Norfolk Safeguarding Children Partnership

Serious Case Review
Overview Report
in respect of:

Child AH

June 2020

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Contents

Note: This Overview Report has been anonymised throughout, dates of events and the gender and names of the children and professionals have been given pseudonyms to protect their identities.

In memory

The Norfolk Safeguarding Children Partnership, the author of this report and all the professionals who knew Child AH, wish to extend their sincere condolences to the family and friends.

1. Introduction

1.1 This Serious Case Review concerns the tragic death of a child by accident. The child suffered an accident involving stair gates and died, following a cardiac arrest. Concerns about neglect had been known by some agencies to be an issue throughout the children's lives.

1.2 There are several children in the family, ranging in age from pre-school to secondary school. The children lived with their mother in a three bedroomed, rented council house in an area known to be socially deprived. All the children are of White British origin.

1.3 The children had never been the subject of child in need or child protection plans; shortly before the incident that led to the review, a referral had been made to Children's Social Care and a decision was made for Tier 3 support- targeted intervention by the Early Help Family Focus team.

1.4 Following the incident that led to this review and the subsequent criminal investigation, an Interim Care Order was granted by the Court for all but one of the children to be placed in foster care placements. Their cases are currently in Legal Proceedings. The parents agreed initially to a single period of accommodation under Section 20 of the Children Act 1989 for the oldest sibling, who has since been made the subject of an Interim Care Order.

1.5 In accordance with 'Working Together to Safeguard Children' 2015, the 'Local Safeguarding Children Board Regulations' 2006 and 'Working Together: transitional guidance 2018', the case was considered by the independently chaired Serious Case Review Sub-group; David Ashcroft, the Independent Chair of the NSCB endorsed the subgroup's recommendation and commissioned the Serious Case Review on 21st May 2019.

1.6 The purpose of Serious Case Reviews is to objectively review what happened and how agencies worked together, to identify learning that can lead to improvements in safeguarding practice. They are not about culpability or apportioning blame nor about criminal, coronial or disciplinary matters; they should also identify good practice and seek to learn from it.

1.7 Between the start of the review and September 2019, the NSCB became the Norfolk Safeguarding Children Partnership (NSCP) in accordance with new legislation. References to both titles are made accordingly.

2. The Terms of Reference

2.1 The terms of reference and information about the review process are attached at Appendix 1.

Scope of the review

2.2 The Panel decided the scope of the review would cover the two years between April 2017 and the date of the child's death in April 2019 and would include any relevant events outside this period.

Pseudonyms

2.3 The children who are the subject of this review are referred to in this report in descending order of age, between seventeen and two, as:

- Sibling: Child AH1
- Sibling: Child AH2
- Sibling: Child AH3
- **Subject: Child AH** who was aged 4 when he died
- Sibling: Child AH4

The parents of the children are referred to in this report as:

- Mother of the children: MAH
- Father of the children: FAH

Neglect

Neglect is defined in England as: '*…. The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.*

Neglect may occur during pregnancy as a result of maternal substance abuse.

Once a child is born, neglect may involve a parent or carer failing to:

a) *provide adequate food, clothing and shelter (including exclusion from home or abandonment)*
b) *protect a child from physical and emotional harm or danger*
c) *ensure adequate supervision (including the use of inadequate caregivers)*
d) *ensure access to appropriate medical care or treatment*

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Working Together HM Government 2018.

The involvement of the family

2.4 The children's parents, MAH and FAH, and their eldest child, Child AH1, were invited to meet the Lead Reviewer to share their views of the services they had received and any learning they wished to contribute. The NSCP and the Lead Reviewer understand that it was difficult for the family to talk about what had happened and are very grateful to them for doing so.

2.5 MAH said that she came to live in England in her late teens and lived with members of her extended family. They and other relatives continue to live in England, and initially she had contact with them, but gradually this became unacceptable to her husband. She said she first talked to a health visitor about his controlling behaviour when her eldest child was young, and the health visitor helped her to be given a separate house. She said she had never shared with professionals, the continuing difficulties with her husband as there was "no point" as she thought she would never be able to completely end the relationship.

2.6 She recognised that with each baby the demands on her increased and in the months before the accident she was really struggling. Reflecting on what had happened, she said

she hoped the review would highlight to parents, carers and professionals the risks of stair gates and this valuable contribution has been included as a recommendation in this report.

2.7 FAH said that although professionals had his contact details, he felt no one ever contacted him about the children. He explained that he suffers from a number of physical illnesses that meant he had not been able to support the children as much as he wanted to, but he had been actively involved in their lives and loved them very much. He said he had worried that the children were not properly supervised by their mother and knew the house and garden were often dirty and untidy. Both parents expressed views in their respective interviews that meant they were both aware of issues in the family home and levels of support provided but neither acted in a supportive way of each other to seek a remedy to these.

2.8 AH1 described how much time he spent helping to look after his siblings as his mother could not cope. He said the family had a very poor diet and the 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. He said his father had always been supportive but was often unwell and could not do as much as he would have liked. He said he rarely saw the professionals who visited the family as he was at school, that teachers were not aware what things were like at home for him, and had not asked him, and he had not told anyone, he said that overall, his senior school had been supportive to him.

3. Narrative

Family history

3.1 Some of the children had additional needs which included, speech and language difficulties, attention deficit hyperactivity disorder, dyslexia, general learning difficulties, autism and developmental delay and one had a genetic condition that can cause a wide range of health difficulties.

3.2 FAH is some 20 years older than MAH and by the time he met MAH he had two children from a previous marriage. He frequently accessed medical support from his GP and suffered a mild stroke in 2017.

3.3. In 2015, MAH was reviewed by a clinical psychologist for possible learning difficulties, or Asperger's syndrome. The assessment was that she was able to socialise and process information sufficiently well. There are some records of MAH having periodically suffered from depression.

3.4 MAH left her husband when their eldest child was four years old. Although they have continued to have children, they have not lived together since the separation and the couple divorced in 2007. MAH had a history of miscarriage and still births which has continued to distress her; since the review commenced another child has been born to the family and is subject to an Interim Care Order.

3.5 Relationship counselling was offered to both parents during their involvement with the Family Support Service but was not accepted.

3.6 Neither parent has a history of addiction in relation to substances, alcohol or gambling and apart from MAH being cautioned for common assault several years ago, there are no records of criminal offences or debt.

3.7 Both parents were in receipt of state benefits that included: Employment and Support Allowance; Personal Independence Payment; Income Support; and a Carer's Allowance.

4 Summary of key events

4.1 Prior to the period covered by this review the family were known to: universal services; midwifery; education; primary care; and housing. In 2012, the first concerns about the family arose when the health visitor reported that the house was cluttered. MAH had no support from friends and family members and FAH was reliant on her for transport, shopping and to meet his health needs. Following these concerns, Family Support was provided by the Children's Centre and continued for several years. In addition, the family received an enhanced level of support - Universal Plus or Universal Partnership Plus- from the Healthy Child Programme from 2013 until 2018.

4.2 A plan based on a Common Assessment Framework included actions to help MAH integrate into the community, support the children's development, encourage more equally shared parenting and improvements to the condition of the home. A meeting at the end of this period indicated that the parents were pleased with the support they had received.

4.3 By the time the three oldest children started attending nursery or school they were stepped down from Family Support, as the family was described as 'strong and happy' with good school attendance.

4.4 When MAH was in hospital giving birth to AH's fifth sibling, FAH's aggressive attitude to staff led them to raise the issue of domestic abuse with her but she denied this, saying he just became stressed when looking after the children. Three weeks later the first significant concerns about the state of the house were raised by a different health visitor, and the family were re-referred to the Children's Centre for Family Support.

4.5 In the three months before the period covered by this review, concerns were expressed about MAH's ability to manage the children's behaviour and their development needs were of concern, but she was also observed to be warm and loving and the home and the children were reasonably presented. However, there was one occasion when the words she used to describe one of the children were considered by the health visitor to be very inappropriate; the health visitor discussed this with MAH who accepted her view.

4.6 In compiling the chronology for this review, the author of the health chronology reflected that the role of FAH was 'confusing' and some of his behaviour could have been indicative of his being coercive and controlling of his wife but this was never explored.

4.7 The state of the home varied, but there were no tenancy concerns by the Housing Department who had not visited as there were no arrears. Family Support services and enhanced health visiting were provided appropriately and MAH appeared to welcome their help.

4.8 The five years summarised above whilst outside the scope of the review, provides valuable background information that shows that MAH had an increasing number of children all quite close in age, several with additional needs, that she had very little family support and it was recognised that with the birth of each baby she found it more difficult to cope.

The period between April 2017 and January 2019

4.9 In April 2017, a referral was received by the health visitor, requesting an Early Help Family Practitioner to provide Targeted Support within Universal Services. The case did not meet the Threshold for Social Work intervention at that time. Because the Children's Centre appeared to be already engaging with the family, consideration was to be given to initiating the Family Support Process, by consulting the school.

4.10 It took some time for a Family Support practitioner to be appointed and start working with the family but despite the demands of the children, overall, the situation remained acceptable with the house sometimes being cluttered, with lots of toys, but clean enough. However, professionals had different opinions of the level of support the family needed.

4.11 In July 2017, a Family Support Plan was considered but not taken forward, due to a lack of clarity and shared agreement about the concerns.

4.12 In September 2017, concerns were expressed about Child AH1 and the impact on his self-esteem by the widening gap between him and his peers.

4.13 In October 2017, both parents were present at Child AH4's developmental review and it was noted they could not answer the questions about whether the child could complete age related tasks and actions. At this point there were five children in the family and perhaps this prevented the parents from having a focus on each one. The health visitor's notes did not identify this as an issue.

4.14 Apart from two records about Child AH not having his dirty nappy changed, the records of the children are generally positive. In July 2018, school described Child AH3 as a 'popular and happy child, reaching nationally expected standards in all subjects'.

4.15 However, in July 2018, there is also a report of the children being observed in the hospital as being hungry; they were unkempt, and the girls were wearing odd shoes and dirty clothes and were out of MAH's control. Despite MAH not wanting a referral to be made to the Multi Agency Safeguarding Hub, (MASH), she was told this would be done by the hospital. Following a discussion with the MASH a referral was not made but the health visitor was informed by the hospital of their concerns.

4.16 Concerns about Child AH4's developmental delay and MAH appearing 'flat and tired' led to increased support by the Children's Centre but there appears to have been no exploration of the child's developmental delay nor whether MAH's tiredness was the due to a medical problem.

4.17 In early August 2018, the Education Health Care Plan was finally completed for AH and Child AH3 is described as being 'top of her class but very difficult to manage at home'; the health visitor had to remind MAH that it was her responsibility, not the older children's, to keep the younger children safe. At the end of the month the health visitor discussed the family in her safeguarding supervision using the Signs of Safety assessment but there appears to have been no consideration of using the Graded Care Profile to assess the extent of the neglect.

4.18 At the end of September 2018, MAH reported that she was happy with the house, that FAH sometimes gave her a break by looking after the children and she had no financial concerns. In October the house was described as 'tidy and spacious'. By mid-November the

family had been stepped down from the health visiting Universal Plus programme to the Universal programme due to the ages of the children, the home situation not being of particular concern, the children appearing to be well and their developmental needs being more appropriately addressed by school.

4.19 In the above period of almost two years, the house was sometimes noted to be clearer and tidier and some support by FAH was mentioned. There are some positive comments about the children however, concerns remained:

- Child AH's dirty nappy not being changed remained a constant issue;
- Child AH4's speech development continued to be slow;
- There were issues of MAH's lack of supervision of the children. and sometimes of the physical care of the children; and
- MAH was sometimes noted to be extremely tired.

Professional perceptions about the care of the children and the state of their home were not always the same and were not always expressed at meetings.

4.20 The period between January 2019-April 2019: the three months before the incident that led to Child AH's death were of significance and marked an increase in the level of concerns by the health visitor, the pre-school and the primary school.

4.21 In January, Child AH, then aged four, was reported to have worn the same clothes all week and despite the support given to MAH about this, he was not toilet trained and not always cleaned after soiling his nappy. The school had no historic records about this issue, despite their previous concerns.

4.22 Later the same month, the family support worker made her last visit before leaving her job. She contacted the health visitor to ask for an update on the Education Health Care Plan and that MAH be informed of progress as it was going to have an impact on Child AH when he moved from the nursery to school. The records made by the school do not provide a sufficient level of detail about this period as they were of a poor standard. Concerns were expressed about the communication between the Children's Centre, the school, the nursery and the pre-school and that the parents needed to be more pro-active in seeking information.

4.23 Follow-up medical appointments for Child AH were made by the health visitor and were attended. The same month, he had an accident at home when he tried to lift a bed which then fell on him and cut his head. MAH took him to Accident and Emergency and he was discharged home with no safeguarding concerns being recorded.

4.24 Child AH4's development continued to be slow and there were concerns about her care and cleanliness, particularly in relation to her nappy not being changed and her under-developed communication. MAH said she was concerned Child AH4 would hurt herself as she was very active.

4.25 In January when the health visitor visited and heard that Child AH4 had been climbing on the upstairs' windowsills she stressed to MAH that it was her responsibility to supervise the children and keep them safe. The record of this visit describes the unsatisfactory state of the house and garden.

4.26 In February the pre-school spoke to MAH about Child AH4's cleanliness, particularly the importance of changing her nappy and cleaning her.

4.27 Throughout this period, Child AH continued to be reported as being happy but in mid-March school raised concerns with MAH about him wearing the same dirty clothing all week and having no socks. The nursery offered to wash his clothes for him and provide additional clothes which MAH declined as she said she had many clothes for the children.

4.28 In mid-March the pre-school leader again spoke to MAH about Child AH4's cleanliness.

4.29 The house deteriorated and was clearly indicative of MAH being increasingly unable to cope and properly supervise the children. These issues were raised with MAH by the health visitor and MAH agreed and said she needed help. In March 2019, MAH said she was pregnant. The health visitor made a joint visit with the community midwife which was good practice. During the visit, MAH did not agree to their looking at all the rooms in the house which was unusual, but she explained by saying the house was a mess.

4.30 The health visitor and community midwife noted that the stairgate MAH had put up to keep the children in the living room and stop them going upstairs to the bathroom or into the kitchen, was higher than average. On hearing that the children were climbing over it, and witnessing Child AH trying to force the stairgate open by ramming it with a box, the health visitor told MAH the gate was unsafe. MAH told the health visitor that school were sending letters about Child AH2 being late for school. MAH agreed to a referral to Children's Social Care but said the things that would help her most would be a cleaner or a large washing machine.

4.31 In her consultation with the Children's Advice and Duty Service (CADS) in March 2019, the health visitor raised her concerns about the filthy condition of the home and garden, the safety of the children, the risks presented by the stair gate, poor levels of stimulation and supervision, MAH's inability to understand and respond to the children's needs, her increasing struggle with so many young children, another pregnancy and a lack of clarity about FAH's contribution and support.

4.32 It was recognised that the health visitor's long engagement with the family gave her a very informed view of the situation. Her recognition that despite the involvement of the Children's Centre and the family support worker, there had been no significant improvements and the situation was markedly worse, was of particular importance.

4.33 The outcome of the consultation with CADS resulted in a referral to family support (formerly early help family focus) for a tier 3 targeted intervention assessment as the threshold for a social work assessment had not been met.

4.34 The health visitor was not in agreement with the decision and discussed this with her manager however, the decision that the family would be best be supported by an Early Help Tier 3 Targeted Intervention remained and a referral to Early Help was made on the 26th March and accepted as it met the threshold for level 3 targeted intervention.

4.35 The following day, the primary school held a meeting with MAH to raise several concerns about the children not being appropriately dressed and being very dirty and one of the children had said she was unable to concentrate as she was hungry.

4.36 On the 3rd April, Child AH was found trapped in the gap between the original stairgate and an additional one that MAH had added to prevent the children climbing over the lower one. At the time, Child AH2, Child AH and Child AH4 were in the care of Child AH1 while their mother went with Child AH3 to her parent's evening at the school. The police who responded to Child AH1's emergency call described the home as being in 'absolute squalor'.

4.37 Child AH died in a hospice, three weeks after the accident.

4.38 As stated above in paragraph 1.4, following the incident that led to this review all but one of the children moved to foster care and after AH's death proceedings were commenced and are now concluded.

4.39 After the accident and Child AH's death, the police took photographs of the home and a company was employed to clear and clean the house. The house was described as 'cluttered with an unpleasant odour from the stained carpets and piles of unwashed clothing'. 45 bags of dirty washing were removed by the cleaning company.

4.40 However, there was also evidence of children's toys and games and several indicators of the things a large family would need to help life being more organised and some areas of the home such as the kitchen and bathroom were accessible and less dirty.

5. The Key Questions

5.1 At the outset of the review, the following areas were identified to be specifically explored:

How effective has the Norfolk Strategic Partnership's neglect strategy been in practice?

5.2 From the information provided to the review it is not possible to conclude precisely how effective the neglect strategy has been from this one case.

5.3 The use of the Graded Care Profile at all stages of involvement by any members within the team involved with the child was not used and it is not clear how many people involved in this case had completed the Graded Care Profile and Parenting Capacity training, as expected in the strategy.

5.4 In interview, the review was told that professionals know about the Graded Care Profile and it is used by practitioners in early help and family support but some staff lack confidence in completing it; others find it takes a long time to complete which can be an issue if short visits are the norm and there are competing issues to address, and it can feel intrusive for families.

5.5 Vital Signs for Children including Signs of Safety, Signs of Wellbeing and Signs of Success, are the core foundations of safeguarding practice in Norfolk. Vital Signs offers a robust and rigorous framework that analyses risk and considers family strengths and resources. The clarity of purpose alongside an open and balanced approach, enables professionals to engage with families and work with uncertainty and different perceptions in a more constructive way.

5.6 From discussions during the review it appears that the issue of neglect is widely recognised as a safeguarding matter and most people are aware of the harm it can do.

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?

5.7 It is not possible to generalise from this individual case but there are examples of professional challenge, for example, the concerns expressed to school about delays in the Education Health Care Plan. In talking to professionals during their interviews and the professionals learning event, it is evident that professional disagreements/challenges are raised between agencies, however, the significant concern the health visitor had about the CADS' decision was not escalated. At one of the Serious Case Review Panel meetings it was suggested this may have been because health had previously raised their disagreement as to whether cases met thresholds in relation to other cases, but decisions had not changed.

To what extent were the practitioners' assessments of neglect and its impact, influenced by their opinion that the mother loved the children?

5.8 The professionals involved in this case shared the view that MAH loved the children. They observed the warmth of her interaction with them and their attachment to her; the children never appeared unhappy or reluctant to go home from school. They found her co-operative and receptive; she was not hostile or defensive but over time, they queried whether she shared their views about risks and had the capacity to make improvements. The school have commented that when they challenged her about the children's appearance this would temporarily improve but soon deteriorate again.

5.9 At the professionals' event that was part of the review, comments were made about the risks of being 'seduced by loving, engaging families leading to misplaced optimism'. The decision by the health visitor to refer to Children's Social Care is evidence that she was able to consider the needs of the children, despite her positive view of their mother and this was based on an accurate and non-judgemental assessment.

To what extent was social deprivation in the wider community a factor in this case and is this systemic?

5.10 The agencies involved in this case were all working in an area where neglect and deprivation is prevalent. They were able to recognise neglect and prioritise the needs of the families they worked with and to provide more support when the needs arose and reduce their involvement when the situation improved.

5.11 Some agencies said that this family did not stand out as being more at risk or a higher priority than the other families they supported, but towards the period before the accident they were becoming frustrated at the lack of improvement and wondered what more they could do.

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**

5.12 The professionals involved in this case have reflected that it would have been helpful to explore the role of FAH in his family, and better understand the complex dynamics in the

parents' relationship, however, whether the parents would have been prepared to talk about this is debatable.

5.13 There was a psychological review of MAH's possible learning difficulties, but the advice was that she did not have a learning difficulty and was able to socialise and process information well enough. There were no documented concerns about her mental health but there are some professional references to her being depressed and often being low in mood, which they felt was understandable, given her situation.

5.14 There was no consideration of Child AH1 as a young carer, despite occasions when he was seen looking after the children e.g.

- when he was 12 he went in an ambulance with a baby sibling as MAH was unable to contact FAH and leave the children at home, so she could not go in the ambulance and followed with all the children in her car
- at the doctors' surgery where he was seen to be very responsible and helpful in looking after the children when MAH went in to see the GP.

Child AH1 was seen by school as a mature and helpful child without looking behind this and exploring what the impact on him was. In interview, Child AH1 told the Lead Reviewer that he never shared with anyone that he helped with his siblings, partly because he felt it was normal in families to do so, but it did mean he had little time for himself although he recognised that his mother supported his martial arts hobby, taking him to his frequent training sessions and to his classes and competitions.

5.15 At the professionals' event some people said they were unaware of the Young Carers services available in Norfolk and said they had not considered this in respect of Child AH1 but it was something they would consider in future. A helpful point was made that it is sometimes easier to identify young carers if they are supporting a parent rather than a sibling/s.

5.16 The Norfolk Young Carers website provides helpful, accessible information about the services they provide. Professionals have a statutory duty to assess children who appear to be young carers. The local authority has a duty to consider whether there are any children involved in providing care, and if so, what the impact is on that child. The local authority has a duty to assess 'on the appearance of need' i.e. without a 'request' having to be made. They also have a more general duty to take reasonable steps to identify young carers in their area. The assessment itself must look at whether the young carer wishes to continue caring, and if so, whether it is appropriate for them to do so.

6. The Experiences of the Children

6.1 The records that provided information to the review contain little about the children's lived experience, so we can assume little was known. We can surmise some views from what information we have but must avoid making erroneous assumptions.

6.2 The children were described throughout the records as being happy, lively and resilient. They appeared to have a warm relationship with their mother who clearly loved them very much and took a pride in their achievements. She always attended their parents' evenings, took them to health appointments and out of school and holiday activities and displayed their artwork on the walls of the house. They never appeared reluctant to go home at the end of the day and were just as happy when they arrived in school in the morning.

6.3 The children all had the same mother and father but also had half-siblings from their father's first marriage, one of whom lived with MAH and FAH when Child AH1 was born but was asked to leave by FAH which upset MAH very much and made her first question her husband's behaviour. The extent of contact between the half-siblings and the children in this case is unknown, although FAH is known to still have contact with the children of his first marriage.

6.4 Although the children lived with their mother, they had some contact with their father, Child AH1 described his father positively and said he knew his father could not be very involved with the care of the children due to his health. Apart from a reference to his visiting the children on Fridays and Saturdays, we do not how or when the other children saw their father and in what way.

6.5 During the review, there were comments that FAH found the children's additional needs difficult to accept and had been heard making inappropriate comments about them. There is also a record of MAH smacking one of the children and saying inappropriate things about Child AH3.

6.6 The relationship between the children is unknown but we know Child AH1 helped to care for them and was seen as mature and responsible.

6.7 We do not know from information provided to the review by the agencies involved, what the all the children thought of the house but the fact that it was frequently dirty and packed high with piles of clothing, certainly had an impact on Child AH1 who said how ashamed he was of it, how this stopped him from inviting friends home and how determined he was to keep his own room clean.

6.8 The children were often kept inside because the garden was not fenced in and financial assistance to remedy this was not available, despite its importance to the safeguarding of and well-being of four lively young children.

6.9 The following examples from this case provide evidence and indicators of neglect in this family:

- There is a report of one of the children being unable to concentrate as they were hungry and the offer of free places at the breakfast club in school may have been because staff were aware the children were not always fed before school, or it may have been to help MAH.
- Child AH1 told the Lead Reviewer there was often no food in the house and they and the younger children had to cook for themselves; 'takeaways' were frequent.
- There are frequent descriptions of the youngest children, Child AH and Child AH4, being left in soiled nappies and how this had made them sore.
- There are descriptions of the children not wearing shoes and having been outside in their bare feet, in the winter.
- The accident that led to this review occurred when the children were unsupervised by either parent or an appropriate adult.

6.10 Given the length of time neglect had existed and increased in this case, a joint professionals-only meeting to reflect on progress or lack of it would have been helpful but agencies were working separately and there was no identified lead.

7 Conclusion

7.1 The accident that led to this review elicited an emotional response in everyone who knew Child AH and his family.

7.2 It is important that in reviewing this case we avoid being influenced by hindsight bias i.e. being influenced by what we know happened and the Serious Case Review Panel has worked on the basis that the review seeks to understand what it was like for workers and managers who were working with the family at the time and could not have known what subsequently happened. In particular, it sought to explore what sense the frontline professionals were making of the case, and the contributory factors that influenced their practice.

7.3 We know that neglect is a complex and challenging area of work and it is generally acknowledged that there is no single cause of neglect and that it is most likely to result from a complex interplay of factors .[1] We know too that in the absence of a physical injury or another significant event, professional opinions of cleanliness, behaviour and care can be subjective and differ widely.

7.4 The following characteristics of neglect, identified in the Department for Education research report *'Missed opportunities: indicators of neglect – what is ignored, why, and what can be done?'* (published November 2014) may make it harder for professionals to recognise that a threshold for action has been reached:

- *'First, given the chronic nature of this form of maltreatment professionals can become habituated to how a child is presenting and fail to question a lack of progress.*
- *Second, unlike physical abuse for example, the experience of neglect rarely produces a crisis that demands immediate proactive, authoritative action.*
- *Third, neglect can in some cases be challenging to identify because of the need to look beyond individual parenting episodes and consider the persistence, frequency, enormity and pervasiveness of parenting behaviour which may make them harmful and abusive.*
- *Fourth, there is a reluctance to pass judgement on patterns of parental behaviour particularly when deemed to be culturally embedded or when associated with social disadvantages such as poverty.*
- *Fifth, the child may not experience neglect in isolation, but alongside other forms of abuse as multi-type maltreatment.'*

7.5 We know that there are factors than can increase the likelihood of neglect and those that can reduce it and that these need to be looked at as part of a holistic assessment that focusses on the lived experience of the children.

7.6 In this family there were some factors that were likely to increase the possibility of neglect, but there was also an absence of some of the most commonly found factors:

[1] (Crittenden, 1999; Gaudin, 1993).

Factors	Present or not
Lone mother with little support from family or friends	Yes
Young mothers	Not particularly
Isolated mother	Yes
Large family	Yes
Several pregnancies and unplanned pregnancies	Yes
Premature or very low birth weight baby	No but miscarriages and still births
Low income family	Yes
Unemployed carers	Yes
Carers with low educational attainment	Not known
Relationships featuring domestic abuse or high levels of conflict	Yes
Substance misusing parents or carers	No
Parental mental health problems, including maternal depression	Not significant but occasional depression in MAH
Personal history of childhood maltreatment	Not known but FAH describes having had a strict father
Insecure attachment patterns in the parents own childhoods	Not known
Maternal low self-esteem	Yes
Families that are less cohesive and poorly organised, with little positive interactions between parents/carers and their children	To some extent-little evidence of joined up parenting
Parents/carers lacking sensitivity or responsiveness towards their children	No

7.7 There were also some factors that commonly make the recognition of neglect more difficult that were **not** present in this case:

- staff turn-over was not an issue, the health visitor and both family support workers, were involved for a significant period of the children's lives;
- the children all went to the same schools which meant teachers knew the family over several years;
- the family only moved house once, within the same county; and
- the family stayed with the same GP practice.

7.8 Professionals also look for indicators that the children are being affected by neglect - for example, being unhappy, hungry, underweight, dirty, withdrawn, reluctant to go home, ostracized by other children – although there is one record of one of the children being bullied at school and another of the children being laughed at for wearing the wrong underwear and the children were often dirty and inappropriately dressed, however, they always appeared happy, well adjusted, lively, resilient and confident.

7.9 The children were clearly loved by their mother and professionals felt that she did her best but was simply overwhelmed by the demands of a big family, a low income and having no friends or family support, but these were not explored to gain a fuller understanding of the causes. There were many positive factors: she actively sought support and never denied access to her home, apart from one occasion when she did not want the health visitor and

midwife to look at all the rooms in her house, or access to the children. She took an interest and a pride in her children's achievements, supported their out of school activities, attended parents' evenings, did not resent being challenged and apart from one known incident of a smack there was no evidence of physical or sexual abuse. The children were not taken to the doctor more than is usual nor did she avoid contact with the GP, who described the children as being 'appropriately dressed and their relationship with their mother appeared loving'. She took the children to a significant number of health meetings and assessments, due to their additional needs.

7.10 However, there were also less positive descriptions of the children's behaviour and MAH's control and discipline of them: sometimes they were observed and described as lively, active and unruly children who used bad language and took little notice of their mother's instructions.

7.11 There was little known about the children's father FAH. Professionals knew that he did not live with his wife and children. In interview for the review he maintained they knew how to contact him but rarely did, however, he was invited to and sometimes attended assessments where he was often preoccupied with his health needs rather than the children's needs. GP recording system do not automatically link the records of parents to children or spouse if they live at different addresses which is an issue that is already being looked at by the NHS Designated Safeguarding Children Team.

7.12 There was little known about what appeared to be a complicated relationship between the parents. There were regular discussions between the health visitor and MAH about her continuing to have babies and family planning, despite sometimes saying she did not want any more, but there is no record of encouraging FAH to take responsibility for contraception.

7.13 Professionals could see and sense that MAH was isolated and the first support she received was to help her become more socially integrated in the area in which she lived. Professionals who contributed to the review were surprised that several members of MAH's maternal extended family live in England or that contact with them had gradually been discouraged. Had there been more exploration of her background and networks these could have been discovered.

7.14 There were few conversations about the possibility of coercion and control and although MAH and Child AH1 were supported to leave by a voluntary organisation, the records of this were archived following the introduction of a new recording system; the health visitor who had the most involvement in case was not aware of this, however, when MAH was asked about domestic abuse by the Lead Reviewer she said she would never have told anyone even if they had asked her, because it would have created more difficulties with FAH and would not have led to her being able to fully separate from him.

7.15 The review of this case has borne in mind that the family lived in a deprived area where neglect is not uncommon, although: the number of children subject to child protection plans in the children's schools were not significantly high; the GP said that fathers not living with their families was not uncommon in the area; the family support worker did not see the family as particularly worrying; and the health visitor stated that although her case load had not increased, the complexity of the needs of families in the area had.

7.16 Poverty can be a factor in neglect which is not to say that all poor families neglect their children, as the majority do not, however, the impact of the stress associated with poverty and social deprivation on parenting is widely accepted explanation as a contributory factor in

parental functioning. What MAH said when asked what would help, she said what she most wanted was a big washing machine and a fenced in garden, in which her children could play safely. The difficulties she experienced, and her care of her children were more complex than this but were not explored.

7.17 There was some good practice in this case, consistent diligent and committed support was given to the family and this enabled good relationships between MAH, the children and the professionals, to develop. Considerable efforts were made to support the children's development and meet their health and education needs, additional practical help with the children was given and a respectful empathy and understanding for MAH's position developed which, though compassionate, may have been misplaced and prevented further exploration and challenge.

8. Areas for improvement

8.1 Taken individually, the following recommendations for improvements in practice may not have had a significant impact on the case but, as part of a holistic approach, they are areas to be addressed. Some have already been identified in other Serious Case Reviews of neglect in Norfolk and some could be used in training or inter-agency discussions and supervision.

8.2 There was not a shared view of the family that included information about the parents' relationship or their individual backgrounds. The extent of the support MAH had or did not have from her family, friends and husband was never fully known.

8.3 The views of the children were not gathered or recorded; although there are many descriptions of their care, the link to how they might have felt was not made explicit or informed professionals of the children's lived experiences.

8.4 There was no use of a multi-agency chronology, nor of an effective plan that was measurable and monitored and included a reflection as to why the neglect was continuing for so long to answer the questions: what was the cumulative impact and overall and was the care of the children good enough?

9. Recommendations

9.1 The Norfolk Safeguarding Partnership should consider the following recommendations and, if accepted, ensure they are addressed:

1. 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:
    a. The family's cultural background.
    b. Issues of isolation linked to depression.
    c. The possibility of coercive, controlling relationships.

2. 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.

3. 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.

4. 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.

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

6. 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.

Appendix 1

The Serious Case Review Process

Lead reviewer
The NSCB appointed Glenys Johnston as the independent Lead Reviewer and overview report author. Mrs Johnston has extensive experience, in child protection, inspection, serious case reviews, audits and chairing safeguarding boards. She has worked independently as the Director of Octavia Associates since 1999. She has had no previous involvement in this case.

Panel
The following agencies, which were involved with the family, provided a senior manager to be a member of the Panel established to support the review:

- Norfolk County Council Children's Services
- Designated Safeguarding Children Team, Norfolk & Waveney Clinical Commissioning Groups
- Norfolk Constabulary who were not involved with the family until the point of the incident that led to the review.
- Norfolk and Norwich University Hospital
- Norwich City Council
- Early Years
- Education
- Cambridgeshire Community Services
- EACH East Anglia's Children's Hospices

Methodology
NSCB agreed the review would be carried out under its Thematic Learning Framework with a proportionate, 'blended' approach which included an integrated chronology; interviews with staff and managers by the Lead Reviewer and Panel members; a professional's learning event; and meetings with the family. Information from these sources and the Panel discussions has informed the case specific details of this report; research and other published work of relevance is included in the bibliography in Appendix 2.

Scope
The Panel decided the scope of the review would cover the two years between April 2017 and the date of the child's death in April 2019 and would include any relevant events outside this period.

Specific areas to be considered in the review of this case
The Panel agreed that the review should specifically consider the following questions:

- How effective has the Norfolk Safeguarding Children Board's 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

Parallel processes and investigations

The Panel were mindful of other processes that arose following the death of Child AH:

- A criminal investigation undertaken by Norfolk Constabulary and subsequently referred to the Crown Prosecution Service in November 2019.
- It is anticipated that an inquest will be held on completion of the Crown Prosecution Service's consideration.
- Norfolk Child Death Overview Panel were informed of the death and will complete their review following the Serious Case Review

Appendix 2

Bibliography and Reference Materials

'In the child's time - professional responses to neglect'. Ofsted survey report - March 2014.

Department for Education research report 'Missed opportunities: indicators of neglect – what is ignored, why, and what can be done'? - November 2014.

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'The Child's World, Third Edition: The Essential Guide to Assessing Vulnerable Children, Young People and their Families': Jan Horwath (Editor), Dendy Platt (Editor), Danielle Turney (Contributor). - December 2018.

'The relationship between poverty, child abuse and neglect: an evidence review' Paul Bywaters, Lisa Bunting, Gavin Davidson, Jennifer Hanratty, Will Mason, Claire McCartan and Nicole Steils. The Joseph Rowntree Foundation- March 2016