Norfolk Safeguarding Children Partnership

Learning from Serious Case Reviews

Case AH

Serious Case Review: Case AH

This presentation sets out:

- Summary of the case
- Terms of Reference: key research questions
- Areas of Learning
- Recommendations
- The NSCP's response

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Summary of the Case

- Death of a child (AH) in an accident involving stair gates, resulting in cardiac arrest
- Neglect was a feature of the case, however, the children had never been the subject of child in need or child protection plans
- Sibling group of 5 children, some with learning difficulties; mother pregnant with sixth child
- Consistent input from Health Visitors, Early Years and school over time
- Parents lived separately and relationship not well understood
- Following the incident that led to this review all the children moved to foster care.

Timeline: Prior to scope of review

- Family known to universal services: midwifery; education; primary care; and housing
- Concerns about clutter and lack of family network
- Family subject to a Family Support Plan – stepped down: family was described as ‘strong and happy’ with good school attendance
- State of the home varied, but no tenancy concerns

Timeline
Scope of Review: April 2017 – April 2019

Between April 2017 and January 2019

- Concerns predominantly about state of home but professional perceptions varied
- Also some concerns about basic care and meeting children's developmental needs
- Mother's lack of supervision; she was sometimes noted to be extremely tired.

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Timeline, cont.

Jan 2019-Apr 2019,

- Increase in the level of concerns by the health visitor, the pre-school and the primary school
- Mother pregnant again and appearing unable to cope
- Joint visit by Health Visitor and midwife led to referral to social care: concerns raised during visit about use of stairgates and supervision
- Referral accepted by Children's Services: threshold for social work assessment was not met - support to be provided by Early Help
- Early April: Child AH trapped in the gap between stairgates while in care of eldest sibling; Mother was attending a parents evening at school with another child
- Child AH died in hospice three weeks later

The views of the family

Mother said:

- Moved to England in her late teens
- Twenty years younger than father.
- Health visitor helped her to separate from husband when eldest child was three; relationship continued living apart.
- Did not tell professionals about continuing difficulties with husband as there was “no point” - she thought she would never be able to completely end the relationship.
- With each new baby, demands on her increased
- In the months before the accident she was really struggling.

The views of the family, cont.

Father said

- Professionals had his contact details but he was not contacted regularly
- Health issues meant he had not been able to support the children as much as he wanted to, but he loved them very much.
- He worried children not properly supervised by their mother
- Knew the house and garden were often dirty and untidy.

The oldest child said

- Spent time helping to look after his siblings as his mother could not cope.
- House was often very dirty, but he kept his own room clean. The state of the house embarrassed him and so he never invited friends to visit.
- Rarely saw the professionals who visited the family as he was at school,
- School was not aware what things were like at home for him; overall, he felt his senior school had been supportive to him.

Terms of Reference

- How effective has the NSCB neglect strategy been in practice?
- To what extent are thresholds for intervention understood and escalated in relation to cases where risk in longstanding cases of neglect are raised and actioned?
- To what extent were the practitioners' assessments of neglect and its impact, influenced by their opinion that the mother loved the children?
- To what extent was social deprivation in the wider community a factor in this case and is this systemic?
- To what extent were the family dynamics understood, or not, to the way the system responded to the children's needs? This should include consideration of:
  - Father's role in the family
  - Parental mental health
  - The role of young carers

Areas of practice learning

- Some good practice in this case:
  - consistent support by health visitor and family support workers enabled good relationships
  - Considerable efforts to support children's development and meet their health and education needs
  - Additional practical help with the children was given.

- Neglect is a complex and challenging area of work: no single cause of neglect and often a complex interplay of factors .
- Professional opinions of cleanliness, behaviour and care can be subjective and differ widely.
- Holistic assessment need to focus on the lived experience of the children.

Recommendations

- Norfolk's Family Networking training should be promoted across the partnership to encourage all frontline professionals to attend. It should highlight the learning from this review namely the importance of exploring and assessing the impact of:
  - The family's cultural background.
  - Issues of isolation linked to depression.
  - The possibility of coercive, controlling relationships.

- In cases of neglect, the children's voices and views of their family's strengths and weaknesses must be evidenced through the use of existing tools, e.g. Signs of Safety

Recommendations

- Risk assessment tools to assess neglect should be reviewed to ensure that there is a common language and understanding of levels of concern over time. For example, the Graded Care Profile could be strengthened with photographs adapted from the Norfolk Safeguarding Adults Self Neglect and Hoarding Strategy, to better assess and share the views of professionals about the living conditions of children

- The NSCP should work with public health, trading standards and fire and rescue services to review the published risks of using stair gates, issue advice to parents and practitioners and consider raising this as a national issue in children's safeguarding.

Recommendations, cont.

- The Young Carers Service should be promoted across the partnership and the NCC Young Carers Service monitored against referrals and outcomes.

- The NSCP's District Council Safeguarding Group should audit the housing offer to families and housing providers should adopt national policies to ensure that children can enjoy the home and its gardens, by providing fencing and other safety features.

NSCP's Response

- Neglect as a priority area in business plan: strategy review, strengthened leadership and independent scrutiny focus
- Assessment tools, such as Graded Care Profile, to be developed in response to learning from this and other SCRs relating to neglect
- Family network training being rolled out as part of multi-agency training programme
- Report shared with
  - Child Death Overview Panel and trading standards to implement learning in relation to use of stairgates
  - Young Carers service and providers to implement learning about role of older siblings in neglect cases
  - NSCP's District Council Advisory Group to implement learning about housing and assessing families' needs

Learning Activities

- Discuss the challenges to understanding parents' relationships
- How well do you understand the family networks in the cases you manage and how can you help them access support and resources from the network? Reference: Family Network training
- What can you do to help address issues raised by lack of parental supervision?
- Research the offer for Young Carers and think about older siblings you are working with who might be taking on caring responsibilities
- Ensure your team is up to date with the NSCP neglect strategy, including nominated neglect champions, assessment tools and clear interventions to address drift
- Discuss the emotional impact of neglect on yourselves as individuals and the wider safeguarding system: what helps to maintain professional curiosity?