother could be helped.

The Health Visitor had left the service when this case review took place, and was not able to be involved. This meant that a valuable source of information was not available to the Review Team.

9.2 Family involvement in the SCR
As in traditional SCRs, family members are normally invited to participate in a Learning Together review. Their experiences of services and the professionals involved with them are the source of important insights for the review process. In addition, they may offer a clearer, and possibly different,
picture of what was ‘going on for them’ during the time covered by the case review.

In this case, Mother, Father, Child 1 and maternal grandparents were invited to meet separately with the two Lead Reviewers. Only Father agreed to do so. He was able to give a very helpful account of his views about services, and significantly added to our understanding of the children’s circumstances in the home. What Father told us is woven into the body of the report, where relevant.

9.3 **Limited information about Children 1, 4 and 5**
For most of the review period – until late 2012 – the multi-agency work with the family was carried out under the remit of the Common Assessment Framework, with Team around the Family meetings taking place periodically in 2011, and again in 2012. These commenced when the fifth sibling was not yet born, and when Child 1 was still a child, though in her late teens. In 2012, the meetings continued to include all (now) five siblings. However, a disproportionate focus of the TAF meetings was on Children 2 and 3, and Mother’s difficulties in managing them; thus, the majority of the information shared was about these children.

The Review Team considers that the unbalanced view of the sibling group has had an impact on this case review, in that we have learned less about the individual needs and risks for the three remaining siblings (Children 1, 4 and 5) than for Children 2 and 3. This view now stands out more starkly as an omission, in light of the post-removal assessments of the youngest children as suffering significant developmental delay and disturbed behaviour.
B. Findings

10. Introduction

10.1 Statutory guidance requires that SCR reports ‘...provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence (WT 2013:71).

These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.’ (2013:65)

10.2 The Findings – the main body of the report – begin with a synopsis of the appraisal of practice. This sets out the view of the Review Team about how timely and effective the interventions with the L children were, including where practice fell below expected standards. Where possible, it provides explanations for this practice, or indicates where these will be discussed more fully in the detailed findings.

10.3 A bridging section (What is it about this case that makes it act as a window on practice more widely?) explains the ways in which features of this particular case are common to other work that professionals conduct with children and families, and therefore how this one case can provide useful organisational learning to underpin improvement (‘a window on the system’).

10.4 Finally, the report discusses in detail the 8 priority findings that have emerged from the SCR. The findings explain why professional practice was not more effective in protecting the children in this case. It also outlines the evidence that indicates that these are not one-off issues, but underlying patterns – which have the potential to influence future practice in similar cases. We also consider what risks they may pose to the wider safeguarding of children.

11. Appraisal of professional practice in this case: a synopsis

Introduction

11.1 This case featured a familiar dilemma for those involved in working with vulnerable families: the difficult balance faced by professionals of both supporting parents and ensuring that their children are safe and well cared for. For most of the period of this case review, the work with the children and Mother was via the voluntary process of the Common Assessment Framework (CAF), within which plans were made to improve the children’s circumstances and their outcomes.

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4 Vincent, C., 2004
11.2 Our appraisal of practice outlines the Review Team’s views about how well professionals carried out their roles and responsibilities in working with the L family. It also provides a link to the analysis of why things happened as they did, including the wider systems factors. It is these general findings which allow us to translate the learning from an individual case to the wider work of safeguarding agencies.

The family’s brief time in a women’s refuge some distance away, and referral from the refuge upon their return home

11.3 The review period begins in early March 2011, when Mother sought help from local district Housing services to flee domestic abuse (DA). Her story was somewhat confused, but she indicated that she and the children were not at immediate risk. The Housing Officers dealt with her according to normal practice and procedures: establishing that she did not need emergency placement by the District Council housing services, offering to negotiate a placement for her (she declined), and giving her information about her options, including local services and the National Domestic Violence Helpline.5

11.4 Mother and the children obtained a place in a refuge some considerable distance away, and stayed there for two weeks. Staff within the refuge and from its local Health and Education services became involved with supporting them and planning for their next steps, as well as observing Mother and children. Contact was made by the refuge with Child 3’s infant school in Norfolk, which resulted in the removal of his and Child 2’s names from their schools’ rolls (infant and junior schools). In the event, Mother abruptly returned home after two weeks, leaving her refuge accommodation in what was described as an ‘appalling’ state.

The Health Visitor attached to the refuge, in conjunction with refuge staff, made a full and appropriately detailed written referral to Norfolk Children’s Social Care (CSC), outlining child protection (CP) concerns which had emerged from their contact with the family. The referral included both observations of the children and their expressed fear of returning home, as well as describing Mother’s poor ability to provide safe care. It was followed up by telephone contact from the referrer with: CSC, the Norfolk Health Visitor (who happened to know the family well), and the family’s ADHD Nurse. The ADHD Nurse was told that a CP referral was being made, based on the refuge staff’s observations of mother’s care of the children, and their relationship with her.

Although the referral came from a women’s refuge, and the family’s stay there appeared to have been triggered by fear of violence, the history and potential ongoing risk of DA remained unassessed, both at the point of referral and during the subsequent Team around the Family meetings, when Mother regularly declined to talk about DA, and stated that there was no current

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5 The helpline is run in partnership between Refuge and Women’s Aid. It is open 24 hours a day, seven days a week for women experiencing domestic violence and in need of a refuge place. All calls are confidential.
violation. The capacity for parents to unduly influence what is or is not discussed in TAF meetings is explored in Finding 2.

11.5 The referral from the refuge was discussed between the CSC Duty Worker (not a qualified Social Worker) and Duty Manager, who concluded that it would not be allocated for a SW assessment, despite the existence of previous records which showed a history of DA. In recognition that some assessment was necessary, the Duty Manager suggested that a multi-agency assessment should be conducted using the Common Assessment Framework (CAF).

It remains unclear why this judgement was made. The Duty Manager has recalled that only one feature of the referral (the mess left by the family in the refuge, and a previous, similar account of the family’s home in Norfolk) was discussed by the Duty team; but he could not say why the referral details of other concerns were given little weight or attention.

The Review Team was provided with relevant background context for this part of the CSC service, including a reorganisation and heavy demands on the ‘front door’. There had recently been a three-fold expansion in the geographical area covered by the Duty Team, as a result of which extra staff had been allocated to the service. However, the Duty Manager’s recollection is that these extra staff had not yet been recruited at the time of the referral in March 2011, and his service remained under extreme pressure. By his admission, the threshold for accepting cases was too high at that time, and the increased workload had a negative impact on the quality of decision-making. These factors made this individual decision more understandable, as well as highlighting flaws in how workers understood DA.

This service has since been strengthened by extra managers and staff, and the introduction of the Multi-agency Safeguarding Hub (MASH) structure for dealing with incoming referrals, which offers further assistance via information-gathering and guidance about further action.

The Duty Manager had had positive experience of the CAF process when it was piloted in Norfolk, and supported by greater resources than was now the case. His decision to advise its use for this case may, therefore, have been affected by optimism about the potential effectiveness of CAFs.

11.6 The Norfolk Health Visitor knew about the referral from her counterpart in the area of the women’s refuge, and contacted CSC about it. She was persistent in trying to get the case accepted, but in the end was not successful. She discussed her concerns with her Team Leader, but this ‘escalation’ went no further. Other professionals in this review have referred to a shared degree of ‘defeatism’ about efforts to meet the CSC threshold, especially where it is not clear that there are safeguarding concerns (though there should have been no doubt in this case). Finding 8 explores the link between perceived CSC thresholds and the impact on partner agencies.
11.7 Despite her indignance that the case was not accepted by CSC, the Norfolk Health Visitor ‘picked up the baton’ and completed the required CAF form with Mother in a timely way. This form shows very clearly how much a parent-led process (see Finding 2) this was (is); the Health Visitor’s interview with the parent created the list of areas to be covered in the Team around the Family (TAF) meetings.

The CAF was then initiated and largely seen by the professionals involved as a ‘supportive’ process, led by the mother and by her needs and concerns. In this sense, it was no different from many other such CAFs (or Family Support Plans, as they are now known in Norfolk). Perhaps for this reason, the chosen framework – with multi-agency Team around the Family, or TAF, meetings – was ill-equipped to enable professionals to evaluate more assertively the parental care of the children, and to insist on evidence that things were improving for them. The absence of consistent co-ordination, independent oversight and lack of rigour in the CAF framework are explored further in Finding 1.

There are two findings about the CAF process, Findings 1 and 2, which suggest how its principles and structure may be unhelpful to cases where more challenge is needed.

CAF process - 2011

11.8 At the start of the CAF, a divisional CAF Co-ordinator was available for advice and help with any difficulties, and she chaired the first TAF meeting. The family’s Health Visitor was appropriately named the Lead Professional (LP) at this point.

Most of the relevant professionals who were involved with the children were invited and were able to attend, and the meetings were held in a user-friendly part of one child’s school. An exception to the inclusive attendance was the School Nurse (SN); there is not capacity in the SN service to enable them to attend all TAF meetings, highlighting a resources issue for Norfolk. This can be a significant drawback where a multi-agency process involves school-age children, especially those with special health or development problems, which was the case here.

Also, it is unclear whether the Midwife, who attended the first TAF meeting, was invited to the next two meetings.

11.9 The other exception was that of Father. It seems an invitation was sent to his home address for the first TAF meeting, but is unclear whether or how he was invited to any further TAFs (the invitation lists suggest that he was not). In his conversation with the two Lead Reviewers, Father said he had not received any invitations to these meetings (nor any others, until the Initial CP Conference). He said that he very much regrets his exclusion from meetings, and that he would have made every effort to attend. His important input was missed throughout, and this – relatively common – disregard for the father or male partner is discussed in Finding 7.
11.10 The professionals involved in the TAF meetings identified some positive changes during this period (mid-2011), although, according to one of the Head Teachers, it appears that they felt that even ‘small steps’ counted as progress (especially for Child 2). Most of the alleged improvement was self-reported by Mother, whereas there was in fact insufficient evidence of meaningful and sustained changes, in the shape of better outcomes for the children. Cursory attention seems to have been paid to the history of DA and the possibility of ongoing conflict or violence in the home. After the first TAF meeting, where risks from DA were identified by professionals, Mother seemed inclined to avoid further exploration, usually asserting that ‘things were now all right’.

11.11 There were exceptions to how professionals were ‘distracted’ by Mother’s descriptions of home life. During this period, Mother’s Midwife was persistent in raising DA with her, but when she asked about the trip to the women’s refuge, Mother said ‘it was all a misunderstanding, and she didn’t want to discuss it.’ The Midwife was not put off, and in light of historical DA, she submitted an internal ‘Cause for Concern’ notification which followed Mother through her pregnancy with Child 5; she also made a point of raising DA at every meeting with Mother. The Health Visitor, too, made home visits – something which is no longer routine (partly because she knew Mother would not come to the clinic). This was based on her awareness of the past and possibly present risk of DA. This stood out in this network as a better understanding of DA.

11.12 The Review Team saw the TAF meetings generally as lacking professional curiosity, not asking ‘What was it like to be a child in this family?’ There was no evidence that members of the group considered the need to observe the older children (those of greatest concern) in their home environment, despite a description in one of the children’s ‘Wishes and Feelings’ forms about the parents’ fighting on a regular basis, and Mother hitting Child 2. As noted above, TAF meetings appeared to accept without challenge Mother’s statements that the threat from Father and their upsets and arguments were ‘all in the past’. (Most, but not all, of those working with the family were aware of a history of DA between the parents. However, there was little exploration of what this meant, especially for the children.) But, even if not to assess for that risk, it was odd that there was not a plan to assess the difficulties of managing the children at home, about which Mother consistently complained, and to explore how Child 3 behaved, given Mother’s description of him as completely unlike how he presented at school. Again – the absence of curiosity by professionals is striking. The nature of the CAF, and its constraints as a voluntary, parent-led process, are discussed in Findings 1 and 2.

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6 An internal health service ‘flag’ which alerts professionals dealing with an expectant mother about vulnerabilities such as DA, problems with previous pregnancies, etc. – and enables a different level of service to be provided, where appropriate.
7 Brother 3’s HV did see Mother and baby on home visits, but only once were the older children present. The Midwife also visited at home. FSWs planned to make home visits as part of their support plan, but Mother did not engage, so these did not take place.
11.13 The supportive approach towards Mother, as ‘a disorganised single parent with a huge amount on her plate’, was an important element of the professionals’ attitude to her, which led, more often than not, to their giving her the benefit of the doubt. **The systems implications of a professional mindset that errs too much on the side of sympathy are explored more in Finding 5.** Linked to this, professionals in the TAF meetings seemed unable or unwilling to identify much of her behaviour as neglectful parenting, with a negative impact on the children (e.g., the level of school absences, and the regular late arrival of the children at school). Conversations with school staff suggested that Child 2 and Child 3 ‘did not stand out’ in comparison to other children, and this fact seemed to militate against the idea that they might be receiving inadequate parenting. **The limitation of the professional understanding of neglect and the impact of this is discussed in more detail in Finding 3.**

11.14 All the children in the family had some form of extra needs and/or developmental delay, so a large number of professionals were involved at different times, offering a variety of services. These professionals were able to assess each individual child’s needs (in relation to their specialist area), and there was generally appropriate information-sharing among them regarding referrals, plans, and the progress or otherwise of the children. However, some information could be misleading: for example, the ADHD Nurse for Child 2 was very concerned about him (April 2012), but was reassured by being told that the Psychologist was involved with the family. While it was true that the Consultant Clinical Psychologist had seen the Mother and some of the children for a consultation, and had offered a detailed plan of support and intervention – Mother had not attended any further appointments.

As time went on, Mother increasingly failed a number of important appointments for the children, and her ability to get the children to school regularly and on time continued to be poor. The TAF meetings did not reflect this lack of meaningful improvement for the children.

**Finding 4 looks at how patterns of non-attendance (Did Not Attend, or DNA) for children’s essential appointments can be missed,** and how they may not be recognised as a feature of neglectful parenting, even within a multi-agency group meeting.

With the exceptions referred to above, the appropriate professionals were represented at the TAF meetings. However, singly and together, they did not give sufficient attention to the role that parenting played as underlying the children’s special needs and problems. The reasons for this will be touched upon below.

11.15 Child 2 and Child 3 were identified by Mother as causing her the greatest management problems at home, and by their schools as having the
most serious and worrying difficulties: Child 2 with ADHD\(^8\), and Child 3 with a range of symptoms and disabilities which were as yet not fully assessed. Members of the Case Group confirmed that less attention was given to the two youngest children, who were perceived as having fewer difficulties, and indeed about whom less was known. Child 4’s nursery was not included in TAF meetings (in 2012; she was not in nursery during the previous year). The oldest sibling, Child 1, attended several of the meetings, and, although it was clear that she was extremely vulnerable and struggling with her problems (and was still a child at that time), there is no record of discussions which demonstrate an understanding of her needs or how she might be helped.

11.16 Mother’s insistence on a specific medical diagnosis for the children’s difficulties (ADHD, and later ASD\(^9\)) seems to have served in many ways to dissipate any consideration of other family and environmental features of their lives – in particular the quality of the parenting they received. The lack of knowledge about possible other explanations or factors for a child’s behaviour, particularly in relation to ‘ADHD’, is of concern. As described above, professionals in the TAF meetings – including the schools, who knew the children best – showed little curiosity about the children’s experiences at home, and of Mother’s own history; they were not curious at all about Father. **Finding 6 explores how medical labels may distract professionals from a more holistic approach to understanding a child's problems, including the impact of parenting.**

11.17 In November, Mother did not attend the scheduled TAF meeting; she had recently given birth to Child 5, and the family had moved house. At this point, it was not apparent to the Review Team, and apparently to the professionals involved in the TAF meetings, what was expected to happen next. The Lead Professional had to change, replacing the previous Health Visitor. A proposed TAF meeting for early January does not appear to have been arranged. Responsibility for co-ordinating the process was unclear (see **Finding 1, below**), and this led to a gap of several months before the CAF was re-started.

The main reason for the CAF discontinuing at this point was a perception (in conversations with the Case Group and in TAF records) that Mother was no longer engaging with the CAF. What particularly concerned the Review Team was the lack of any recorded response to this about a) what had already been achieved for the children, and b) whether further efforts were required – either at CAF level or via a ‘step-up’ to Children’s Social Care. The key event of the birth of a fifth child to a mother who was not coping well was not considered a trigger for reassessing the overall needs of the family.

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\(^8\) Attention deficit hyperactivity disorder (ADHD) is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.

\(^9\) Autism spectrum disorder (ASD) is a condition that affects social interaction, communication, interests and behaviour. It includes Asperger syndrome and childhood autism.
CAF process 2012

11.18 A period of drift and delay
The potential members of the Team around the Family changed when the family moved, thereby breaking some of the consistency in the previous meetings. A consequence of this, and the lack of co-ordination outlined above, was a considerable delay in any further TAF meetings, until late May 2012. There appears to have been a vacuum in arrangements for the CAF to proceed, especially with no identified new Lead Professional (LP). When the role was eventually allocated – to a Family Support Worker in the local Children’s Centre – this was not in keeping with usual practice, which is that parents should choose, or be involved in choosing, the LP. It was one of the jobs of the Divisional CAF Adviser to advise and assist with getting the CAF going again, but she was not consulted (after her earlier involvement with the initial CAF in 2011).

It remains unclear how the two subsequent LPs, both from Sure Start, were assigned this role. Neither knew the family at all, and in any case, most of the focus in the TAF meetings was again on Child 2 and Child 3, who were outside the age range for the Sure Start programme. At this time, there was significant disruption within the Children’s Centres, relating to the commissioning process for their services and a delay in new arrangements for Sure Start staff; as a result, vacancies were being carried and there was uncertainty for staff. All this contributed to a situation in which the individuals undertaking the LP role did not have appropriate support and guidance, which might have enabled them to challenge their suitability to be LP, or to carry out the role more confidently. (See link to lack of managerial support in Finding 1). Nonetheless, the third assigned LP made several attempts to contact both parents, although without success.

11.19 Not all the professionals associated with the younger children were included in the second round of TAF meetings – e.g., no one from Child 4’s nursery was invited. (In her conversation, Child 4’s Key Worker stated that the nursery were ‘totally unaware of any concerns about the family, until informed by CSC about the CP Conference in February 2013.’) This unexplained gap supports the Review Team’s assertion (Para 9.3) that the younger children in the family received less attention in the CAF process. There were plans for two family support workers from Children’s Centres to support Mother at home. She, however, did not respond to the contacts made, and the work never took place.

11.20 In 2012, the TAF meetings adopted similar plans to the previous year, although there was now a new baby in the family. It proved a challenge for the meetings to plan for and review the needs of four children ranging from school-age down to small baby, and in essence the plans tended to focus on Child 2 and Child 3 and their challenging behaviour and its impact on their education. (Child 1 was now an adult, and no longer part of the CAF, but it had been apparent in the previous TAF meetings that her considerable vulnerability and serious needs were poorly addressed in this process.)
11.21 Both schools continued to review the children’s needs in schools, and to cater well for these, using a range of special provision to promote both their educational attainment and their social development. However, although the children’s difficulties were recognised, Case Group members from the schools stated repeatedly that there were other children in similar circumstances; the boys ‘didn’t stand out’. An example given was that almost all of Child 2’s year group had entered school with similarly low attainment, below the national baseline.

Professionals in the schools did not see it as their role to put together a picture of what was – or, just as importantly, what wasn’t – happening in the children’s family. In the Review Team’s experience, this lack of interest in the children’s lived experience outside of school, especially in their home environment, is unusual in primary schools, and would not be considered good practice. School-based staff have more contact with children than any other professional group; this unique position confers on them a responsibility to be alert to any welfare issues beyond those in the classroom.

In addition, new guidance for schools – *Keeping children safe in education* (2014) echoes *Working Together*, with an emphasis on early help for children and their families, when additional needs are identified, and a responsibility to contribute to inter-agency plans to support children subject to child protection plans.

> All school and college staff have a responsibility to identify children who may be in need of extra help or who are suffering, or are likely to suffer, significant harm. All staff then have a responsibility to take appropriate action, working with other services as needed. (Para.8)

It is difficult to see how these responsibilities can be carried out by any school, without a sufficient alertness and understanding of a child’s parental care and family life.

Referral from school to CSC in November 2012, leading to allocation of the case and to Initial and Core Assessments and formal CP actions

11.22 In autumn 2012, Child 3 had a new Acting Deputy Head Teacher and SENDCO (Special Educational Needs and Disability Co-ordinator), and her ‘fresh pair of eyes’ saw a child with highly worrying, withdrawn behaviour, in contrast to his mother’s description of him as violent and out-of-control at home. In this school term, both boys’ school attendance began to deteriorate again, from an already low level (and, at the same time, a number of vital health appointments were missed). The teacher decided, upon conferring with her Head Teacher, that a referral to CSC was needed. This appropriate and well-constructed referral was focused on serious concerns about the child, and it was accepted in a timely way. (In this respect, it was of similar quality to the referral regarding concerns for all the children from the refuge in March 2011, although the response was in stark contrast.)
11.23 CSC moved quickly to carry out an Initial, and then a Core Assessment. These were done jointly by a Student Social Worker and an experienced qualified Social Worker, who had a special interest in complex neglect cases. The result was an excellent piece of work that included observations of the children at home, reading historical records, and gathering information from the relevant members of the professional network: in other words, all the necessary ingredients of a high quality, holistic family assessment. The qualified Social Worker in question ascribed this significantly to the quality of his line management and expectations about what constituted good practice. The same Social Worker also had a very high level of professional and theoretical knowledge in relation to neglect. The only weakness in the assessment was scant information about Father’s involvement with the family.

11.24 The Initial CP Conference was chaired by an independent person, and was well-attended by relevant professionals and both parents. All the children were appropriately made subjects of a CP Plan, and this resulted in an opportunity for intervention in the family in a different and more formal way, providing the authority for agencies to offer both intensive support and to monitor closely the children’s wellbeing and safety, including in their home. The plan also included a suitable time frame within which improvements in the children’s care were required, and a parallel plan for legal action if these did not transpire.

This was good practice, and there was now more (but not entire) success in engaging with Mother and focusing on the care of the children within the home. This at length enabled agencies to be able to explore more fully the question ‘What was it like to be a child in this family?'

11.25 In the weeks following the ICPC, the CP Plans were carried out as required, and now the children were being seen at school and home on a regular basis. As a result, a number of risky circumstances came to light, including an unexplained injury to Child 5 (now aged 18 months), and an incident in which the toddler was found with an adult’s medicine in his mouth. Child 2 and Child 3 were reported as both having injuries, from a fight between them. In addition, the chaotic and unhygienic home conditions were now apparent to any visitor. Practice during this period was more coordinated within CSC and across agencies, and there was a better focus on the children’s safety and wellbeing.

11.26 In light of Mother’s inability to keep the children safe, the decision was made in CSC to remove the children from home and place them in care. This was because of the ongoing risks and the lack of comprehension about these from the parents. CSC and Police worked well in partnership to remove the children, and were able to get Mother’s agreement to their accommodation (S20, Children Act 1989).

11.27 The review has illustrated how professionals may not intervene proactively in cases of continuing neglect, even when there are poor, and possibly deteriorating, outcomes for children. Decisions to act more assertively seem to be dependent either on a) ‘incidents’ of harm coming to
light (such as the injury to Child 5), or b) professionals gaining regular access to the family home, with the specific remit to observe and assess the quality of parenting and the lived daily experience of all the children. In this case, both of these circumstances converged, and led to the formal CP steps to protect the children from further harm.

It is of concern that, without one or the other of these circumstances arising, the neglect of the children might have continued without intervention to prevent further harm.

12. What is it about this case that makes it act as a window on practice more widely?

12.1 The NSCB expected that the review of this individual case would shed light on areas of practice which feature in much of the work of the local safeguarding children network. This has proven to be true, and the review has been able to look beyond the story of the L Family, in order to address the wider questions (listed in Para 6.2 above) identified by the NSCB for the SCR to consider:

- How professionals respond to and work with neglect
- The effectiveness of the CAF/Family Support Plan system within Norfolk
- The effectiveness of interventions in families to achieve long-term changes in poor parenting
- How professionals respond to and work with DA and its impact on children

12.2 In exploring these questions, and, in the course of analysing the work of agencies, the Review Team has uncovered other connected challenges, e.g.:

- Working with disguised compliance, and parental disengagement from voluntary Tier 2 processes
- Understanding children’s disturbed behaviour within the ‘nominated’ context of a medical condition
- Shared understanding of thresholds for Tier 2/Tier 3 services and referrals
- Recognising failed appointments and poor school attendance as potential indicators of neglect – especially ongoing patterns of missed appointments (Did Not Attend, or DNA)
- Encouraging all agencies to think: What was it like to be a child in this family?

12.3 The foremost area of investigation for the Board, however, was working with neglect. This underpins its desire to scrutinise, via this case, what gets in the way of offering appropriate and effective help to families and children who are suffering from long-term neglect.
The NSCB has mounting evidence that this is a vulnerable area of practice in Norfolk, with various sources providing information about the prevalent nature of the problem and the often ineffective response from agencies. In this context, three of the eight findings from this review relate to how partner agencies understand and work with neglect, and the particular challenges of this work.

12.4 Two extensive findings concern the workings of the CAF process (now Family Support Process, or FSP), reflecting another of the original questions for the SCR.

All the eight findings overlap to a degree, and shed light on the third question, regarding how to achieve long-term changes in poor parenting. However, it was not possible to answer this question in full, as the focus of the multi-agency work, for most of the case review period, was on ‘voluntary’ supportive action with the parent, rather than on more direct intervention to help a family achieve long-term change.

12.5 Practice in relation to DA in families (Question 4)

The Review Team debated at length what this case revealed about professionals’ understanding of and response to DA in families. This is a familiar theme country-wide in case reviews, including SCRs and Domestic Homicide Reviews. It is a difficult area of practice, but one where there is evidence of considerable progress in how agencies work together to improve the protection of children and parent-victims. This is true both nationally and in Norfolk.

In this case, the professionals working with the family under the CAF process gave minimal attention to DA (or, according to their understanding, the ‘past DA’). What this might suggest about professional understanding of the impact of domestic abuse on the children was difficult to evidence, but most clearly this seemed to reflect the pattern of: a) professionals’ acceptance of Mother’s reports at TAF meetings; b) their lack of curiosity about what else might be going on in the family home; and c) the fact that there were no Police or other reports about DA/DV during the period of the CAF meetings, or the later CP Plans. These aspects of their work are addressed in the Appraisal of Practice and in several of the findings. However, although we were left with some questions about their response to DA in this case, we did not have the evidence to produce a systems finding about how local agencies work with DA in particular.

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10 Norfolk is not alone in this; research evidence suggests that local authorities and partner agencies around the country struggle to respond effectively to neglect of children (Gardner, 2008; Action for Children, 2014; Ofsted, 2014; Turner and Tanner, 2005).

11 The Common Assessment Framework (CAF) is now known in Norfolk as the Family Support Process (FSP). The CAF generally referred to both the assessment form which initiated the process, and, perhaps confusingly, to the process which followed: a series of multi-agency meetings and plans for children requiring additional help from more than one service. The meetings are called ‘Team around the Family’ meetings, also known as TAF meetings.
There is, however, a point made, in the later section ‘Additional Learning’ (Para 18.1), which highlights how ‘gender’ assumptions about DA in this case tended to mislead, and are likely to have been unhelpful.

12.6 The 8 findings for NSCB and partner agencies to consider are listed below:

<table>
<thead>
<tr>
<th>Finding</th>
<th>Multi-agency response to incidents and crises</th>
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<tbody>
<tr>
<td>1.</td>
<td>Despite the expectation in Norfolk that the CAF should operate as a formal ‘early help’ process for children with additional needs, it lacks any of the inbuilt mechanisms for pro-active review and challenge that are present at higher thresholds (Child in Need, CP), leaving cases that are in the system for any length of time susceptible to collusion and drift.</td>
</tr>
<tr>
<td>2.</td>
<td>The CAF process in Norfolk risks being parent – rather than child – focused as a consequence of its being voluntary and consent-led, with the result that the individual needs of children are not adequately addressed.</td>
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<tr>
<td>3.</td>
<td>There is evidence that some professionals most readily recognise neglect in terms of poor home conditions, rather than more general deficits in child-parent relationships and care. This can leave children at greater risk (and parents unsupported) from a range of neglectful behaviours that go unnoticed.</td>
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<tr>
<td>4.</td>
<td>There is no system to track/recognise patterns of missed appointments, within and especially across agencies, making it harder for professionals to share a critical sign of neglectful parenting.</td>
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<tr>
<td>5.</td>
<td>There is a tendency for professionals to make allowances for struggling parents, which militates against a recognition of neglectful behaviour and child-focussed practice, leaving children at risk of long-term harm.</td>
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<tr>
<td>6.</td>
<td>There is a pattern whereby routine attribution of a label such as ADHD to a child distracts attention from what may be the result of poor parental care, resulting in a range of the child’s particular needs not being recognised and not met.</td>
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<tr>
<td>7.</td>
<td>Professionals involved in the CAF process are not commonly seeking the active participation of the less visible parent (usually the father), making them less visible to the professional process as well, and risking the loss of valuable information about parenting and children.</td>
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<tr>
<td>8.</td>
<td>Multi-agency partners tend to perceive CSC thresholds as either inconsistent or too high, resulting in uncertainty about how referrals will meet the criteria for acceptance. As a result, some children may not receive appropriate and timely referrals for intervention.</td>
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13. Findings in detail

Working with CAFs

13.1 Finding 1: Despite the expectation in Norfolk that the CAF should operate as a formal ‘early help’ process for children with additional needs, it lacks any of the inbuilt mechanisms for pro-active review and challenge that are present at higher thresholds (Child in Need, CP), leaving cases that are in the system for any length of time susceptible to collusion and drift. (Multi-agency long-term work)

The Common Assessment Framework (CAF), introduced in 2003, was offered as a positive way to work with families, below the statutory threshold of Child in Need or CP Plans. But this case suggests that the lack of consistent co-ordination and independent oversight, plus no clear time requirements for review, means that plans for children can drift, without a requirement to ensure they are making a difference to children in a timely way.

13.1.1 How did the issue feature in this particular case?
A CAF was in place for the family between May and November 2011; in November, Mother did not attend a Team around the Family meeting and appeared to ‘disengage’ from the process. She had just given birth to her fifth child, and professionals appeared to see this as an almost inevitable reason for her non-availability. At the same time, the family’s house move to a different area of the county meant that some of the professionals in the TAF changed, and the newly appointed Lead Professional (LP) was not someone who knew the family at all.

Lack of co-ordination
Late in this review process, it has come to light that the family were (probably) subject to a CAF only a few months earlier, in late 2010. This was not referred to when the CAF of May 2011 commenced. This suggests that the system did not, and perhaps still does not, require a link to be made between the contents of recent/new CAFs for a family, and their success in terms of improving outcomes for children. This leaves those commencing a new CAF without key information: what was recently tried with this family, and with what success? What were the reasons for the previous CAF ending? ‘Starting again’ without such relevant evidence does not make sense, and is almost certain to waste time and effort, where such efforts may have failed in the recent past.

In terms of co-ordinating an individual CAF, the requirements about how to do this are not necessarily straightforward. In the case of re-starting the CAF for the L Family, this took several months of the LP trying to contact Mother and negotiate with her for the TAF meetings to be re-established; the next meeting was in May 2012 (a gap of 6 months). The responsibility for arranging meetings and drawing up a full and accurate list of invitees is an important one, and may cause difficulties for a LP who, as in this case, was not yet familiar with the family and the network of professionals involved.
Role of the Lead Professional
The LP is meant to be a professional 'chosen by the parent', and thus who has a good chance of helping the parent to engage with the CAF. The Review Team heard that this role, which includes organising TAF meetings, is sometimes allocated to a person with access to back-up administrative resources, rather than familiarity with the family, and this is what appeared to happen here. After November 2011, there were several more changes of LP, none of whom knew Mother or the children. This lack of consistency was, to a degree, inevitable, when the family moved and when professionals left their jobs. However, it highlights the difficulties for the process when there is little consistency in the nominated LP, alongside poor preparation for the role.

Independent oversight
During the period when the TAF meetings were happening – but not making a consistent difference for the children – and during the gap of 6 months, there was no routine arrangement for either the LP, or the whole network of TAF members, to have independent oversight of the 'health' of this CAF process. Unlike for other multi-agency processes (CP Conferences and Core Groups; looked-after children reviews), there is no independent Chair of TAF meetings, and the LP has no independent supervision for his/her role as Chair. This is in contrast to the independent Chairs of CP Conferences and LAC reviews, where there are established supervision arrangements, meaning that process problems can be identified and dealt with.

In Norfolk, there is the offer of advice from the three Divisional CAF (now FSP) Advisers. However, the Review Team were told that the capacity of these three posts is unlikely fully to meet the need for independent help and advice. They are not pro-active, but await a request from professionals where a CAF is encountering problems of various kinds. In this case, there was no such request, even though the CAF was floundering after November 2011.

Framework for review
When the CAF recommenced in May 2012, the children’s problems and Mother’s descriptions of her difficulties in managing them were almost identical to before. Little if any progress had been sustained from the first period of TAF meetings. In 2012, Mother attended two TAF meetings (May and September). At the second of these, the notes state:

‘Mother appeared at the meeting to be finding things difficult although also appeared reticent about accepting support with parenting and relationships. Sure Start will offer this and continue to try to engage Mother and the family in community-based activities that would be of benefit to the children’s social and cognitive development.’

The picture is of a professional network continuing to try to identify and offer helpful support measures, without any critical or independent review which could have considered this in the context of possible risks to the children, and should at the very least have assessed what was, or was not, being achieved. The TAF members seemed accepting of a situation which ‘didn’t change over time, but didn’t get worse’. (Comment from Health Visitor, in her
conversation). Mother’s ‘reticence’ about accepting support was apparent throughout the almost two years of TAF meetings, in that she appeared to want things to be better and to get help (mainly for herself), but did not follow through on the proposed plans. This is evident with the benefit of hindsight, and should have been apparent had there been any opportunity for critical stock-taking at the time.

Unless the LP and TAF members themselves recognise a ‘stuck’ situation, and call upon help from the Divisional CAF Advisers, there is no one independently reviewing the length of time a CAF has been in place, or the quality of outcomes for the children.

One further example of drift and lack of progress: the very first TAF meeting in June 2011 notes that Child 2 had injured Child 3 in the previous week, and that ‘all professionals and Mother are concerned about the safety of the children.’ ‘Fighting a lot at home’ was also noted in the September 2011 TAF meeting, but no action was taken to visit the home or intervene more assertively. Injuries between the same two siblings, in early 2013, were later to be one of the triggers for their removal from home.

13.1.2 How do we know it is not peculiar to this case?
Using their knowledge and experience, members of the Case Group and Review Team did not see this pattern as unique or indeed unusual.

The national CAF programme, introduced in 2003 as an ‘early help’ process for meeting children’s ‘additional needs’, was not given the same formal structure as Child in Need or CP meetings. Thus, there is no independent Chair, no strict time-table for review meetings, and no explicit expectations (via performance targets) about the review of plans and their effectiveness within a specific time frame (in comparison with the target for CP Plans that they should generally not run for longer than two years). The minutes of the meetings in this case suggest a lack of reflection, and challenge, in relation to how the plans were working effectively to make a difference for the children.

These features have contributed to a ‘looser’ system, where drift in plans can continue (in conjunction with other features of the CAF, discussed below in Finding 2). The Norfolk template for recording the review TAF meetings, at the time, had one question on it: ‘Can the CAF be closed?’ – with a yes or no option. There was no prompt question about whether the CAF was working effectively or whether it should be ‘stepped up’ – via a referral to CSC for an assessment under Child in Need or CP procedures. The new Family Support Process template addresses this omission, and there is now a clear requirement for the meeting to decide whether the FSP should be closed, should continue as is, or be ‘stepped up’ via a referral to CSC.

A final constraint for the CAF process: it has not, in the past, required knowledge, or assessment, of the parents’ own histories, thus potentially missing essential information for planning and work with the parents: ‘If we are to make sense of parents’ capacities to care and protect, we need to consider both their childhood and adult experiences.’ (Brandon et al, 2008,
This is as true of ‘early help’ processes, as for the statutory Child in Need and CP frameworks for intervention. The revised FSP assessment form now provides a holistic model which uses the triangle from the *Assessment Framework of Children in Need and their Families*\(^\text{12}\). Had this been in use for the L family, it should have identified significant features of the history – e.g., the fact that Mother had previously suffered from severe post-natal depression, and continued to use anti-depressants.

13.1.3 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?

The CAF is a national programme in England designed to support children who have additional needs and may require additional services, but do not reach the threshold for Child in Need (S17) or Child Protection (S47) responses under the Children Act 1989. Evaluations of the programme have identified inconsistent use of CAFs in different local authority areas, with varying rates of success; some areas are adapting it considerably, or discontinuing its use altogether. It is not known whether the potential for drift features in the barriers to good outcomes in other areas, but it seems likely that this might be the case.

In Norfolk, the uptake of CAFs has also varied widely across the county, and overall has reduced significantly between 2009 and 2013. Evidence about the effectiveness of CAFs in Norfolk has come from a number of sources, alongside recommendations about how to make changes to the process. (Some of the following references also link to Finding 2 below.)

- An audit of CAFs undertaken for NSCB in 2012-13. This identified a number of positives in practice, but significantly more defects, including the following comments from the 25 cases sampled:

  ~ *In only about half of the audited cases was a positive impact achieved and appropriate help assured for the child and family.*

  ~ *Focus is not always on the child or children. In the process to help the family to safeguard a child, focus on the actual child themselves is sometimes lost.*

  ~ *There needed to be a clearer focus on the outcome for the young person being met, rather than merely an action being completed.*

  ~ *Risk and Safeguarding are not being assessed, or managed. Risk issues are rarely even a consideration.*

  ~ *It is sometimes unclear from the record what the concerns are and difficult to ascertain whether it is indeed an early intervention. Limited information, on incomplete forms, often resulted in a lack of clarity as to who needs help.*

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\(^{12}\) *Framework for the Assessment of Children in Need and their families, 2000*
~ *Inadequate cases featured poor assessment leading to poor plans.*

~ There were no clear indicators of success, and actions are very broad and non-specific. No evidence is provided as to why outcomes are what they are. No connections are shown between risks and the need for interventions. Parents’ needs override that of the child and there is a lack of clarity about the needs of children.

- The Ofsted Inspection of Norfolk County Council (2013) also included a number of criticisms of the use of CAFs, summarised as follows:

  *Use of the common assessment framework (CAF) to coordinate the range of services available to improve vulnerable children’s lives is also uneven, and when it is used, the quality of CAFs is too variable.* (Para 14)

- A Multi-Agency Case Review (Child I, 2012) commissioned by NSCB expressed concerns about the use of the CAF process at that time (the same period as this case review):

  ‘There was no systematic process of assessing, monitoring and reviewing: protective factors which would reduce risk, and trigger factors which would indicate increased risk.’ (Para 7.2)

  And

  ‘…there was a strong view that the CAF process was not targeted at this level of case but designed for families who want to co-operate, have the capacity to do so and require support.’ (Para 7.2)

The last point was echoed by members of the Case Group and Review Team, who suggested that a number of inappropriate cases end up in the CAF/FSP framework (usually those which may require a CiN or CP response from CSC). This prompted the question: Is it then difficult for cases – which have been assessed as not meeting the threshold for CSC involvement (as in this case) – to be stepped up to CSC, when the CAF is not making a positive difference for the children?

Norfolk has had a CAF Co-ordinator (now the FSP Strategy Manager) for the county, from the beginning of the CAF programme. The role of advising about CAFs/FSPs which are not progressing or are problematic in other ways falls to three Divisional Advisers, who sit under the county-wide Co-ordinator. This demonstrates a recognition that such a role is needed to support the effectiveness of FSPs. However, the Review Team learned that these three posts do not always have capacity to respond to the potential need. A flag system (as used in Suffolk) to alert the Divisional Advisers of when a FSP has gone over a year is not used in Norfolk, but could be helpful in triggering a review of progress.
Finally, on a more positive note: The new FSP has built in a number of quality assurance measures, largely at the point of the commencement of a FSP, which are designed to support a more holistic assessment as the starting point. New forms have been produced including the improved assessment form, described above, which are available on the Early Help website. The template for TAF meetings now ensures that outcomes for each child are recorded. Training for Lead Professionals and others is offered, recognising that workers need different skills in working with families within a consent-led process such as the FSP (see also Finding 2).

13.1.4 What are the implications for the reliability of the multi-agency child protection system?

The CAF (now FSP) framework was and is intended for collaborative work between professionals and parents, in order to identify and meet the additional needs of children who would otherwise not develop or achieve as they ought to. As a system, it works best where there is a child-centred approach by everyone, and when parents welcome and contribute to a thorough and holistic assessment of their children’s needs.

This case has demonstrated that, where these positive elements are missing, there are vulnerabilities in how the CAF process is equipped to recognise or respond: to slow or uneven progress, to misleading information from parents, or new information that might suggest a child is at risk of neglect or other harm. In such circumstances, children can be left for long periods without proper assessment of their needs and without more assertive intervention – a particular risk where a CAF is nominally active for a significant period of time.

**Finding 1: Despite the expectation in Norfolk that the CAF should operate as a formal ‘early help’ process for children with additional needs, it lacks any of the inbuilt mechanisms for pro-active review and challenge that are present at higher thresholds (Child in Need, CP), leaving cases that are in the system for any length of time susceptible to collusion and drift.**

This case illustrated how easy it was for the professionals and the family to continue to get together, in TAF meetings, over an extended period of 18 months, without a review of progress and a re-think about what was being accomplished. There are a number of reasons for this, which include both the lack of an independent Chair and of review mechanisms, but added to these must be the absence of a culture of reflection and questioning, which any multi-agency intervention process must encourage. In fact, the CAF only came to an end when Mother was seen as withdrawing from it, and there was no decision by the members of the TAF to ‘step up’ at that point.

**Considerations for the Board and partner agencies**

- Is the Board aware of the potential structural vulnerabilities of the FSP framework for multi-agency working?
- It is suggested that there are a number of FSP cases which are too ‘heavy’ for this process. How could the Board get further information about this – including a better picture of which cases become FSPs (and from what source – step-down from CSC, or other referral)?
• How might the Board establish what are the essential features of an effective FSP process?
• Would the Board consider reviewing the co-ordination of FSPs, given the lack of co-ordination exposed in this review?
• How might the Board and its constituent agencies promote a reflective and challenging approach in the FSP process? Is there a way to keep checking whether this is the right process (rather than just follow a process blindly)?
• Given the important role of the FSP process for early help with families, it is vital to be clear about its vulnerabilities and what it cannot do. How will the Board tackle this challenge?
• How can the Board ensure that all inter-agency frameworks, including ‘consent-led’ FSPs, keep the safeguarding of children at the forefront of everyone’s minds?
• How can the Board measure (and provide for) the skills needed for professionals to work effectively using a consent-led process? What are the skills needed for TAF members?
• How can an effective Early Help process be resourced?

In addition:

• The Board should review actions taken in response to the recommendations regarding CAFs which appear in several recent MARs.

### 13.2 Finding 2: The CAF process in Norfolk risks being parent – rather than child – focused as a consequence of its being voluntary and consent-led, with the result that the individual needs of children are not adequately addressed. (Multi-agency long-term work)

The FSP (previously CAF) is described in guidance as a consent-led support process, and this means that it cannot be undertaken without parental agreement in the first place. But this should not prevent the FSP being driven by the interests of the children. The idea that parents need to be kept ‘on board’ can in some cases shift the attention to meeting their needs and following their wishes, with the result that their children’s needs are seen and interpreted largely through them – possibly inaccurately.

#### 13.2.1 How did the issue feature in this particular case?

As is usual for CAFs, the Lead Professional (the original Norfolk Health Visitor) filled in the CAF application with Mother, who thus had the principal input into the identification and definition of issues which she would like to be addressed in the Team around the Family (TAF) meetings.

In these meetings, Mother’s self-reporting of what was going on at home – for her and for the children – was generally accepted as true, and there was little if any challenge or exploration of these accounts. Small, positive changes reported by Mother were given undue weight by TAF members, and records of the meetings indicate that when these changes were not sustained, there was little critical exploration about this. In fact, when the first series of TAF meetings ended (November 2011), one member of the group, in her conversation, reported that there were ‘no difficulties at school or at home’.
The new larger home was assumed to be a positive change, especially for the children, and the impact of a new baby on a mother, who by her own account was struggling to care for her other children, was not apparently considered.

Members of the Case Group said they would not have felt entitled to question Mother’s statements, nor to use other means, such as home visits, to gather more information about the family’s circumstances. They were conscious that Mother could withdraw her cooperation from the process at any time, and they did not want this to happen. (One example of this reticence was that the TAF group saw it as very positive when the family moved to a house with one more bedroom – something that Mother had long wanted. No one considered visiting the home to see whether the children were now benefiting from having more space. It was only in late 2012, when a Core Assessment was undertaken, that workers going into the home found that one of the bedrooms was not being used for the children, but as a storage space, and that Child 2 and Child 3 were still sharing a room.)

The professionals in the TAF meetings appeared to view the process as supportive of Mother, and the plans did not adequately define nor measure the desired outcomes for the children. This was in spite of the fact that (see below) the focus of the CAF is meant to be on the child’s additional needs. All of these children had additional needs, and some of these were both severe and very concerning (e.g., Child 1’s deliberate self-harm; up to two years’ learning delay for Children 2 and 3). The ADHD Nurse felt the TAF meetings ‘did not really grip the issues after the first meeting’, but instead accepted Mother’s updates of progress without demur.

It now also seems likely that Mother’s descriptions of Father were designed to keep him from being included in the process, and may have been untrue. (See Finding 7, below)

**Domestic abuse:** The first TAF meeting included in its plan the statement that: ‘All the children including unborn baby to be safe and not experiencing domestic violence.’ This was based on a history of DA (which only some members of the TAF group were aware of), and the fact that the family had recently spent two weeks, apparently escaping from Father, in a women’s refuge. In addition, Mother advised the group that her and Father’s arguments continued to upset the children. At each meeting thereafter, there was a brief record to say that Mother reported that there were now agreed arrangements between her and Father about his visits, and there had been no further problems. As a consequence, she said, the children were calmer and less anxious. These statements were not questioned, including when Child 3’s ‘Wishes and Feelings’ questionnaire stated that he didn’t like his parents fighting; Mother said this was an outdated historical account, and no longer the case.

For the reasons outlined above, the group’s response to Mother’s reports about how the risks from Father were being managed was passive. No doubt they felt reassured that progress was being made.
13.2.2 **How do we know it is not peculiar to this case?**
Review Team and Case Group members described usual practice for professionals in a TAF group, in line with the principles of the CAF process: that it is voluntary, parent-led, with the purpose of meeting the additional needs of children. The parent/parents are entitled to choose the Lead Professional, as someone they know and feel comfortable with, and to limit the level of information-sharing about themselves and their family.

*(Finding 5 below suggests other reasons why professionals tended to believe and want to support this mother.)*

**Different skill set needed**
The FSP Strategy Manager (a post which has replaced the CAF Co-ordinator) for the county and the three Divisional Advisers continue to audit how well CAFs are being used and the outcomes for children. Their view is that working in this voluntary framework requires a particular set of skills from the professionals who make up the TAF network, and it is not surprising that these skills are not consistently present. Among other things, ‘disguised compliance’\(^\text{13}\) by a parent can be particularly difficult to manage in the CAF/FSP, given the constraints felt by professionals described above. Conversely, aggressively non-compliant parents can intimidate and undermine professionals’ attempts to work with families and children.

13.2.3 **What numbers of cases are affected, and how widespread is the pattern – local, regional, national?**
CAFs were introduced nationally in 2003, in conjunction with the Report of the Public Inquiry following the death of Victoria Climbie, as a means of providing early help to children who have additional needs. A group of professionals, led by a Lead Professional and in partnership with parents, would then decide how these needs should be met, via a multi-agency plan for service provision.

But, as Brandon et al (2009) noted, ‘*Many of these families are not straightforwardly voluntary or co-operative, which provides considerable challenges for making the voluntary CAF system work.*’ (p62) The system will only succeed in helping and protecting children if professionals are confident about working with and supporting parents, but maintaining a focus on the needs of the children. They must be able to recognise when it is necessary to step-up to a different framework for intervention, and how to put this across when there is no obvious change in presenting circumstances. (See finding from Multi-Agency Review of Child I, reported in Para 13.1.3, above.)

13.2.4 **What are the implications for the reliability of the multi-agency child protection system?**
In their study of SCRs between 2005/07, Brandon et al noted the responsibility of all practitioners to remain ‘aware of the risks of significant harm to children across all levels of need and intervention’:

\(^{13}\) Reder et al, 1993
'For the many children who did not come to the attention of children’s social care [or who did not reach the CSC threshold], abuse or neglect should have been considered a possibility by all who came into contact with the child. These children serve as a reminder of Lord Laming’s comment that “child protection does not come labelled as such” (VC Enquiry, 2003). This comment continues to have significant implications for all practitioners.’ (2009, p60)

The voluntary nature of the CAF/FSP process should not divert professionals from this aspect of their safeguarding role and responsibility towards children. If it does, then children may continue in circumstances of needing, but not receiving, appropriate help and protection.

**Finding 2: The CAF process in Norfolk risks being parent – rather than child – focused, as a consequence of its being voluntary and consent-led, with the result that the individual needs of children are not adequately addressed.**

The CAF process in this case was seen to rely on the voluntary participation of Mother, and it led to a reluctance to criticise or challenge what she reported at each meeting, for fear of losing the parent’s cooperation. There is a difficult tension between this principle, of engaging and involving parents, and the original aim, that the CAF should be about identifying and meeting a child’s additional needs. This case demonstrates the risk that the needs of children may be unfaithfully, or falsely, interpreted by a parent, and that the TAF members may be steered away from a clear and robust focus on the children’s needs, on the parenting they are receiving, and on desired outcomes. This risk seems particularly present for large sibling groups, where there may be a wide range of additional and ‘special’ needs, covering different age groups.

**Considerations for the Board and agencies**

- Are the vulnerabilities of the CAF/FSP process a recognised problem in Norfolk?
- Have the changes from CAF to FSP addressed the limitations of the CAF exposed in this case review?
- If not, what further efforts should be made?
- Are there ways in which the suitability of a case for a voluntary process like the FSP can be established more appropriately – at any point in the process?
- To what degree can the FSP become a child-centred, not a parent-centred, process?
- What would demonstrate improvement in the working of this system – e.g., that it was being used for the ‘right’ cases more frequently?
- How will the Board measure outcomes as a result of the changes in the FSP process?
Working with neglect

There is a plethora of useful research evidence about different aspects of working with childhood neglect, most of which highlight the complexity of the work and the challenges to ‘getting it right’. What we have tried to do in the following three Findings is to identify what patterns, or systems, may be affecting the ability of practitioners here in Norfolk to offer better protection to children who are being neglected by their parents.

13.3 Finding 3: There is evidence that some professionals most readily recognise neglect in terms of poor home conditions, rather than more general deficits in child-parent relationships and care. This can leave children at greater risk (and parents unsupported) from a range of neglectful behaviours that go unnoticed. (Multi-agency long-term work)

In this case, there was evidence that the poor state of the family home was what was most likely to catch the attention of professionals (and even this was seen in the light of the overwhelming demands on Mother). This chimes with a traditional and persistent understanding of neglect, which has relied on physical signs, such as squalid home conditions or a smelly and unkempt child. More recent research evidence has uncovered how differently we now need to recognise and assess many other important facets of neglect, and the related long-term harm to children:

‘The perception of child neglect has changed significantly over time. It is now recognised as one of the most dangerous forms of abuse because of its harmful and sometimes fatal effects (Turney and Tanner, 2005).

Neglect can be difficult to define because most definitions are based on personal perceptions of neglect. These include what constitutes “good enough” care and what a child’s needs are. Lack of clarity around this has had serious implications for professionals in making clear and consistent decisions about children at risk from neglect.’ (NSPCC, 2012)

13.3.1 How did the issue feature in this particular case?
Before the period covered by this SCR, an outline chronology of professionals’ involvement with the family features several reported incidents of DA, witnessed by the children, as well as accidents to the children, which appeared to relate to inadequate supervision. These include 3-year old Child 2 falling from a first floor window, and suffering two other injuries at about the same age, outside of adult supervision (once when found with ‘bump on his head on the main road at dusk, wearing grubby T-shirt and nappy’). The chronology includes repeated comments from Police and Health Visitor that Child 1 ‘is the carer’ for her younger half-siblings, and that Mother ‘has difficulty providing stimulation for the children and often leaves them in front of the TV’.

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14 Referral from NSPCC to Norfolk CSC, October 2005
15 Norfolk CSC Core Assessment, December 2005
The referral to CSC (March 2011) suggested that there were a number of ways in which Mother was neglecting her children, as observed during their stay in the refuge. The attention this received within CSC, however, focused on the ‘appalling’ state of the property when they left the refuge, and this chimed with an Initial Assessment carried out in the previous year, when the family’s physical home conditions were also the main focus – even though the referral in that instance had been about a ‘bust-up’ between Mother and Child 1.

Some professionals working with the family were aware of other aspects of the children’s care which were not up to standard. For example, the school-age children did not have PE kit nor adequate uniforms. They regularly missed school, either through absence, or very routinely coming late to the start of the school day. This poor attendance was in the context of significant learning delay, with Child 2 and Child 3 each already a year behind in school and now falling further behind.

The level of schooling missed, which was Mother’s responsibility, was harmful to the children, and it is surprising that it was not seen as neglectful, in the wider context of what was known.

After the birth of the fifth child in the family, there was a deteriorating pattern of missing children’s essential health appointments (For details, see Finding 4 below). The baby, Child 5, was seen by the Health Visitor in his first year to need more freedom to move about and exercise, but her suggestions of taking him to play settings where this could happen were not complied with by Mother. It seems likely that Child 5 spent many hours each day in his car seat. Finally, the fighting between Child 2 and Child 3 and the physical risks this posed were flagged up by Mother at TAF meetings, but her inability to manage this behaviour and protect the children was, again, not seen as neglectful.

The Review Team found it striking that the quality of the children’s care was not regarded – at least not in the ongoing TAF meetings or the ADHD reviews – as of serious concern or as presenting a risk of harm to the children. Even the poor state of the house, picked out as the most significant aspect of the referral to CSC, did not prompt a home visit by anyone in the CAF process, bar the Health Visitor who found it very cluttered – with not enough space for the baby to develop physically.

In this case, there seems to have been an assumption that offers of support for Mother via the CAF would improve the home conditions (plus the fact that she finally got the larger house she wanted). The ongoing evidence of the children’s emotional and behavioural difficulties was, as already stated, not recognised as signs of neglectful parenting.

13.3.2 How do we know it is not peculiar to this case?
The table below sets out broader information about how ‘Neglect’ is dealt with by the safeguarding children network in Norfolk.
1. Previous Multi-agency Reviews within NSCB
   A recurring theme has been the challenge of working with neglect – sometimes ‘low level’ and poorly perceived – and sometimes chronic and more severe, but with professionals often feeling helpless to make a ‘difference’. There has been a flawed understanding of what constitutes neglect and the impact on children over the long term.

   Lessons from these reviews have not adequately been translated into learning and practice improvements.

2. Ofsted Inspection Report, 2013
   This highly critical report noted that ‘…the issue of neglect is acknowledged by partners interviewed to be a prevalent issue in the county, with partner agencies stressing the importance of appropriate shared responses, but there is as yet no overarching strategy in place to ensure that all agencies’ front line services recognize and respond consistently to the issue.’ (Para 57)

3. Referrals to the SCR Group of NSCB
   Neglect is a recurring theme in the referrals coming to the SCR Group for review, not all of which meet the criteria for an SCR.

4. Prevalence in Norfolk
   Neglect is overwhelmingly the most common category for children on CP Plans, with 69.45% of cases having this as the identified main area of significant harm (end April 2014).

It isn’t surprising that, for many professionals, an unhygienic, cluttered, possibly unsafe home environment for children signals that a parent is struggling to look after his/her children adequately. A number of case reviews and Serious Case Reviews suggest that, as a result, concrete solutions (e.g., a clean house) are often seen as the answer, in place of a wider understanding of how the parents are unable to perceive and meet their children’s needs.

An NSPCC review of research on neglect (2012) suggests various ways in which partner agencies may struggle to identify other features of neglect:

‘Most neglectful families have complex needs so interventions frequently involve different agencies. Practitioners’ understandings of neglect, however, are often shaped by different professional backgrounds and can vary within and across different services. This can contribute to vital pieces of information, being lost or not being effectively communicated across agencies. An effective interagency approach to cases of neglect is essential.’

On a positive note: the NSCB is currently responding to concerns about the quality of practice in this area. The county-wide Neglect guidance (2008), is being updated as part of the work on a neglect strategy, and one planned
element of the strategy will be the adoption of a standardized tool for assessing neglect – the Graded Care Profile (GCP). Based on Maslow’s hierarchy of needs, this offers a model of assessment which addresses four areas, or “domains” of care – physical care, safety, love and esteem. The professional filling in the GCP form should not give ‘reasons’ for the behaviour observed, making it less easy to offer parent-centred observations (e.g., about a busy, disorganised parent; or a parent who is ‘trying their best’). Practitioners are asked to judge the outcome of the parenting which they observe against simple predetermined criteria. The GCP is structured to help workers identify the range and complexity of neglect, within the four domains of care. This model should also clarify how neglect need not be chronic to be harmful, but may indeed pose grave risks for a child at any given moment.

13.3.3 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?

Nationally, neglect of children is a significant area of risk and harm. Gardner explains:

\[\text{Neglect makes up half of all child protection registrations (cases requiring a multi-agency protection plan); up to three quarters in some areas when joint categories of registration are included. A high proportion of children who are looked after have suffered neglect. All professions agreed that thresholds are so high that these figures represent the extreme tip of a much bigger phenomenon. Community based workers such as head teachers, school nurses and health visitors in some areas described up to eighty per cent of children they saw as showing signs of neglect. (2008, p3)}\]

Action for Children’s recent study on neglect adds the following evidence:

\[\text{[Neglect] was a factor in 60 per cent of all reviews into the deaths and serious injuries of a child. It can affect children and young people of all ages and includes deaths related to malnutrition, medical neglect, preventable accidents and suicide among young people. It was a feature in over a quarter of child homicides and fatal physical assaults. (2014, p3)}\]

Finally, the NSPCC reports that

\[\text{Neglect is the most common reason for someone to contact the NSPCC and...is the most common reason for a child to be put on the child protection register or to be made subject to a child protection plan in the UK. (NSPCC, 2012)}\]

Despite the fact that many professionals will encounter neglect on a regular basis, they continue to respond less effectively to children living in chronically neglectful circumstances, in comparison to ‘incidents’ of physical harm or allegations of sexual abuse. The latter tend to elicit a more confident use of formal CP investigations and CP Plans. In the case of neglect, there seems less certainty for a number of reasons:
• The harm to children is usually less concrete and visible.
• Neglectful home conditions and parental behaviours tend to fluctuate, with parents improving the care of their children from time to time, when pressure is imposed by professionals (e.g., via the CAF).
• Each single example of neglect may not be enough in itself to hit a threshold for more assertive CP action.
• It becomes hard to know when ‘enough is enough’ and when more assertive action needs to be taken.
• Neglectful parents are usually very vulnerable adults who themselves need support and help, and this may distract from the situation of the children. (Mother, in this case, demonstrated what Patrick Ayre has called ‘Depressed neglect’ – with ‘no structure, poor supervision, care and food’.16)

Added to this list is evidence that ‘Neglect and emotional harm are some of the most highly stressful and demanding areas of work for individuals and groups of professionals.’ (Gardner, 2008:8) In order to work effectively, they require high quality training, reflective and challenging supervision, and a framework of a neglect strategy which is championed from the highest levels of their organisations.

The consequence of uncertainty about when and how to act is that cases drift and children remain in neglectful circumstances. In their recent thematic survey of neglect cases, Ofsted noted that ‘One third of long-term cases examined on this inspection were characterised by drift and delay, resulting in failure to protect children from continued neglect and poor planning in respect of their needs and future care.’ (2014, p4)

13.3.4 What are the implications for the reliability of the multi-agency child protection system?
There is ample evidence from national research that professionals across agencies struggle with recognising the nature and extent of neglect in families – despite the fact that harm to children from chronic neglect is increasingly identified as most damaging of all. When neglect is recognised, there are further challenges in creating an effective, child-centred plan for intervention and improvement. This is not made easier by the fact that many neglectful parents have longstanding emotional difficulties, which may be exacerbated by mental health problems (including depression and personality disorder), or a degree of learning disability.

The very recent Ofsted and Action for Children reviews of practice in this area indicate the degree to which local and national bodies need to create a more effective, multi-agency approach/framework for responding to neglect. Without this, children will continue to suffer significant harm in a way that, as in this case, is not recognised as a product of neglect. The NSCB’s intention to focus on neglect this year is a positive and hopeful development.

16 Patrick Ayre, Why do they carry on that way? Understanding and responding to neglect, Powerpoint presentation to Tavistock Training for SCR Authors, 2010
Finding 3: There is evidence that some professionals most readily recognise neglect in terms of poor home conditions, rather than more general deficits in child-parent relationships and care. This can leave children at greater risk (and parents unsupported) from a range of neglectful behaviours that go unnoticed.

National research, alongside practice wisdom, is very clear that neglectful parenting should be seen as far wider than poor home conditions (despite the fact that these can reflect a more general disregard of children’s needs). Neglectful parenting is almost inevitably a sign of complex and longstanding problems for a parent his/her herself. Although these causes of neglectful parenting need to be assessed, the focus of multi-agency work must remain on the children, who are not receiving adequate care – physical, emotional and psychological – in their daily lives. Both in the short- and longer-term, they are suffering harm which needs to be identified and understood to be a result of neglect.

Considerations for the Board and member agencies

- What data does the Board collect about neglect in Norfolk? Is it possible to create a ‘profile’ across the county? This might assist in understanding where it also relates to poverty and social deprivation.
- What is known about how neglected children are enabled to seek and receive help? Or how their parents are enabled to seek and receive help?
- Given that schools are well-placed to recognise neglect, how can they be supported to work with multi-agency partners to get appropriate help to children and their parents?
- What is known about the support workers in Norfolk need in working with neglect? (Social workers overwhelmingly pointed to informal and formal support from colleagues and supervision from their line managers as most helpful in working with neglected children, enabling them to remain balanced and objective so that the needs of the child remain paramount.) (Ofsted, 2014, p30)
- Are there professionals in agencies who do have the required knowledge and skills in this area, who could support others more widely?
- Is Norfolk’s neglect strategy linked to national strategic developments in this area?

(The following three questions are adapted from ‘Noticing and Helping the Neglected Child Literature Review’, Daniel et al, DCSF Research Brief, 2009)

- Does the Board know to what extent practitioners are equipped to recognise and respond to the indications that a child’s needs are likely to be, or are being, neglected, whatever the cause?
- What is known about the ways in which children and families directly and indirectly signal their need for help?
- Does the evidence suggest that [in Norfolk] professional response could be swifter?
Practical suggestions

- The Board (or the task group working on neglect) should consider the evidence and guidance in *Child Neglect: the scandal that never breaks*, Action for Children, March 2014
- Assessments of neglect need to consider ‘not only the child’s perspective and experiences, but also…the long-term prognosis for change and the potential long-term impact on children living with neglect.’ (Ofsted 2014 p19)
- The Board should develop ‘effective methods to map and measure the impact of neglect on children over time and to evaluate the effectiveness of interventions’. (Ofsted 2014 p5)

13.4 Finding 4: There is no system to track/recognise patterns of missed appointments, within and especially across agencies, making it harder for professionals to share a critical sign of neglectful parenting.

(Management systems)

Patterns of missed appointments (DNAs) for children, and their significance, are difficult to recognise, for a number of reasons. They are recorded and information is shared about them in different ways within and across agencies. The significance of each individual DNA is not necessarily obvious, especially when a wider pattern of non-compliance is not known about.

13.4.1 How did the issue feature in this particular case?

Mother’s patterns of non-engagement with services included a number of different behaviours. She was often impossible to reach on the telephone, even by her children’s schools. In some instances (e.g., late 2011 and early 2012), this might go on for several weeks. She appeared to agree with plans made at the Team around the Family meetings, but regularly failed to carry through with actions (e.g., to take Child 5 to a Children’s Centre to give him opportunities to play and develop physically, as well as socially). The TAF meeting minutes do not include a record of these difficulties, nor of any missed appointments, nor the discussion which might have taken place about the impact on the children.

An example of Mother’s pattern of approaching professionals for help and then declining further contact was her involvement with the Consultant Clinical Psychologist in the ADHD service: on two separate occasions, she asked for a referral to him, attended for a consultation about ways to manage Child 2 and Child 3’s behaviour, and then did not turn up for the agreed further sessions.

Throughout the period of the case review, but increasingly in 2012, Mother failed a number of the children’s health appointments. These included the following:

- speech and language input (for two of the children)
- investigation for chest pains (Child 2)
• neurophysiology checks for the possibility of epilepsy (Child 3)
• hearing screen tests (3 missed) for Child 5
• paediatric dietician for Child 2 (following referral from the community Paediatrician in August 2012, the chronology notes: ‘parents have not contacted department to arrange an appointment, therefore Child 2 discharged without receiving dietary advice’.)

In addition, Mother declined to use any of the activities offered by Sure Start, to benefit the younger children’s physical and social development and to deal more generally with the family’s isolation.

At school, as we have seen, the children missed an unacceptable proportion of their education, and Mother rarely attended important school meetings such as parent-teachers’ meetings, SEN reviews, or Attendance Panel (November 2012), to discuss the children’s poor attendance.

One class teacher said that Mother ‘was never resistant to meetings being held, but when she didn’t attend meetings this felt like it was a consequence of her disorganisation rather than avoidance.’

The consequences for the children would be the same, whatever the reasons for Mother’s failure to attend appointments or meetings. This is neglectful parenting, and should be seen in this light. Children are unable to access these services without their parents’ support, and where this is not provided, they simply do not receive the services which they need for their healthy development and wellbeing.

13.4.2 How do we know it is not peculiar to this case?
Using their knowledge and experience, members of the Case Group and Review Team did not see this pattern as unique or indeed unusual.

The lists of failed appointments and other areas of non-engagement have been compiled from chronologies produced for this SCR. In these formats, patterns of non-compliance and DNAs stand out, and can be recognised more readily. But this is not easy under normal operating circumstances, in busy agencies. Instead, electronic systems are different and do not speak to each other; agencies have various responses to DNAs, and various ways in which they communicate about them (e.g., from hospital departments back to GP referrers).

The meaning of individual missed appointments varies, with some being critical and others insignificant – and, in some cases, to be expected. We know from GP surgeries, and other health settings – e.g., outpatient clinics in hospitals – that failing appointments, with or without notice, is extremely common, and creates a problem for these services. For example, GP surgeries may regularly experience up to 9% DNAs for each session, and Paediatric services report a higher percentage, at 15% DNAs. In these

17 A recent SCR in a London borough, with a similar finding about DNAs, discovered up to 25% DNAs as routine in the GP practice, and generally not explored further.
busy settings, it is difficult to know which non-attendances are worrying. (Locally, GP practices are making successful efforts to reduce DNAs, by sending text message reminders to patients who have appointments.)

It may be difficult to achieve an understanding of its significance, when a child is not being brought to health appointments, including those which relate to his/her emotional health. And a pattern of DNAs for a child may not be recognised as such, given the complexities of operating these systems, for a variety of reasons:

- By their nature, missed appointments and DNAs occur as “drip, drip, drip”, and rarely ‘stand out’. The impact is therefore diluted, and patterns may be missed, or go unnoticed for some time.
- Different agencies have their own ways of recording and responding to DNAs, and may not share the information with anyone else (indeed, may not be allowed to).
- The opportunity to pool information about the patterns of non-attendance for the children in regular meetings, such as the TAFs in this case, is not always utilised.
- Some appointments (e.g., Children’s Centre services) are voluntary, and therefore the parent is seen as having a ‘right’ not to attend – despite the negative consequences for the child.
- There is no individual agency who has both the access to all the information or the capacity to analyse what it means

13.4.3 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?
It is not known the extent to which this pattern exists in other parts of the UK. However, it is likely that the variations in how missed appointments are regarded, recorded, and dealt with are common elsewhere. The degree to which patterns of DNAs for children are linked to neglect is unclear.

13.4.4 What are the implications for the reliability of the multi-agency child protection system?
Parental control over children’s access to necessary health and other developmental services means that a child may be neglected in a way that causes harm, but which – for the reasons outlined above – is not readily recognised by agencies working with the family. This represents a significant risk for children’s health, development, safety and general wellbeing. As things currently stand, the potential and actual damage done to children, whose health and educational needs are being neglected, can continue and remain unnoticed by professionals, even those who are working closely with a family. Finding ways to diminish this risk is a serious challenge to the Board and member agencies.
Finding 4: There is no system to track/recognise patterns of missed appointments, within and especially across agencies, making it harder for professionals to share a critical sign of neglectful parenting.

This case demonstrates the ease with which patterns of behaviour that might appear glaring with hindsight can be missed at the time. A number of factors make this more likely: if a case is being managed at a threshold level without any inbuilt mechanism for independent review or scrutiny; whether the professionals with whom the (missed) appointments are made are part of the TAF or outside it; if they are outside it, what are the mechanisms, if any, for making sure that their perspectives are included within meetings.

Considerations for the Board and member agencies

- Does the Board recognise this as an aspect of neglectful parenting which requires more attention?
- Does the NSCB have access to type of information about the performance of the system in relation to the monitoring and response to DNAs and missed appointments, to assess improvement in this area? Is a change needed to the information collected and analysed?
- Are multi-agency partners aware of their respective definitions and procedures in relation to identifying, recording and responding to missed appointments and DNAs for children, including ways that they are similar and/or different, why and to what effect?
- Is there a piece of work to be done on how agencies can track and share information about missed appointments and DNAs across a multi-agency network when working together – including in FSPs, as well as Child in Need and CP cases?
- Could the Board help to identify when/how practitioners should intervene to overrule parental choice in not taking children to essential medical appointments?
- All NHS providers in Norfolk have a DNA policy that requires a risk assessment for DNAs. Are there audits or monitoring tools to evaluate how well these are working? Are other agencies in the safeguarding network sufficiently aware of the policy/policies?

Practical suggestions

- Multi-agency meetings such as the TAFs (or Core Group meetings, for CP cases) could list the forthcoming appointments for the children in the family, and review these at the next meeting – thus creating a system for flagging up any problems.
- The recommendation from the NSCB’s Multi-Agency Review (MAR) of Child D (2011) should be revisited by the Board: ‘All services should have processes for follow-up when children do not attend appointments. These processes should include a risk assessment and a plan to facilitate attendance if it is felt to be in the child’s best interest.’ (Para 22.8)
13.5 Finding 5: There is a tendency for professionals to make allowances for struggling parents, which militates against recognition of neglectful behaviour and child-focused practice, leaving children at risk of long-term harm. (Family-professional interaction)

Those working with children, in education, health and social care settings, are inevitably involved with their parents as well. For users of many Tier 2 and Tier 3 services, the parents are themselves vulnerable, may be struggling with poverty and social isolation, and may have unmet needs which affect their parenting capacity. A natural desire to help and support these parents can result in making allowances for their difficulties, and can distract from seeing and addressing the unmet needs of the children in the family.

13.5.1 How did the issue feature in this particular case?
A few months before this case review period (2010), CSC carried out an Initial Assessment (IA) of the family, in response to a Police referral about a fight between Mother and Child 1. The first visit to the family by Police reported a squalid and unhygienic home, and a statement by Mother that she no longer wanted Child 1 to live there. The record of the IA, which was somewhat delayed after this visit, included the following information:

‘no professionals contacted during the IA process disclosed any concerns regarding Mother’s parenting, all praising her for the way she copes with three children who have ADHD.’ (N.b., There were two, not three, children diagnosed with ADHD.)

‘The Health Visitor states she has no concerns in regard to the care given to the children considering the daily challenges Mother copes with.’
(author’s underlining)

It could hardly be more clear how this mother and her parenting were viewed, through two explanatory prisms: sympathy for the mother’s circumstances, and low expectations for what might be changed in the family. In conversations, some members of the TAF meetings stated that they had limited expectations of what she would be able to improve in caring for her children. By extension, this equated to low expectations for outcomes for the children.

Mother was described by several professionals as having a warm bond with her children, but also that she found it difficult to give them adequate care. She ‘had good intentions, but easily forgot’, according to her Health Visitor, who was trying to get Mother to provide more stimulation for her youngest child. One of the boys’ teachers described her as a ‘busy, disorganised single mum’, and the boys’ regular lateness to school was put down to the long journey Mother had to bring them to school each day. A Family Support Worker said ‘She felt sorry for mum – ‘poor woman’, ‘had a horrible time’, ‘had nothing going for her’.

At the same time, Mother was clearly not meeting all her children’s needs – most obviously, the older boys’ need for consistent attendance at school. It
seems, however, that professionals were largely sympathetic, and inclined to make allowances for this and other deficits; for example, her time-consuming drives to school were accepted as a reason for the boys being late on a regular basis. She was, after all, caring for 4/5 children, with a range of additional and some special needs, including challenging and aggressive behaviour, severe anxiety (including deliberate self-harm by Child 1), and the boys’ poor sleeping patterns (‘up until 1 or 2am playing on Xbox’). Her ex-partner was portrayed as a ‘looming presence’, and Mother frequently said she was fearful of his behaviour in the home, thus casting herself in the role of victim.

There is no record that professionals discussed, or were aware of, the idea that children with special needs required a quality of parenting ‘over and above’ the average. Neither was there recognition of the environmental component of ADHD. Mother’s ongoing experience of depression was known to the TAF members; but, again, the idea that this might adversely affect her ability to care for the children was not addressed.

As we have seen above in Finding 4, Mother’s failure to take children to important appointments was not seen as neglectful. Instead, this was explained as her being ‘disorganised’, with the implication that she needed to be provided with help, but also that it would be difficult for her to be otherwise, given the family’s circumstances. There were a number of times when the boys’ non-attendance at school reached the threshold for legal action, but this step was not taken. Her disguised compliance, in the TAF meetings and elsewhere, was not recognised.

13.5.2 How do we know it is not peculiar to this case?
Some parents in Mother’s circumstances, who have a history of emotional difficulties and conflictual relationships, are likely to have complex unmet needs themselves, relating to their personal and family history. Thus, they will often absorb a lot of the professionals’ attention and concern, as well as sympathy. The needs – and the voice – of the children may then be overlooked. (Example: In this case, one of TAF meetings considered the ‘Wishes and Feelings’ form from Child 3, which clearly described his unhappiness about physical conflict between his parents, and Mother physically punishing Child 2. The minutes show that Mother was able simply to assert that Child 3 was referring to something that had happened in the past, and this was accepted.)

A Norfolk Multi-Agency Review (of Child D, 2011) included a very similar finding, as follows:

‘Professionals had sympathy for Stepfather and his struggle to care for D and the other children. It appears that this sympathy may have at times caused them to minimise their concerns regarding [his] parenting and offer him a high level of support…This focus on Stepfather’s neediness and difficulties appears to have prevented professionals from keeping D at the centre of their interventions.’ (Para 21.11)
‘Disguised compliance’ by a parent, is known to be effective in keeping professionals from taking more assertive action in relation to children’s poor care. This was a common feature in cases reviewed by Ofsted (2014) and by Reder et al (1993). The effect, as in this case, was to reassure professionals, based on the parent’s intention to cooperate and/or change their parenting behaviour in order to meet their children’s needs.

An associated, and frequently encountered, attitude from workers is a failure to identify neglect as a CP matter, when the harm to the children is seen not to be intentional by the parent(s). This reluctance to judge parents is another understandable human response, but it can contribute to responses which allow the harm to children to go unnoticed.

13.5.3 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?
This pattern is likely to exist in all parts of the country, given that it springs from a normal human response by professionals to parents who are ‘struggling’ and apparently trying to cooperate. This applies to a large number of families known both to universal services, and especially to targeted services; they are often single-parent households, with a range of practical and social problems and emotional vulnerabilities. Most professionals in health, education and social care want to help the parents, and believe in the possibility that change is possible. The evidence about disguised compliance, however, adds an extra layer of complexity to professionals’ responses.

Brandon et al (2009) have also identified an associated vulnerability in practice, found in the SCRs they reviewed between 2005/07. This was where professionals’ efforts not to be judgemental towards parents resulted in a failure to exercise professional judgement: ‘There was reluctance among many practitioners (including among health and social work staff working with children) to make negative professional judgements about a parent.’ (p47)

13.5.4 What are the implications for the reliability of the multi-agency child protection system?
Strengthening and supervising the skills and awareness of professionals in working with vulnerable parents will require concerted effort by the NSCB and constituent agencies. This is a complex and difficult area of work, and this case has demonstrated how the neglectful care of children can be poorly understood, especially where there is legitimate reason to sympathise with and wish to support a vulnerable parent.

The framework and tools for the work need to promote a consistent child-centred focus. Without this, the needs of parents may continue to distract from the neglect of children and the harm they are suffering.
Finding 5: There is a tendency for professionals to over-sympathise with struggling single parents which militates against recognition of neglectful behaviour and child-focussed practice, leaving children at risk of long-term harm.

Professionals in this case saw Mother as struggling with a large brood of children, having her own health problems, and with the threat of a violent partner in the background. She appeared to want to cooperate with professional plans to help her children, even though she rarely followed through with these.

Being kindly disposed towards a parent who is trying hard fits neatly with a government imperative placed on keeping families together, and supporting families under pressure. Combined with the principles of working voluntarily with a parent through the CAF/FSP process, this can create a natural bias towards ‘making allowances’ for ongoing parenting deficits, and accepting a parent’s reports of progress, despite little evidence to support this. This ends up being a largely parent-centred approach, and risks leaving the children’s circumstances poorly understood and addressed.

‘Disguised compliance’ has been recognised and written about as a powerful dynamic in working with families, often in cases where a tragedy has occurred. Staff in all agencies will inevitably need help – and challenge – to understand and anticipate this type of dynamic interaction and identify and rectify it when it occurs. Designing a safe system requires building in obstacles to prevent such a pattern going unnoticed and unaddressed – including in a voluntary, ‘early help’ framework.

Issues for the Board and member agencies to consider

- Is the Board aware of how ‘parent-centred’ responses present a difficulty in Norfolk? What might be the mechanisms for finding out more about this?
- What is known about the extent to which supervision identifies and explores family-professional interactions – both in individual sessions, and in multi-agency peer or group supervision sessions – especially where parents are compliant and ‘nice’?
- Are any other techniques used routinely to promote ‘respectful uncertainty’ in workers? (Sheryl Burton’s C4EO briefing\(^\text{18}\) has useful guidance about promoting this via supervision, case discussions, and peer reviews.)
- What other safeguards might be introduced?

\(^{18}\) Burton, S., The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information?, National Children’s Bureau, C4EO, 2009
Working with ADHD

13.6 Finding 6: There is a pattern whereby routine attribution of a label such as ADHD to a child distracts attention from what may be the result of poor parental care, resulting in a range of the child’s particular needs not being recognised and not met. (Family – Professionals interaction)

The way this family was understood by the professional network, and how it was handled in the different agencies, was significantly influenced by the naming of a ‘condition’ which was said to cause major problems for their mother in looking after them at home. As a result, the idea that the children might be affected by deficits in her parenting was not properly assessed for 18 months, and deterioration in the children’s wellbeing and care was not addressed. This finding overlaps with Finding 5, above, which describes how Mother was dealt with sympathetically, because her children ‘had ADHD’.

13.6.1 How did the issue feature in this particular case?
Two of the children in this family have been diagnosed with ADHD: Child 1 (now no longer a child) and Child 2. Mother suggested to professionals that Child 3 also had ADHD, but an investigation concluded that this was not the case. She also said that Father might have ADHD, and that this might account for his behaviour (it was unclear what she meant by this).

The family were therefore well-known to the Community Paediatricians and the ADHD Team. Child 1 and Child 2 received medication for their condition, and Child 3 was also prescribed medication to help regulate his sleep.

Records of the TAF meetings and conversations with the boys’ schools have suggested that the ascription of this label has been regarded as sufficient explanation for their emotionally distressed behaviour, and other problems (including poor use of speech/language, violent aggressive behaviour and/or being extremely withdrawn and unable to interact with others – as well as two years’ delay in their learning). Not only that, but it appears that most attention was spent in TAF meetings on considering how Mother could be supported to ‘manage’ the difficult behaviour of her older sons. Child 1, despite her ADHD diagnosis, was by this time assisting Mother as a carer for the youngest siblings, and her own needs were not a focus of attention.

13.6.2 How do we know it is not peculiar to this case?
We have already noted, in Finding 2, that Mother spoke for and interpreted what was going on in the family at the TAF meetings. This chimes with the way that ADHD is generally approached, especially for younger children, with Paediatricians relying principally on what parents tell them about a child’s behaviours in order to reach a diagnosis. Observations at school (less often at home) may sometimes be added to the picture, but this is not always the case. There would be considerable resource implications for observations to include both school/nursery and home.

We have also noted that there is a significant ‘secondary gain’ (Disabled Living Allowance) for parents to have this label for a child. There are also
other less tangible gains for some parents who consciously or otherwise experience this label as permission not to acknowledge their own difficulties in the parenting role. So, it seems there are reasons to wonder about how ADHD diagnoses are made – especially in light of the growing numbers in Norfolk, and the very high prescription of ADHD drugs in the county.

What we found in this case was that professionals in the TAF appeared to accept ADHD as a purely objective medical diagnosis. There is little evidence that consideration was given to the impact on the children of social or environmental aspects of the ‘condition’, in particular the parenting they received. The idea that they were being neglected, including lack of proper attention to their physical safety and wellbeing, and to their emotional needs, as well as inappropriate use of physical chastisement (admitted by Mother at a TAF meeting), was not explored.

The ‘supportive’ nature of CAFs, already referred to above, synchronises with an approach which saw Mother as the ‘carer’ of children with a particular diagnosis, rather than as a parent with the full range of responsibilities for meeting all the children’s needs, such as helping them to learn how to regulate behaviour.

The approach found in this case raised the question for the Review Team about the adequacy of professionals’ understanding of ADHD, including in schools. There appears to have been poor awareness of the social and parenting factors which play a major role in how this ‘condition’ is either managed well or exacerbated. This suggests a need for more education about ADHD for those working with children in various settings.

13.6.3 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?
We do not know how commonly this ‘medicalised’ approach is adopted in Norfolk, or elsewhere. (This is something that the Board may wish to explore.) However, there are possible reasons why it might be so. For example, it is no doubt more straightforward to deal with ADHD as a medical phenomenon than to assess parenting deficits, with all the resource implications this entails. In the absence of adequate services to assess and support families, professionals may feel they have few options other than medical responses. In fact, services and funding follow ADHD diagnoses, in a way that they do not, for example, for ‘attachment disorders’ (which generally have poorer long-term outcomes). For the parent, the benefit of a solely medical interpretation of a child’s difficulties is that the possibility of poor parenting may go unexplored, and they may receive Disabled Living Allowance for their child.

13.6.4 What are the implications for the reliability of the multi-agency child protection system?
Children with disabilities, or ‘conditions’ such as ADHD, are children first, and a child with a disability, or condition, second. Professionals working with them and their families need to remain aware of all the child’s needs – for warmth, safe supervision, appropriate stimulation, proper attention to their health and
education requirements, and positive affirmation. The risks for children with conditions and labels are that their basic needs, which have nothing to do with their condition, are disregarded within a focus on the specific problems arising from his/her condition. In addition, their parents are often seen as deserving of extra support and sympathy (see Finding 5 above), rather than an assessment of whether they are meeting their children’s needs adequately. In fact, neglect may not routinely be seen as a factor affecting children with complex problems and behavioural difficulties, leaving them without a thorough assessment of the adequacy and quality of their parenting.

**Finding 6:** There is a pattern whereby routine attribution of a label such as ADHD to a child distracts attention from what may be the result of poor parental care, resulting in a range of the child’s particular needs not being recognised and not met.

The children’s mother in this family routinely asked for a medical diagnosis of her children’s difficult behaviour. The condition of ADHD was ascribed to Child 1 and Child 2; when Child 3 was deemed not to have ADHD, Mother asked for an assessment of Autistic Spectrum Disorder. The representation of the children’s needs and difficulties, as springing from ‘conditions’, served very effectively to divert attention from the overall adequacy and quality of the parenting the children were receiving.

This ‘diversion’ is often seen in dealing with children with a range of disabilities, where the parenting care is generally seen as a function of managing, well or not so well, the child’s medical or disability problems. The child’s basic needs for love, warmth, stimulation, play, learning, communication from his/her parents can be left poorly explored and poorly supported.

**Considerations for the Board and member agencies**

- Is this a problem recognised by the Board?
- What is known about the prevalence of ADHD as a diagnosis in Norfolk, including a comparison with comparator local authorities?
- What is the impact on schools overall of the numbers of children diagnosed with ADHD on their rolls?
- Do health professionals in Norfolk feel they have sufficient resources for providing holistic services for children deemed to have ADHD?
- How is the quality of parenting regarded in the understanding and treatment of ADHD in children?
- Is there training needed to help child care professionals, including those in schools, respond more effectively to children diagnosed with ADHD?
- Are there any triggers for undertaking parenting capacity assessments in cases where there are multiple diagnoses of medical conditions within a family?
Poor inclusion of fathers

13.7 Finding 7: Professionals involved in the CAF process are not commonly seeking the active participation of the less visible parent (usually the father), making them less visible to the professional process as well, and risking the loss of valuable information about parenting and children. (Human reasoning – cognitive and emotional bias)

A number of SCRs, as well as other research sources, have highlighted the negligible involvement of children’s fathers in the work of agencies with children. This neglect may mean not inviting a father to meetings, such as TAF meetings, not soliciting his views about his children, and, in some cases, not providing important information about his children. This is especially (but not exclusively) true for fathers who are believed to pose a risk to the children. The consequences are that those risks may go unassessed; a father may remain unaware of concerns about his children; and the potential benefits to the children from father and his family are lost.

13.7.1 How did the issue feature in this particular case?
Some of the information in this section came from a conversation with Father. This amplified the records which showed how he was/was not involved in the multi-agency work, and how he was regarded by professionals in the course of this work.

Father did not live with the family, but saw them on a regular, sometimes daily, basis. He wanted to be part of his children’s lives, and he also hoped to be helpful to Mother – though this was not always possible, or accepted by her. At times (though reported inconsistently by Mother), he clearly stayed overnight with the family, and was sometimes the carer for the children (e.g., when Child 5 fell over and hurt his nose in early 2013).

It quickly became apparent, in talking to the professionals in this case review, that few of them knew Father, had possibly never met him, or had only ‘seen him once or twice’ (outside the school). He was not part of their thinking, and there was little effort to consider his role with the children, or to include him as a parent who had a relationship and regular involvement with his children. This was true even within the TAF meetings/plans. The records of the first two TAF meetings suggest that Father was invited, but he states that he did not receive an invitation, and did not attend. It has not been possible to find out where the invitations were sent. After those two meetings, there appear to have been no further attempts to meet with him, or to find out what time the meetings could be arranged so that he could attend (before or after work). The only exception to this picture was the efforts made by the Sure Start Family Support Worker, who was tasked with getting the CAF process restarted in 2012.

The TAF meetings then made plans based on the understanding that Father needed to be kept out of the home, as Mother consistently represented any involvement with him as being a bad thing. This was not adequately explored, and it now seems that it may have been inaccurate. There is evidence that
their relationship continued to be stormy, but not necessarily that Father was the powerful aggressor towards Mother as a victim.

The suggestion that Father was a risk to his children is discussed below, under Para.18 Additional Learning. Suffice it to say here that this was not assessed, and in fact Mother frequently said that his violence was ‘in the past’. Her messages about this were inconsistent, but it seems that the CAF network of professionals came to regard him as a negative presence, if not currently a risky one. In all this, it was Mother’s voice which was entirely followed regarding a view of Father. This acceptance of Mother’s representation of the risk from Father may be an unintended consequence of raising the profile of domestic abuse or domestic violence, and exhorting professionals (rightly in most cases) to believe what the female victim has reported.

A later exception to the pattern of leaving Father out happened when the case moved into a Core Assessment and then a formal CP framework. Father was invited to the Initial CP Conference, and he did attend. It is less clear how much he was asked to contribute to the Core Assessment, as most of the information in it is still heavily weighted towards Mother and her descriptions and views about the family.

13.7.2 How do we know it is not peculiar to this case?
When asked whether they knew Father, the responses of health professionals, nursery staff, and Head Teachers and teachers indicated that it is routine in their practice for fathers not to be included in visits, meetings, or other events relating to their children’s care. On some home visits, the sense that Father was ‘in the garden’ or upstairs did not lead to an invitation to join the discussion of the children.

All this suggests a culture of disregarding fathers who are not living with their children (and even some who do), despite the fact that they may have very frequent involvement with them. The consequence of this lack of inclusion (as Father indicated very clearly was true for him) may be of great sadness for the parent. More significantly, it may contribute towards children losing the potential benefits of contact and a warm relationship with their other parent. Helpful information about the children from a regularly-involved father, as was true in this case, is lost when no one speaks to him.

Members of the Case Group and Review recounted how ‘gender bias’ of this kind is common in many children’s settings, including Children’s Centres and health services for children. For example, fathers are not expected to be present for Health Visitor meetings, even though they may share in looking after a small baby, and need to know how to offer safe care. Another reported example was given of schools not sending routine information about a pupil to fathers (with Parental Responsibility) who no longer live with their child.

13.7.3 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?
Brandon et al’s review of SCRs (2009), alongside a number of other high-profile SCRs (e.g., Peter Connelly), corroborates this as a common pattern across the country, where ‘absent men’ are often ignored within the professionals’ work with the mother and children. They identified the following:

‘The failure to know about or take account of men in the household was also a theme in a number of serious case reviews. Assessments and support plans tended to focus on the mother’s problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given histories of domestic violence or allegations of or convictions for sexual abuse. The failure to take account of men in assessments occurred sometimes even when good information was available.’ (p52)

Whilst Brandon was specifically referring to the risks posed by some men, the same concerns apply to the potential benefits that they might offer to the children. This case suggests that it is both universal services (Health visiting, nurseries and schools) as well as targeted services where this may hold true. In our conversation with Father, we found out useful insights about the children and their routine care which he may have been willing to share with professionals in the CAF process.

13.7.4 What are the implications for the reliability of the multi-agency child protection system?
Men who are regularly involved in children’s lives, whether as father, stepfather or a mother’s boyfriend, have an impact on their children. It follows that, where there are concerns about children’s care and the possibility of risks to their safety or wellbeing, the man needs to be assessed (just as the mother should be) for both the risks he may pose or the benefits he may bring. These benefits may take many forms, including offering links with his wider family, financial contributions, or a supportive relationship with him. He may be able to help professionals understand what has happened to the children in the past/present. As practice stands at the moment, it is much more common for ‘absent men’ to be viewed negatively, with the consequence that it may seem safer (or easier) to leave them out of the picture entirely. Whilst there will at times be legitimate reasons for decisions made to exclude some men who clearly pose a danger from direct involvement with children in the family, it seems that many others are ignored without sufficient reason. They do need to be included and assessed. Where they are excluded, without adequate assessment, the losers will be their children, who may continue to live in unhappy or conflictual circumstances (e.g., parents rowing constantly), or alternatively may miss out on a more positive input from their father.
Finding 7: Professionals involved in the CAF process are not commonly seeking the active participation of the less visible parent (usually the father), making them less visible to the professional process as well, and risking the loss of valuable information about parenting and children.

This case demonstrated an extreme level of professional exclusion of a father who was regularly involved in his children’s lives. What risks he posed to the mother and children, and what he had to offer his children, were not subjects of discussion, and Father was not included in essential meetings.

There is a culture, found both in Norfolk and elsewhere in the country, of not including men who do not live with their children, even where there is very regular contact between them. This exclusion can become more extreme when a man is viewed as being ‘bad’ for his family and posing a risk to both mother and children.

Children are the losers when professionals have little or no contact with a father, and therefore are not able to assess or engage with him. It means that in many cases, there will not be enough information about risks to the children from the man, possibly leaving them at greater risk. And, conversely, not enough will be known about what he (or members of his family) might have to offer the children, or what understanding he can offer about the children’s needs, wishes and feelings.

Considerations for the Board and partner agencies

- Is the Board aware of this culture of minimal contact with many fathers/male partners?
- How could a different culture be developed, where routinely everyone with Parental Responsibility (PR) for a child is involved where that person did not constitute a risk to a child?
- How would the Board be able to find out more about this culture across agencies?
- What kind of guidelines might support a more child-centred view of involving fathers?
- How might professionals be supported to work with fathers, with whom they may not have very much routine contact?
- How could this be done, whilst ensuring that children remain safe from a violent man? Are there sufficient resources to provide supervised contact, if this is seen as the safest and best way to support contact?
- What are the barriers in different agencies for involving non-resident parents (usually fathers)?

Referral and assessment

13.8 Finding 8. Multi-agency partners tend to perceive CSC thresholds as either inconsistent or too high, resulting in uncertainty about how referrals will meet the criteria for acceptance. As a result, some children
may not receive appropriate and timely referrals for intervention. (Multi-agency response to incidents and crises)

The experiences of referrers into CSC have a considerable impact on their future behaviour in dealing with their concerns about cases. Where there has been unjustified (in the referrer’s view) refusal to accept a referral, or lack of clarity and/or inconsistency in applying thresholds, referrers will remain unsure about what to do in future where they have similar concerns. It seems more likely that cases of neglect will suffer from this hesitation or ‘defeatism’, as referrals about ‘incidents’ of physical or sexual abuse are generally experienced as getting over the CSC threshold. Where improvements are made, with clearer and more consistent responses to partners’ referrals, it may nonetheless take some time for this to be experienced and accepted as reliable by professionals across different settings.

13.8.1 How did the issue feature in this particular case?
At the beginning of this case review (March 2011), a referral came from the women’s refuge where the family had been staying (via the Health Visitor attached to the refuge) to Norfolk CSC, in the area where Mother and the children lived at the time. This referral was refused by the CSC Duty Team. The appraisal of practice (above) explains how the Manager viewed the referral as principally related to extremely messy home conditions, and how he did not take account of the other areas of concern about the children. CSC were lobbied by the family’s longstanding Health Visitor, who knew the family very well and who was concerned about the issues raised in the referral. These were explicitly and appropriately articulated but the initial decision stood. A CAF was recommended and was then instigated by the Norfolk Health Visitor.

The context for this decision was explained to the Review Team via the conversation with the Duty Manager. At the time of this referral, the CSC office had a few months previously had their catchment area trebled, so that it now covered something like 600 square miles. The Duty Manager’s recollection is that, at the time of the referral, there had not yet been extra resources allocated to his team. (A senior member of CSC suggests that they had in fact been put in place, though it is unclear whether all posts had been recruited to.) The Duty Manager told us that the duty systems at the time, including a one-on, one-off manager, were insufficient to give proper attention to the heavy workload coming through their front door.

(The Duty Manager involved in this case described how things have changed for the better since then. There are now more social workers in the team, and more managers. The county-wide MASH has been established which relieves Duty managers of gate-keeping and the first ‘filtering’ of referrals, and means they are able to focus and reflect more on what is passed through from MASH, and on making suitable plans for these cases.)

We found how this CSC decision had an impact on the workers who continued to be involved with the family. In her conversation, the children’s ADHD nurse described feeling very uneasy (in TAF meetings) when Mother
reported that ‘everything was okay and better’. She didn’t believe in this, and wondered about talking to CSC about it. But she didn’t do so because she felt the threshold at the time would not allow for a different response from their initial refusal of the case. She said this was ‘because of how things were at the time’ – with an overwhelmed system trying to cope with too many referrals.

In individual conversations with some Case Group members, and at the Workshop Day, we had feedback that, at that time (2011), many professionals regarded it as ‘not worth’ making a referral to CSC, as it was unlikely to be accepted. The Health Visitor, who continued to feel uneasy about Mother’s care of the children, said she had ‘known from the previous Health Visitor that her referral had been turned down’ (March 2011) – and so she ‘wasn’t tempted to make a referral to CSC.’ Some practitioners had had varying success with consulting the CSC Consultation Line, and were at times refused advice about a possible referral, unless they had already discussed it with the family. This was seen as a barrier to understanding thresholds.

13.8.2 How do we know it is not peculiar to this case?
The experiences in this case were not unfamiliar to Case Group members. They described inconsistencies in which cases are accepted by CSC, with the routine expectation that the threshold will be hard to reach. This is especially true where a family has been referred before and ‘turned down’ – despite the fact that families’ circumstances do change, and it is vital to a safe system that professionals are able to re-refer when need be.

Other members of the Case Group described a routine ‘defeatism’ about making referrals to CSC, based on the number of times they were unsuccessful in getting a case allocated.

Unfortunately, it is more likely to hold true for chronic problems like neglect, than for ‘incident-based referrals relating to physical or sexual abuse. This is potentially another challenge in working with neglect: how to characterise it in a way that makes for an effective referral?

Other Norfolk evidence

- The Multi-agency Review (MAR) for Child I (2012) points to confusion about what may make for a ‘successful’ referral, suggesting that the referral form does not assist referrers in describing protective or risk factors in a case. (Para 5.2.2)
- The MAR for Child K (2013) describes agencies’ behaviour when a CP investigation ended in no further action:

‘After a CP investigation with an outcome of NFA, the original referring agency may feel disempowered to make further similar referrals. This may leave a child at risk of further harm.’ (Para 5.4)
‘School staff have stated in their interviews that they felt frustrated and unable to bring the continuing concerns to colleagues in CSC or Police.’

Although there were ongoing ‘signs and symptoms’ in a child which raised serious concerns, the school did not think a further referral would reach CSC’s threshold, and was therefore not worth making.

This response was similar to that of the professionals in this case, after the referral of March 2011 did not reach CSC’s threshold.

- **However**, the Ofsted inspection of NCC in 2013 reported that:

  *Understanding of the thresholds for referral to social care is generally sound and the MASH team effectively gathers information, signposts to alternative services where necessary, and refers appropriately to duty social work teams when more detailed assessment of children’s needs is considered necessary.*

A positive interpretation of this somewhat contradictory evidence would be that it will simply take some time for a better understanding of thresholds and what makes for an effective referral to be consistently and generally in place.

In order to make the referral process work as well as possible, *Working Together to Safeguard Children* (2013) makes clear that:

*The LSCB should publish a **threshold document** that includes:*

  - the process for the early help assessment and the type and level of early help services to be provided; and
  - the criteria, including the level of need, for when a case should be referred to local authority children’s social care for assessment and for statutory services under:

    - section 17 of the *Children Act 1989* (children in need);
    - section 47 of the *Children Act 1989* (reasonable cause to suspect children suffering or likely to suffer significant harm);
    - section 31 (care orders); and
    - section 20 (duty to accommodate a child) of the *Children Act 1989*. (WT:Para.18)

In addition, the referral form itself needs to support the clearest expression about which of the above levels of response is needed.

The NSCB published its Threshold Guide in September 2013, however at the time of writing, it has been agreed that more work needs to be done to improve partners’ understanding and application of thresholds so the guide is currently under review.
Reported improvements in Norfolk:

- The Review Team have been told that the use of the Consultation Line has been clarified with all agencies.
- There is more consistency of decision-making because of the MASH\(^{19}\), and less gate-keeping of referrals. MASH decisions are based on better collation of information across agencies, and benefit from being made in a multi-agency team setting.

But, social care resources are likely to go on shrinking, and this means that pressure on thresholds will not go away. In addition, partners within and outside the service must remain aware that, in any busy ‘front-door’ Duty service, it is impossible to make consistent and ‘right’ decisions in every case. Thus, it is vital that partners/referrers are empowered to challenge a decision not to accept a referral. The NSCB ‘Resolving Professional Disagreement Policy’ needs to be well understood and well used, so that issues can be escalated and resolved without causing difficulties for either side.

13.8.3 What numbers of cases are affected, and how widespread is the pattern – local, regional, national?
There is every reason to believe that the tensions and difficulties described here are shared by multi-agency partnerships across the country. With the continuing programme of cuts to public services, decisions about providing a targeted service such as CSC are bound to become harder, and to put more pressure on early help processes such as CAFs/FSPs, and the work of Children’s Centres.

13.8.4 What are the implications for the reliability of the multi-agency child protection system?
It is not possible to be completely consistent about thresholds for accepting referrals into CSC, for a variety of reasons. Given that this is so, it is vital for the system to ‘name this’, and then to find ways to improve consistency and clarity in these vital transactions between CSC and partner agencies. The consequence of not doing so is that professional colleagues who are concerned about children will continue to lack confidence about how/when to ask for consultation about a referral, or to make a referral, because they expect to be ‘knocked back’. Children will be left without the appropriate level of intervention from extra services.

\(^{19}\) The Multi-Agency Safeguarding Hub (MASH) is a system which co-locates a whole range of agencies, including police, local authority children's social care, education, probation and health staff, at the ‘front door’ of CSC, to share information and decide on appropriate responses to child protection referrals. It has been particularly successful in reducing the time required to investigate CP referrals and therefore to protect children more effectively.
Finding 8: Multi-agency partners tend to perceive CSC thresholds as either inconsistent or too high, resulting in uncertainty about how referrals will meet the criteria for acceptance. As a result, some children may not receive appropriate and timely referrals for intervention.

An effective safeguarding children network relies on clarity and consistency across agencies about thresholds for referrals – at all stages of inter-agency work. Individual experiences of professionals, sometimes outdated ones, have the power to undermine their confidence when considering how and when to contact CSC (or other) colleagues to take a concern forward. Local ‘myths’ may persist about what to expect when a case is referred, and a level of ‘defeatism’ – whether well founded or no – can act against the best interests of helping children.

This case has suggested that work is required, on all sides, to try to improve the effectiveness of referrals. CSC and partner agencies have begun to do this, with staff on ‘both sides’ trying to be clearer about identifying the cases which require a response from CSC, and at what level. Every agency has a contribution to make to this, by providing a thorough and suitable referral, with the support of CSC. CSC can be better guides, by explaining the reasons why a referral does, or doesn’t meet thresholds for action by them.

Considerations for the Board and partner agencies

- How do partner agencies in the Board deal with this area of their joint work (referrals/thresholds – and disagreements)?
- What is the Board’s role in this area – including promoting a respectful use of challenge (both offering and receiving challenge)?
- How can the Board and partner agencies deal with what has been described as ‘defeatism’ about getting a referral through to CSC? Are managers in agencies aware of this ‘defeatism’?
- How can referring agencies and CSC help each other to construct effective referrals? How can CSC convey the message that gate-keeping isn’t the main aim? How can referring agencies respond when they are not satisfied with non-acceptance of a referral?
- How can CSC provide information about why they haven’t accepted a referral, and what would make a difference in future?
- How will the Board encourage suitable and effective use of escalation/resolution procedures?

14. Additional Learning

14.1 Working with Domestic Abuse

14.1.1 The background information provided to NSCB and then to the Lead Reviewers and Review Team about this case suggested that this was a longstanding and ‘typical’ case of domestic abuse (DA) and occasional violence (DV) perpetrated by a manipulative, or controlling, man against a woman victim. The referrals, with several lengthy gaps, included reports by
Mother herself about Father’s violence, and others from neighbours, when they heard angry scenes in the home.

14.1.2 During the period covered by the case review, professionals responded to what they understood as a stereotypical risk from a violent man to his partner by excluding or ignoring him (see Finding 7 above). They apparently saw this as sufficient response, especially given Mother’s reassurances at most TAF meetings that she could keep him away, or that they were getting on better. No risk assessments were carried out for Mother or the children.

The acceptance of Mother’s testimony, and her expressed fears and distress, was in many ways in line with recommended practice in this area of work, with its emphasis on accepting women’s reports of abuse, even though these may later be retracted, and no evidence given against the man. Much has been accomplished by Police and DA/DV agencies to encourage professionals to take seriously the risks to women victims of DA, and find suitable and effective ways to make them and their children safer.

14.1.3 Perversely, in this case, it seems that by continuing to believe all Mother’s reports about DA (whether present, or past, or whether she still felt threatened or frightened), the professionals held onto false assumptions, based on gender, which were never properly tested.

Evidence has emerged from after the case review period that Mother’s presentation of herself as a victim of a recognisable pattern of DA may not represent an accurate picture of what was in fact taking place. Instead, there is equal evidence that she was quite powerful in relation to Father, and was able to manipulate and control him – often by excluding him from the home and disrupting his relationship with the children. It is also likely that she participated in any violent exchanges.

The Review Team believe that, in this somewhat unusual case, an assessment would have uncovered a different picture from that which our original chronology highlighted. This is an important reminder that assumptions, however justified, can be unhelpful and wrong, and these need to be tested out via proper assessments.

14.2 School Nursing Service

14.2.1 Our conversation with the SN highlighted the constraints on her and the 15 school nurses (several, like her, are part-time) who cover the county’s schools. She herself works half-time, and has a caseload of 4,500 children. She is unable to attend most meetings regarding individual children, such as Team around the Family meetings, and CP Conferences. She does normally receive paperwork about the children who are subject to these meetings, and can make recommendations for an Assistant to carry out specific actions for a child, where required.
The SN said that ‘the main role of a School Nurse should be about public health, but because of the depleted service, there is no public health taking place’.

14.2.2 The Review Team wished to bring this situation to the attention of the NSCB. This case has shown that there is a major constraint on how School Nurses can contribute to the safeguarding of children, including early help and CP processes. This appears to be a resources issue.

14.3 Advice about physical chastisement

14.3.1 There was one particular exchange in the minutes for the first TAF meeting, which concerned the Review Team. Child 3’s Wishes and Feelings form had stated that ‘Child 2 is horrible and Mum slaps him’. The notes for the meeting say that ‘it was explained that this is not advisable because it is not a helpful discipline and if she leaves a mark a referral would have to be made to CSC’. This suggests that these professionals had a poor understanding of thresholds for identifying physical abuse and how to advise about the appropriateness of physical punishment by parents.

15. Conclusion

15.1 All Serious Case Reviews are required to report and learn from what happened in a particular child or family’s story. This systems review has tried to do this, and then to move beyond what happened to the L Children, in order to analyse the effectiveness of safeguarding children in Norfolk more generally, and how this might be improved.

15.2 The principal learning from this review has focused on two main, overlapping areas:

- How the CAF/FSP process works to bring effective early help to children, and
- How professionals in partner agencies recognise and respond to the impact of neglect on children

15.3 The L Children were in fact known to services in their local area for two decades, and repeated concerns arose over this long period – including about domestic abuse and neglectful parenting. The family were socially isolated, often found to be in straitened circumstances, and their home was in poor condition. As the older children progressed to school age, their delayed development and their extreme behaviour demonstrated that they were in severe difficulties. After a referral to CSC (2011) was not accepted, the offer of early help, via a CAF, did not prove effective in improving the children’s lives.

15.4 There are significant numbers of families in Norfolk who might fit the L Family’s description, and this is a daunting challenge for already hard-pressed agencies in the safeguarding children network. This case suggests how important it is for professionals to identify and communicate with each other
about children who are showing signs of neglect; to assess effectively; and to agree as consistently as possible what level of response is needed – including what to do when early help efforts are not achieving better outcomes for children.
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## Appendix 1: Acronyms and Terminology

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>ASD</td>
<td>Autistic Spectrum Disorder</td>
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<td>CAF</td>
<td>Common Assessment Framework</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CG</td>
<td>Case Group (the professionals involved with the family and their first-line managers)</td>
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<tr>
<td>CP</td>
<td>Child Protection</td>
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<tr>
<td>DA</td>
<td>Domestic Abuse, including emotional and physical abuse</td>
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<td>DC</td>
<td>Detective Constable</td>
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<tr>
<td>DV</td>
<td>Domestic Violence</td>
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<tr>
<td>GCP</td>
<td>Graded Care Profile (a tool for assessing neglect of children and its impact on their health, development and wellbeing)</td>
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<tr>
<td>GP</td>
<td>General Practitioner/family doctor</td>
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<tr>
<td>HV</td>
<td>Health Visitor</td>
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<td>ICPC</td>
<td>Initial Child Protection Conference</td>
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<td>LAC</td>
<td>Looked-after child(ren)</td>
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<tr>
<td>LP</td>
<td>Lead Professional (in charge of the CAF process)</td>
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<td>LSCB</td>
<td>Local Safeguarding Children’s Board</td>
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<td>MA</td>
<td>Multi-Agency</td>
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<tr>
<td>MAR</td>
<td>Multi-Agency Review (case review commissioned by the NSCB, in relation to a case deemed to be below the threshold of a Serious Case Review)</td>
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<td>MASH</td>
<td>Multi-Agency Safeguarding Hub</td>
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<td>NAI</td>
<td>Non-Accidental Injury</td>
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<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
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<td>NSCB</td>
<td>Norfolk Safeguarding Children Board</td>
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<td>PR</td>
<td>Parental Responsibility</td>
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<td>RT</td>
<td>Review Team</td>
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<td>SCIE</td>
<td>Social Care Institute for Excellence</td>
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<td>SCR</td>
<td>Serious Case Review</td>
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<td>SENDCO</td>
<td>Special Education Needs and Disability Co-ordinator</td>
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<td>SN</td>
<td>School Nurse</td>
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<tr>
<td>SW</td>
<td>Social Worker</td>
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<td>TAF</td>
<td>Team Around the Family</td>
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<td>WT</td>
<td>Working Together to Safeguard Children, 2010 and 2013 National statutory guidance for multi-agency safeguarding children</td>
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Appendix 2: Methodology and process

1. This SCR has used the SCIE Learning Together model for case reviews. This is a ‘systems’ approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2013 revision of Working Together to Safeguard Children (2013) now requires all SCRs to adopt a systems methodology.

2. The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4. The basic principles – the ‘methodological heart’ of the Learning Together model – are in line with the systems principles for SCRs now required by guidance in Working Together (2013):
   a. Avoid hindsight bias – understand what it was like for workers and managers who were working with the family at the time (the ‘view from the tunnel’). What was influencing and guiding their work?
   b. Provide adequate explanations – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
   c. Move from individual instance to the general significance – provide a ‘window on the system’ that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.
   d. Produce findings and questions for the Board to consider. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.
   e. Analytical rigour: use of qualitative research techniques to underpin rigour and reliability.

5. Typology of underlying patterns. To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection are functioning. Do they support good quality work
or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases
4. Family – Professional interaction
5. Tools
6. Management systems

Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

6. Anatomy of a finding. For each finding, the report is structured to present a clear account of:

- How did the issue feature in the particular case?
- How do we know it is not peculiar to this case (not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- What are the implications for the reliability of the multi-agency child protection system?

These 'layers' of each finding are illustrated in the Anatomy of a Learning Together Finding (below).
7. Review Team and Case Group

7.1 Review Team

The Review Team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by two independent Lead Reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints, changes in structure, and so on.

The Review Team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tr>
<td>Sian Griffiths, SCIE independent Lead Reviewer</td>
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<td>Sally Trench, SCIE independent Lead Reviewer</td>
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<tr>
<td>Operations Support Manager, Norfolk Children’s Social Care</td>
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<tr>
<td>Named Doctor for Safeguarding Children, Norfolk Community Heath and Care NHS Trust</td>
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<tr>
<td>Designated Nurse Looked After Children, Deputy Nurse Safeguarding Children</td>
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<tr>
<td>Early Years Lead Advisor</td>
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7.2 Case Group

The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their ‘view from the tunnel’ – about their work with the family at the time and what was affecting this.

In this case review, the Review Team carried out individual conversations with 20 Case Group professionals, and one family member. Case Group members were invited to an Introduction Meeting (to explain the Learning Together model and the SCR process) and later to an all-day Workshop.

### Health:
- GP
- ADHD Nurse
- Consultant Clinical Psychologist
- Health Visitors (2)
- Midwife
- School Nurse

### CSC:
- Duty Team Manager
- Social Worker
- County CAF Co-ordinator

### Early Years and Education:
- Head Teacher, Infant School
- Head Teacher, Junior School
- Classroom Teachers (2)
- Deputy Head Teacher
- Nursery Assistant orker
- Family Support Workers (2), Children’s Centres

### Norfolk Constabulary:
- DC, Vulnerable Persons Directorate (2)

8. Structure of the review process

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

The Review Team form the ‘engine’ of the process, working in collaboration with Case Group members who are involved singly in conversations, and then in a multi-agency full-day Workshop. They also receive copies of the draft report to comment on.
For this SCR, the following meetings were held:

- Scoping meeting (Lead Reviewers and NSCB Manager)
- Preparatory meetings between the two Lead Reviewers
- Planning meeting with the Review Team
- Introductory Meeting for the Case Group
- Conversations with 20 professionals involved with the family
- Analysis meetings (4) with the Review Team
- Briefing to NSCB (halfway through)
- SCIE supervision sessions (2)
- Presentation of report to SCR Group

9. Scope and terms of reference

9.1 Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference, such as in a traditional SCR. This enables the data to lead to the key issues to be explored.

In this SCR, we noted and explored the questions (Para 6.2) which NSCB had posed as of particular interest.

9.2 The time frame for the SCR was decided as March 2011 (referral to CSC from women’s refuge) to late April 2013 (children’s removal from their mother’s care).

10. Sources of data

10.1 Data from practitioners

- Conversations, as described above, with members of the Case Group; these were recorded and discussed by the whole Review Team.

- A Workshop Day in which members of the Case Group responded to the analysis of the case and gave feedback about accuracy and fair representation of their views. In relation to the emerging findings, the Case Group were asked to comment on whether these were underlying and widespread/prevalent. In other words, could we draw conclusions about whether, and in what way, this case provides a ‘window on the system’?

- Members of the Case Group have also helpfully responded to follow-up queries and requests from the Lead Reviewers and the Review Team for clarification or further information, where this has been needed.

- The FPS Co-ordinator for the county met with the two Lead Reviewers to give a detailed picture of the developments which have taken place (CAF becoming FPS) since the period covered by the review.

10.2 Key Practice Episodes and Contributory Factors
The data from the conversations with the Case Group translates into their ‘view from the tunnel’ and thence into a selection of Key Practice Episodes (KPEs) which enable us as reviewers to capture the optimum learning from the case. These KPEs are significant points or periods in relation to how the case was handled or how it developed. Case Group members are also an invaluable source of information about the why questions – an exploration of the Contributory Factors which were affecting their practice and decisions at the time.

10.3 Participation

The Learning Together model relies on professionals contributing very actively to the review and the resultant learning, as it is their unique experiences which help us understand what happened and why.

We know that participation in an SCR can raise anxieties and sometimes distress about what has happened to children, and may prompt self-questioning about ‘could I have done something differently?’. In this context, the Lead Reviewers and the Review Team are especially grateful for the willingness of the professionals to reflect on their own work, and to engage openly and thoughtfully in this SCR.

10.4 Data from documentation

The Lead Reviewers and members of the Review Team were given access to the following documentation:

- The records of the agencies in the case, which were then translated into an integrated chronology
- Referral and information records for the period (CSC)
- Minutes of meetings: TAF meetings, Strategy Discussions, and Initial CP Conference
- Assessments: CAF, Initial and Core Assessments (CSC)
- CP Plans
- Medical letters of referral and assessment
- GP records
- Recent MAR reports
- The Lead Reviewers read the SCR Referral Form, and the decision-making records from the SCR Group in October and November 2013.

10.5 Data from family, friends and community

As in traditional SCRs, the Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies.
In this review, Mother and Father, maternal grandparents, and Sister 1 (now an adult) were invited to take part (see Para 9.2, above). Only Father agreed to a conversation.