Serious Case Review

Martha, Mary and Ben

July 2018

This report will be published in line with statutory guidance. In order to preserve the anonymity for the children in this family, the LSCB has:

- represented the children by names from children's literature which do not necessarily reflect their gender;
- represented people other than the children by use of initials;
- avoided the use of exact dates; and,
- removed details about local services which could lead to the recognition of the children and family

1. Background to review

1.1 In August 2017, police attended the family home of Martha, Mary and Ben. At that point, Martha and Mary were 2 years old and Ben was almost 5 years old. The police were investigating a burglary which they suspected had been committed by the children's mother (MC) and their maternal great uncle (GUC) who lived at the property.

1.2 Officers were concerned that the atmosphere was smoky and smelled of burning heroin and that the children and adults all appeared 'drowsy and incoherent'. Drugs paraphernalia was found upstairs. The electricity meter had been bridged. There was no food in the kitchen. Although Ben was said to be living only temporarily with maternal grandmother (MGM), officers found no evidence that he was a member of the household. The layout of the property led the officers to suspect that MC and GUC were in an intimate relationship. GUC was arrested and removed from the family home.

1.3 Over the course of the next three weeks, there was a period of intensive visiting. Professional concerns mounted that Martha and Mary, in particular, were suffering the effects of neglect and of MC's illicit drug use. Professionals were concerned about their pale, thin appearance and their alternately sleepy and anxious presentations. Ben continued to be largely absent from the family home. At the beginning of September 2017, seeing no improvement in Mary and Martha's circumstances, CSC determined to seek legal orders to remove all three children. In the meantime, MC agreed to their being accommodated by the local authority. Hair-strand testing undertaken during subsequent care proceedings revealed that, over the previous six months, Martha, Mary and Ben had been exposed to significant levels of drugs; including cocaine, heroin and cannabis. The test was unable to state conclusively whether those drugs had been ingested or passively inhaled.

1.4 On 11 December 2017, the Practice Review Panel (PRP) of Sefton LSCB considered whether a Serious Case Review (SCR) should be undertaken, based on information provided by the children's Independent Reviewing Officer (IRO) about how agencies and organisations had worked together prior to the children becoming looked after. The PRP discussed the IRO's referral with reference to Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 which requires LSCBs to undertake reviews of serious cases in specified circumstances.

1.5 In this case, the PRP concluded that it would recommend to the Chair of the LSCB, Paula St Aubyn, that an SCR should be undertaken as:

i. abuse or neglect of a child was suspected
ii. a child had been seriously harmed, and
iii. there was cause for concern as to the way in which the local authority, their LSCB partners or other relevant persons had worked together to safeguard the child.

1.6 The Chair endorsed the PRPs recommendation and, on 20 December 2017, she notified the National Panel of Experts on Serious Case Reviews of her decision. The LSCB Chair noted that the key issues were of neglect, domestic violence and drugs misuse. The LSCB received acknowledgement from the National Panel of Experts the following working day.

1.7 The LSCB subsequently appointed an SCR Panel, comprising senior managers from relevant agencies and organisations, to set the terms of reference for the SCR and to manage the process. The SCR Panel agreed that the review period would be from 1 November 2014 – 7 September 2017: that is, from the time that MC booked-in with maternity services with Martha and Mary until the court granted interim care orders in respect of all three children.

1.8 The SCR Panel agreed that the review should be conducted using a hybrid systems approach. This would include structured conversations with practitioners and managers; Individual Management Reviews (IMRs) from relevant services; and, a learning event for those involved in the case. Relevant family members would also be asked if they would like to contribute to the review process.

1.9 The LSCB appointed a Chair for the SCR Panel; Debbie Fagan, Chief Nurse, NHS South Sefton Clinical Commissioning Group and NHS Southport & Formby Clinical Commissioning Group. A suitably qualified and experienced independent reviewer, Isobel Colquhoun was commissioned: the reviewer would lead conversations with staff, facilitate the learning event and would be responsible for providing the final report.

1.10 The SCR Panel commissioned chronologies from all relevant agencies and organisations to give an overview of professional involvement with family members during the review period. On review of the chronologies, the SCR Panel determined that the key lines of enquiry for the review should be:

i. How effectively was the children's mother's vulnerability assessed?
ii. How effective was the provision of support for the family?
iii. How effective was the assessment of the risk of harm to the children?
iv. How effective was the communication between disciplines, agencies and organisations and across geographical boundaries?
v. How was the lived experience of the children understood?

1.11 The SCR Panel comprised:

i. Head of Service, Children's Social Care, Sefton Council
ii. Designated Nurse for Safeguarding Children, NHS South Sefton Clinical Commissioning Group and NHS Southport & Formby Clinical Commissioning Group (CCG)
iii. Service Manager, Safeguarding and Quality Assurance, Sefton Council
iv. Named GP, Sefton CCG
v. Detective Chief Inspector, Merseyside Police
vi. Matron for Quality (Sefton), North West Boroughs Healthcare NHS

vii. Team Manager, Merseyside Community Rehabilitation Company
viii. Associate Director of Safeguarding Children and Adults, Liverpool Women's Hospital & Aintree University Hospital
ix. Named Nurse Safeguarding Children, Mersey Care NHS Foundation Trust
x. Head of Service, Early Help, Sefton Council
xi. Assistant Director of Safeguarding, Alder Hey Children's NHS Foundation Trust

1.12 The Designated Doctor who would normally form part of the SCR Panel had had direct contact with two of the children who are the subjects of this SCR, during the period under consideration. For that reason, she participated as a practitioner in the review. Support was sought from neighbouring CCG but could not be facilitated within current capacity. It was agreed, therefore, that SCR Panel membership would remain as above but that if additional oversight were required, further efforts would be made to secure this.

1.13 The SCR Panel was supported by the LSCB Business Manager, the Business Administrator and the LSCB Legal Advisor. The reviewer attended and contributed to SCR Panel meeting discussions. SCR Panel meetings took place on 19 March 2018, 30 April 2018 and 4 July 2018.

1.14 IMRs were provided by:

i. School Readiness Services, Sefton Council
ii. Merseyside Police
iii. Mersey Care NHS Foundation Trust
iv. Liverpool Women's NHS Foundation Trust
v. Children's Social Care, Sefton Council (CSC)
vi. Children's Centre, Sefton Council
vii. Northwest Boroughs Healthcare NHS Foundation Trust (NWB)
viii. Alder Hey Children's NHS Foundation Trust
ix. GP practice

1.15 Sefton Council's legal services notified the children's mother of the SCR on 19 April 2018 and invited her to participate in the process. A social worker, known to the family, hand-delivered a copy of the same letter on the same day. Sefton Council's Legal Services also made contact through the children's mother's legal advisor, who has been representing her during care proceedings.

1.16 An introductory practitioner event was held in April 2018 as a means of explaining the review process to those who would be participating in it. This was followed by a number of structured conversations, either individually or in small groups, with professionals who had worked with the children and families. These sessions were mainly led by the independent reviewer. The LSCB Business Manager acted as second reviewer in the majority of sessions and a SCR Panel member in two.

1.17 The learning event was held in May 2018. The day-long session provided practitioners and managers with the opportunity to consider the full description of events and to reflect on single and multi-agency practice.

1.18 The final report was presented to Sefton LSCB on 11 July 2018. The LSCB is responsible for disseminating agreed learning; for ensuring the implementation of changes based on agreed learning; and, for measuring the impact of changes.

2. Information gathered about family members and events prior to the review period

2.1 Although there were gaps in the information which was available to professionals during the review period; important details were known to some or all of those working with Ben, Martha and Mary. The following information has been gathered from the combined chronology of agency involvement and IMRs.

2.2 During her childhood, MC lived in a neighbouring local authority where, for some years, she attended a special school. When she was about 6 years old, she and her siblings were made the subjects of child protection plans. Some records suggested that MC had been looked after. MC's own mother (MGM) was known to have a history of drugs misuse and mental health problems. She was said by professionals in her home authority to be frequently 'agitated and aggressive'.

2.3 The children's great uncle (GUC) is MGM's brother. He was living in the same household as MC and the children during the review period. GUC has a history of chronic drug use and of mental health problems. When MC was around 5 years old, GUC was sentenced to 8 years for robbery. He was released five years later under licence. GUC has subsequent convictions for violent offences. It is suspected that GUC is the father of Ben, Martha and Mary, although this has been consistently denied by MC.

2.4 When MC was around 15 years old, she reported that she had been the victim of a serious sexual offence but, reportedly fearful of reprisals, she did not want the police to take action in relation to this assault.

2.5 Ben was born at home when MC was 18 years old. MC and the infant were taken by ambulance to hospital. This had not been MC's first pregnancy. Before and after Ben's birth, anonymous allegations were made to the neighbouring local authority about MC being sexually exploited by MGM and family members. MC denied these allegations. Enquiries made by the neighbouring authority found the allegations to be unsubstantiated.

2.6 In 2014, MC moved to Sefton with Ben: the family had been identified in health visiting records as vulnerable. At that point, Ben was meeting his developmental milestones. MC told the health visitor that she had had episodes of anorexia in the past.

3. Summary of events and analysis of professional practice during the review period

3.1 In November 2014, MC (aged 20) attended a late booking-in appointment with midwifery services. She was pregnant with twins. MC had previously considered whether she should continue with the pregnancy. MC said that the twins' and Ben's father was the same person, but added that she was not in a relationship with him and had not told him that she was pregnant.

3.2 Midwifery services appropriately identified the various medical and social risks associated with MC's late booking; her twin pregnancy; her previous history; and, her current circumstances. In particular, the midwife asked MC about a note on her records that she had disclosed being abuse by an uncle. MC vehemently denied both having been abused by her uncle or having said that she had been. A range of referrals for support and specialist assessment were made, although the twins' arrival three weeks later meant that some appointments were no longer required. The referral to CSC was accepted and progressed to assessment.

3.3 The allocated social worker spoke to the midwife and to Ben's health visitor about their knowledge of MC and their involvements with her and Ben. She also obtained brief information about MC's contact with the neighbouring authority where she had previously lived. As a result, CSC quickly identified some of MC's vulnerabilities and the impact that these might have on her capacity to care for three young children.

3.4 On visiting the family home, however, the social worker found it to be appropriate for a family with young children. MC did not immediately seem to have learning difficulties or mental health needs, although her appearance gave the impression of 'someone who was vulnerable'. The social worker had no concerns about Ben. She had no reasons to suspect that MC was using drugs. MC again denied being sexually abused by GUC.

3.5 In the meantime, the health visitor had made a referral to the school readiness service to tell MC about the 2-year nursery offer which could benefit Ben. MC told the school readiness worker (SR) that she had learning difficulties, OCD and dyslexia. She said that she could read but she struggled with forms. MC was, however, 'chatty' and 'very calm'. Everything was very neat and tidy and MC said that 'she would clean all the time'. Ben appeared to be friendly and outgoing. His development was good and he enjoyed taking part in play activities. SR felt that MC and Ben had 'a lovely relationship'. MC seemed to be keen to start home play sessions with SR as she 'didn't want Ben to be like her'.

3.6 GUC appeared to be 'very polite' and to be caring towards MC. As she got to know the family, however, SR found that his caring did not always translate into helpful actions (for example, when it came to getting the children out of the house and into social activities). MC seemed to be quite reliant on him and SR came to feel that GUC was 'quite dominant'.

3.7 In December 2014, MC was in labour and was admitted to hospital by ambulance. Martha and Mary were delivered quickly at just less than 30 weeks gestation. Babies born before full term (before 37 weeks) are vulnerable to problems associated with prematurity and, the earlier in the pregnancy a baby is born, the more vulnerable they are[1]. In this case, however, both babies were, generally, 'in good condition': they were transferred to the Neonatal Intensive Care Unit (NICU) for their immediate care.

3.8 Four hours after the babies were born; MC discharged herself from hospital and went home. MC had been offered the opportunity to stay in hospital along with Ben but chose not to. It was expected that the twins would be in hospital for about six weeks. MC had said that travel costs would be a problem for visiting. MC left the ward, however, before the hospital was able to put arrangements to assist in place.

3.9 The following day, MC did not visit the children as she had no money. SR provided practical help, including travel cards. Ben's nursery offered some additional sessions over the Christmas period to facilitate MC's attending hospital but this offer was not taken up. MC and GUC visited the twins the next evening. From that point, MC continued to visit the children most days.

3.10 When the twins were three days old, significant conversations took place between CSC and NICU. The records of the two organisations of these conversations are, however, quite different. The hospital record refers to GUC's visiting the children with MC and the implications of his visiting in the light of allegations that GUC had sexually abused MC. It notes that the question would be discussed further at a strategy meeting which had been arranged to take place three days later. In the meantime, it is recorded that CSC had no objections to his visiting. By contrast, the CSC record of a conversation the same day refers to the twins 'presenting with withdrawal symptoms'. This increased the social worker's concerns about the welfare of the children. It is notable, however, that the hospital has no record of suspicions that the babies were withdrawing from drugs.

3.11 The social worker made a home visit the next day. She attempted to discuss the issue of the babies' drug withdrawal symptoms but MC became upset and denied drug use. The social worker also spoke to GUC about his drugs use. GUC said that he had been drug free since 2011 but that he attended drugs and alcohol services when he needed to. When asked about his offending history, GUC became very aggressive and the social worker was asked to leave. Ben was present throughout this time. The community midwife arrived just as the social worker was on the doorstep. The midwife made an arrangement to visit two days later with a colleague.

3.12 A child protection strategy meeting was held. No representative from the NICU was able to attend, 'but information had been sent'. The strategy meeting discussed the reasons for referral and there was reference to 'historical information about domestic abuse

[1] Premature Labour and Birth: NHS choices

incidents involving MC, MGM and GUC'. Concerns were expressed about MC's capacity to care for three very young children. The absence of a representative from the hospital where there twins were in-patients was a gap. A hospital representative might, at least, have clarified the issue of the twins' 'withdrawal symptoms' as this remained an open question in CSC record.

3.13 An appropriate plan for further assessments and additional support was agreed. CSC informed the hospital of the outcome of the strategy meeting. There is no evidence, however, that MC was made aware of the decision and plan. Arrangements were made to hold an initial child protection conference (ICPC) should this be needed. A specialist assessment for parents with learning disabilities was to be undertaken in respect of MC. GUC was also to be assessed as he was caring for the children. The involvement of the local family centre was proposed.

3.14 It is notable that the strategy meeting took place on the last Friday before the Christmas period began when the local authority would also move into a period of restricted services. This meant that there would be no normal day-time service for 13 of the next 16 days[2]. Although immediate safeguarding and child protection matters would be dealt with, normal services would not be resumed within the local authority until 5 January 2015. At that point, problems which had arisen during the Christmas break would also require more in-depth attention.

3.15 Two days after Christmas in 2014, police were called to MGM's house. GUC was threatening MGM that he would kill her. This incident was unknown to CSC Sefton.

3.16 By the time that the local authority and the allocated social worker returned to their normal working arrangements; more than two weeks had passed since the strategy meeting had taken place. No social work visits to the family home and no work had been undertaken with MC, GUC or Ben. There had been no contact with the substance misuse service.

3.17 Although the only new information which had emerged in the social worker's absence was that MC was providing good care to the twins in hospital, efforts by CSC to gain an understanding of family functioning effectively came to an end. Despite having earlier identified MC's vulnerabilities; from that point forward, social work conversations with hospital staff reflected a focus on whether or not the local authority had evidence that GUC posed a risk of harm to the children. And, in that regard, the social worker was coming to the conclusion that it had not. The basis for that opinion, however, was weak.

[2] 6 days would be weekends; 3 days would be bank holidays; and, for a further 4 days, the local authority would be operating a reduced social work service as staff were 'required to take unpaid leave as part of a series of cost saving measures' (Sefton Council press release, reproduced in full at: http://www.formbyfirst.org.uk/2014/12/sefton-council-services-at-christmas-and-new-year.html)

3.18 A visit to the family home and a visit to the twins in hospital appear to have served to reinforce the social work view that there were no child protection issues for the children in this family. This is likely to have been an example of 'confirmation bias' which is a natural tendency of human beings 'to become attached to their judgements and to employ strategies to ensure that new challenging evidence is not recognised or gathered[3]

3.19 In mid-January 2015, the CSC team manager agreed with the social worker's view. It was decided that the case should close. It is notable, however, that the actions set out at the strategy meeting were not reviewed and the implications of their not having been completed were not considered. The hospital had been informed that case closure was likely, but there is no evidence that partners who had participated in the strategy meeting were either consulted prior to that decision being made or informed of it immediately afterwards. These are gaps.

3.20 The hospital continued to make arrangements for the twins' discharge. The community health IMR highlights that there was effective information sharing by telephone between the health visiting service and health visitor liaison at the hospital. It acknowledges, however, that no formal discharge planning meeting took place. It is noted that current practice is that NICU has weekly discharge meetings attended by members of the hospital Safeguarding Children Specialist Nurses team.

3.21 In the following ten days, the health visitor had seven attempts to complete the primary/ birth visit, despite speaking to MC by phone after each attempt to rearrange. Towards the end of the month, the health visitor spoke to the social worker who said that the case had been closed to CSC.

3.22 On the day that she was told the case was closed to CSC, the health visitor spoke to the Safeguarding Children Specialist Nurse and made a referral. In the event, the case had not been recorded as closed in CSC and so, this new information could have promoted a review of the decision that had been made. Instead, however, CSC appears to have focused on the positive elements of the report of a recent visit by SR and insufficient significance was attributed to a possible connection between the family's withdrawal from the health visiting service and Ben's non-attendance at nursery. This suggests a continuation of confirmation bias. As a result, the decision to close the case was unchanged: the case closed to CSC on at the beginning of February 2015.

3.23 A week later, the health visitor contacted the social worker to find out whether an assessment had been completed. She was told that the case had been closed to CSC as MC was engaging with SR. There is no record that the health visitor challenged CSC's decision. Indeed, there appears to have been an acceptance of CSC's view that there was no evidence that the children were at risk of significant harm, although the circumstances which had given rise to professional concerns were essentially unchanged.

[3] Kirkman and Melrose: Clinical Judgement and Decision-Making in Children's Social Work: An analysis of the 'front door system'. Departments for Education, research report April 2014

3.24 Shortly after CSC ended its involvement with the children, MC dropped out of contact with SR and resisted contact by the children's centre. Ben did not attend nursery. From February 2015 – February 2017, the most significant professional contact with the family was through the health visiting service. By the time that the twins were six months old, however, only two home visits had been achieved by the health visitor, despite numerous attempts. MC had brought the twins, three times to clinic. During this time, when the twins had been weighed, Martha's weight had 'dropped off below the 0.4th centile' and MC had been unable to provide an explanation for Martha's poor weight gain.

3.25 In the same period, the twins had been discharged from three outpatient clinics as MC had not taken them for appointments. Specifically MC had missed: 3 ophthalmology appointments; 2 audiology appointments and 3 neonatal follow-up appointments. It is very unusual for parents not to take their premature babies for neo-natal follow up. The community health IMR acknowledges that discussion should have taken place with the Safeguarding Children Specialist Nurse when the consultant neonatologist expressed concerns that the children had not been seen.

3.26 In June 2015, the first of four changes of health visitor during the review period took place. This first change was at MC's request: other changes reflected issues of recruitment and retention within the service. Each of the five health visitors brought with them different levels of experience; different expectations; and different approaches to their work with the family. The lack of continuity is likely to have affected the extent to which the service could make a difference.

3.27 Home visits by the second health visitor were achieved in June 2015; August 2015; November 2015; January 2016; and, April 2016. Throughout this time, Martha's weight remained around 0.4th centile and her gross motor skills were found to be delayed. The health visitor made referrals for hospital outpatients' appointments for Mary and for Ben. Mary had a squint and Ben had chronic constipation. MC did not take either child to their appointments. Ben did not attend nursery, despite the health visitor's securing a place for him. The health visitor records had begun to refer to the twins being 'taken upstairs' after they had been weighed.

3.28 In April 2016, GUC attended for initial assessment with the local substance misuse service. This was not known to child care professionals. GUC reported taking heroin and crack cocaine in addition to his prescribed methadone. A risk assessment was completed but GUC did not reveal that he was living with young children: he reported that he was estranged from a previous partner and their child.

3.29 Over the next six months, there were seven failed visits by health visitors. The second health visitor left the service and casework responsibility transferred to the third health visitor. The third health visitor made one visit to the family home. MC had no concerns about Ben's development, but he was still constipated and was not yet toilet trained. MC had not yet taken him to hospital. When weighed, Mary was on 9th centile: Martha was

on 0.4th. The health visitor was concerned that Martha looked thin. MC described a diet that included three meals, two snacks and 2 pints of cows' milk daily. The health visitor advised MC to take Martha to GP for a weight review. Mary's squint had resolved, without treatment. The health visitor also repeated advice which had previously been given to register the children with a dentist and to brush their teeth twice daily. This health visitor had no further contact with the family.

3.30 Throughout this period, all three practitioners gave appropriate health advice; actively promoted the children's centre and nursery; and, made appropriate referrals to paediatric services. There is no doubt either that each of the health visitors was concerned about Martha's growth; about missed hospital appointments; and, the apparent lack of access by the children to opportunities to socialise outside the house. These were not, however, clearly articulated as indicators of potential neglect and, over time, there was no consistent intervention plan. It is acknowledged that the number of 'no access' visits is likely to have contributed to difficulties in establishing a systematic approach but, more significantly, they appear also to have led to a shift of focus on potential neglect to simply 'getting in'. In that regard, health visitors demonstrated significant tenacity.

3.31 The pattern of contact suggests that MC was most accepting of pre-arranged contacts which took place where she, or GUC, could control key elements of the setting. MC was also able to provide a narrative of intention to comply with professional expectations which served to disguise her actual non-compliance. As a consequence, when contact was established, or re-established after a number of attempts, professionals appear to have been, on the whole, more reassured than alarmed. There was little direct challenge to MC either in relation to her accounts (for example, of the twins' diet) or her failure to carry out her intentions. GUC's presence in the family had begun to appear commonplace.

3.32 In December 2016, when the twins' 2-year developmental review was due, good use was made of some temporary additional capacity when an experienced health visitor/family nurse practitioner joined the health visiting team. A case review was undertaken and the practitioner was able to make a good engagement with MC on her first home visit.

3.33 At that visit; the twins, Ben and GUC were present with MC. The living room was warm and there was evidence of age-appropriate toys. Ben was bright and chatty and there appeared to be warm relationships between the adults and him. MC was seen to be setting appropriate boundaries for Ben and he was responsive to her. Ben appeared to be a healthy weight.

3.34 The twins were in clean pyjamas but they appeared pale. Elements of both twins' development were behind would be expected for children of their age. Mary weighed between 3rd and 8th centile: her height was on the 2nd centile. Martha's height and weight were both on 0.4th centile. The twins were naked when weighed and the health visitor had no concerns about their presentation.

3.35 MC said that she could not read or write and that she struggled to fill in forms: she needed GUC's assistance to do so. It was noted that GUC lived as a member of the household. MC said that he was supportive and a warm bond with the children was observed. MC agreed to attend the children's centre to collect vitamins; to register the children with a dentist; and, to have Martha's weight reviewed. The health visitor referred the twins to community paediatrician for developmental review.

3.36 The following day, MC took Martha was taken to see the GP as she had agreed. The GP found that she was underweight and referred her to paediatric rapid access clinic.

3.37 The twins were allocated funded placements at the children's centre nursery but they did not attend.

3.38 In January 2017, the health visitor made an opportunistic visit to the family home. Ben was seen at the window of property with no adult in sight. The health visitor tried to get the attention of the adults she suspected were in the house, but without success. As a result, she was obliged to call the police. On their arrival, MC opened the door: she was agitated and was verbally abusive to the health visitor. The police ushered MC into the house and the visit was abandoned. The police ensured that the children were safe and notified Sefton's Multi-agency Safeguarding Hub (MASH).

3.39 The health visitor contacted the Safeguarding Children Specialist Nurse (SCSN) to discuss whether a referral should be made to MASH. Based on their joint reading of Sefton's then 'threshold document'; the health visitor and SCSN agreed that the incident and ongoing concerns did not reach threshold for a child protection referral. They believed that MC would not consent to an Early Help or 'child in need' referral being made. An assessment of risk for practitioners visiting the home was, however, required before further visits could be offered. A letter was, therefore, sent to MC asking her to attend clinic in the immediate future for children's health assessments.

3.40 Four days later, the health visitor was informed that MC had not taken Martha to the paediatric clinic. As a result, she sent a referral to CSC in respect of Martha and Mary. Ben was not included in the referral.

3.41 A second appointment for Martha at paediatric clinic was failed at the end of the month. The consultant wrote to the GP, MC and the health visitor indicating that she shared the GP's concerns about Mary being significantly low weight. In the context of the history of MC's not taking Martha for follow up appointments with neonatal services, she supported the referral to children's social care. The consultant asked the GP and the health visitor to speak to MC about the importance of attending these hospital appointments and to let her know the outcome of those conversations.

3.42 Ten days later, having had no response to her referral, the health visitor contacted the MASH to find out what progress had been made. She was told that the referral had not

been taken forward 'as parents had not been informed'. The health visiting team manager, therefore, sent a letter to MC advising her that a referral had been made.

3.43 The following day, CSC accepted the referral which was allocated for assessment two days later.

3.44 Throughout the first two years of their lives, while Mary's weight and height hovered around the 9th centile; Martha's growth could be described as 'faltering'. The reason for this was not established. The community health IMR acknowledges there was a lack of consistency by health visitors in the application of national guidelines for growth monitoring in children. That IMR indicates that this has been factored into the service's training needs analysis and that revised training will be delivered to practitioners when the 'faltering growth pathway' has been updated.

3.45 The community health IMR also recognises the impact of maternal 'disguised compliance' on practitioner effectiveness. Disguised compliance has been defined as 'a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention'[4].

3.46 On this occasion, the allocated social worker was newly qualified, practising under the national Assessed and Supported Year in Employment (ASYE) programme. The ASYE programme aims to help social workers in the first year post-qualification to develop their skills, knowledge and professional confidence. The social worker was one of four ASYE social workers in the relevant team: she was supervised and mentored by the team's lead practitioner.

3.47 To gain a picture of individual and family functioning, the social worker first visited the family home: MGM was present. Family members, however, did not accept the legitimacy of the concerns raised in the referral. MC offered explanations as to why Martha had missed her hospital appointments and why Ben was not attending nursery. MC suggested that the health visitor had made a referral to CSC because she had not allowed the health visitor into the house as the visit had not been pre-arranged. From the point when discussion moved to the children missing appointments, MGM became 'verbally aggressive' and the visit was terminated.

3.48 The social worker found that home conditions were 'immaculate' and there were 'lots of toys around'. The children were appropriately dressed. The social worker noted good interaction between MC and the children: GUC appeared relaxed with the children and they seemed comfortable with him. The social worker talked to MC about having alopecia for which she wore a hat all the time: MC said that it did not affect her confidence. She stated that she did not smoke, drink alcohol or take illicit drugs. MC

[4] NSCC Factsheet: Disguised Compliance 2010

described the children's routines which included her report that the twins (aged 2 years, 2 months) could dress and wash themselves.

3.49 The social worker also spoke to SR, the children's centre and health visiting service as part of her assessment. Those professionals described their perceptions of family circumstances and the difficulties they had experienced in making contact with MC and the children.

3.50 On a second social work visit, MC talked about the difficulties in her early life, including having been raped in 2009. GUC gave signed consent share his personal information. MC revealed that GUC used to take drugs, but now only had methadone. The social worker did not pursue this matter or contact the substance misuse services for further information.

3.51 The day after the social worker's visit, GUC was seen by a senior nurse practitioner in relation to his substance misuse. Responsibility for providing substance misuse services had recently changed to a different organisation and the nurse practitioner was reviewing the treatment plans for service users who had not had a medical review during that time. The service users concerned were still receiving prescriptions but did not appear on allocated caseloads. GUC was one of those individuals.

3.52 During the consultation, GUC reported no relationships or dependents: he confirmed that he lived with niece. He made no reference to the children. The nurse practitioner did not, however, explore MC's circumstances and there was no consideration of the impact on her, as a member of the same household, of his current drugs use; illness; and, mood. This is recognised by the substance misuse service IMR author who acknowledges the importance of ensuring that a 'whole family' emphasis underpins assessments of adults within substance misuse team.

3.53 GUC was invited to attend a health and wellbeing clinic two days later due to his gaunt, underweight appearance. GUC attended the base as recommended and completed the paperwork but he left before the clinic appointment.

3.54 At the end of February 2017, MC and GUC took Martha to general paediatric appointment in relation to her slow/ faltering growth: this was now more than 2 months after the first appointment had been offered. Martha was unhappy to be examined and remained upset throughout. The paediatric consultant found no signs of wasting and thought that Martha looked 'symmetrically petite'. MC was shown growth charts and was advised to increase Martha's calorie intake. Martha was prescribed iron supplements. The plan was to review her progress in 2 months. The out-patient records indicate, however, that 'parent cancelled' 3 further appointments; in April, June and July 2017.

3.55 The fifth health visitor started working with the family around the time that the social worker proposed that the children should have multi-agency child in need support plans.

The assessment which underpinned the plan, however, did not clearly articulate the impact on the children's development and wellbeing of not being taken to health appointments or of not having opportunities to socialise with other children. It did not consider either whether there was a link between the problems as expressed by professionals at this point and the concerns which had been identified previously. As a result, there was no effective exploration of the impact on parenting capacity of MC's known vulnerabilities; of the roles played by GUC and MGM in family life; or of GUC's drug use.

3.56 Before the Child in Need plans began, health visitors and other community practitioners had tried on many occasions to persuade MC of the importance of attending health appointments with the children and many arrangements had been made to ease MC and the children into attending the family centre or going to nursery. Their efforts had had limited success. Despite this being a firmly embedded pattern, the Child in Need plans essentially recommended 'more of the same'. There is no evidence that Sefton's neglect screening tool was used. In addition, it was not until the fifth child in need meeting that the suggestion was made to use the recommended multi-agency assessment tool for neglect: Graded Care Profile 2. As a consequence, there was little prospect of effecting change.

3.57 Five Child in Need meetings took place. Visits and attempted visits by the social worker and the health visitor continued throughout this period. The social worker referred Ben to the paediatric continence nurse. There were more frequent references to the children being 'brought downstairs' to see professionals.

3.58 In mid-April 2017, MC and GUC took Martha and Mary to developmental clinic for appointment with a Consultant Community Paediatrician. This particular consultant is also Sefton's Designated Doctor for Children's Safeguarding. During this consultation, the children were crying, clingy and reluctant to be examined. They appeared to have some developmental delay 'more marked in language skills', although Martha's development was less immature than Mary's. The paediatrician gave MC advice about the importance of 1:1 play, on the floor, using language and engaging in lots of laptop and singing games. MC reported that the twins would be attending nursery at the children's centre and that there was input from a member of school readiness team. GUC said that CSC were involved 'due to a mix-up' but was unable to say what the nature of involvement was.

3.59 As appropriate services appeared to be in place, the paediatrician planned to review in a year's time. In the meantime, she sought confirmation of CSC involvement: there was some delay before this was confirmed. She was not invited to interpret her findings within the context of Child in Need planning.

3.60 GUC continued to have contact with substance misuse services but, by April 2017, he was beginning to drop out of daily methadone use. He was being strongly advised to seek medical care in respect of his physical wellbeing. The changes to the process by which GUC accessed his methadone prescription appear to have been problematic for him. He

was seen to be gaunt and thin: he was also experiencing symptoms of physical ill health. He was strongly advised to seek medical help and, within the service, his prescriptions were altered in response to his reported circumstances. GUC's mood was said to be low and he had 'no recovery goals'.

3.61 For much of April and May 2017, it was not always apparent where Ben, in particular, was living. He appears to have been spending an increasing amount of time with MGM who was taking him to nursery. After an initial period of settling-in, Ben began to make progress and by June 2017, he was out of nappies and was being prepared for school in September 2017.

3.62 In mid-June 2017, the final Child in Need meeting was held. Since she had first met the family, the social worker had faced considerable levels of hostility and abusive behaviours, particularly, but not exclusively from MGM. This had made it difficult to talk about difficult issues. Over time, MC had also increasingly dropped out of her limited engagement with professionals. Her contact had become more irascible and combative. Most recently, MC had indicated that she had no intention of taking part in any programme of work.

3.63 As MC did not attend the Child in Need meeting, a professionals' meeting took place instead. The children's centre manager had attended on behalf of the nursery. The children's centre manager asked about the Graded Care Profile and was surprised that this had not already been employed. She suggested that one of the trained children's centre staff could support SR to complete the profile as she was the professional who had the best relationship with MC.

3.64 The meeting concluded that if parental cooperation did not improve, then a strategy meeting would be held. This contingency had previously been agreed with the social worker's manager. Within a week, however, the social worker and her manager decided that the plan should end. They acknowledged the positives that Ben was in nursery and that the twins had been seen by paediatricians. Although the twins were not attending nursery as proposed, there was 'plenty of time for that later'. From their perspective, professionals were 'really getting nowhere' and 'there was a lack of evidence of harm'. There seemed, therefore, to be 'no reason to keep the case open'.

3.65 The social worker emailed SR to say that 'her manager had advised that case should be closed' as there were 'no safeguarding or wider child care concerns'. SR sent the email to the children's centre manager. Both were taken aback both by the decision itself and by the fact that the decision was made outside of the Child in Need process. At that point, however, they did not make any formal challenge. At the end of June 2017; the case was closed to CSC as 'MC did not wish to engage'. The health visitor also later accepted the social worker's statement that 'there was not enough evidence to proceed'.

3.66 Around this time, GUC dropped out of contact with the substance misuse service, despite efforts to keep him involved.

3.67 Within days of the case closing to CSC, Martha was found to have a dental abscess when MC was advised by the GP to take her to A&E. It is highly likely that this would have been extremely painful for Martha and, as a result, she would have been in some distress. It is also likely to have affected her eating and sleeping. Yet, MC did not take her for follow up appointment for 3 weeks. At that point, she was found to have severe dental decay requiring extraction of 14 of her 20 baby teeth.

3.68 In mid-August 2017, during police investigations into a burglary; CCTV footage showed MC and GUC using stolen cards at various locations. Police attended the family home on suspicion of MC's and GUC's involvement in the burglary. Officers were concerned that children and adults all appeared 'drowsy and incoherent' and that the atmosphere was smoky and smelled of burning heroin. Martha cried throughout the time that officers were present (even in her sleep) and Mary was silent and 'stared at her own legs throughout the entire search'. The electricity meter had been bridged, leaving exposed wires.

3.69 There was only one bed in the property and officers suspected that MC and GUC were in an intimate relationship, although MC denied this. The bedroom contained drugs paraphernalia. MC reported having depression and was seen to have 'fresh scabs or blisters on her arms and face'. There was no evidence that Ben lived as part of the household. It has been reported by a number of professionals that one of the officers went out to buy food for the children.

3.70 GUC was arrested and remanded to appear at court the following day. As MC was also to be arrested that day, police requested a social worker be present, in case the children would need to be provided with alternative accommodation and care. A third social worker attended with the police officer from CID.

3.71 The social worker was satisfied that the children were not at immediate risk of harm, given the good conditions of the family home and the small amount of basic food items in the freezer. Police checks in respect of a 'friend of the family' (FF), who was present, revealed no cause for concern that he posed a risk of harm to children. MGM was informed of MC's impending arrest and she said she would take over the care of children.

3.72 The police referral to MASH suggested multi-dimensional problems which could have a serious impact on the children's health and wellbeing. In addition, a child in need plan had ended two months earlier; in reality, with no progress having been made. In those circumstances, a strategy meeting should have been held at this point to determine whether child protection enquiries were required. The MASH social worker's report, however, focussed on the immediacy of the circumstances in the family home rather than taking into account the wider circumstances of both the incident and the history. The social worker recommended a new children and families assessment.

3.73 On the same day, the GP phoned MASH about his and the dental surgeon's concerns about Martha's oral health and was advised that the case was closed. Arrangements were agreed by MASH to have further discussion within 24 hours, but despite efforts on both sides to communicate, it was 48 hours before this was confirmed. There is no record of this discussion in CSC chronology, although the enquiry was prompted by a concern about neglect and could therefore have been significant to decision-making about how to respond to events in the family home. Neither the GP nor the dental surgeon made a subsequent child protection referral.

3.74 There was a delay of 6 days from the point of police referral before the first visit to the family home took place: this included a 3-day holiday weekend. This was a gap which the CSC IMR acknowledges as it suggests that the visit could more properly have taken place on the Friday before the long weekend began.

3.75 The allocated social worker was appropriately concerned about the children's health and asked the health visitor to undertake an assessment. The health visitor suggested that, in the circumstances, a specialist child protection examination would be more appropriate. The social worker did not think this would be necessary. The health visitor said that the children should be seen by a GP, but agreed to make a joint visit later that day. She weighed the twins and made arrangements for Ben to be seen by the GP.

3.76 By this stage, a strategy meeting had been arranged, although the reason why it was not due to take place for another 5 days is unclear. In discussion, the assessment team manager acknowledged that the delay in arranging a strategy meeting in this case was unusual and that the record gives no justification for it.

3.77 As the hospital IMR suggests; a more timely strategy meeting would have offered the opportunity to seek specialist medical in respect of the physical medical assessments of the children. It might also have given an opportunity to consider the significance of the report from the paediatric dental/oral and maxillofacial surgeon in relation to Martha and of the issues relating to the investigation of Ben's constipation.

3.78 A timely strategy meeting could also have brought the substance misuse service into the professional decision-making for the first time, although it is notable that when the meeting actually took place, they were not invited to participate.

3.79 CSC continued its assessment. On this occasion, CSC's approach to MC and MGM was both supportive and challenging. This, combined perhaps with GUC's absence, allowed more access to the family home than had previously been given, both for social workers and family centre workers. MC acknowledged that she had been using illicit drugs since 2013. MGM said that she had also had concerns about the nature of GUC's relationship with MC.

3.80 Social workers' observations of the twins led them to be concerned that they were being adversely affected by exposure to drugs. When this was discussed with MC and MGM,

they were both angry and upset. Nevertheless, MC agreed to child protection medicals for the twins. She would not, however, allow paternity tests.

3.81 At the beginning of September 2017, the twins were taken with MC and MGM for child protection medicals. Ben was not included. The social workers wanted to know whether the children were suffering the effect of exposure to MC's drugs use. At the hospital; physical examination was challenging for the examining doctor as both Martha and Mary became distressed if anyone looked at them. He was unable to get height or weight measurements, but Mary looked 'well-nourished' bigger than Martha who appeared to be 'adequately nourished'. Both children appeared to be clean and appropriately dressed. The examining doctor confirmed that Martha had marked signs of dental decay.

3.82 Such physical examinations as were possible during the consultation revealed no immediate cause for concern. During the consultation, however, MC and MGM began to argue; resulting in a 'prolonged verbally aggressive episode between them'. The consultant noted indicated that the twins' had an 'unusual and extreme reaction' to this aggression; initially going very quiet and then flopping to the point of appearing asleep.

3.83 These reactions have been described as 'freeze/flop'. The consultant later commented that, although he had not witnessed this in his clinical practice, the flop response is thought to be a recognised response to trauma or aggression. Its purpose appears to be both to reduce the likelihood of injury in case of impact and, as the child 'completely shuts down' to help from psychological point of view.

3.84 The examining doctor was unable to draw conclusions about exposure to drugs on the day of the consultation. Specimens of urine were taken for toxicology but those results would not be immediately available. Following discussion with the physician, the social worker understood that there was no evidence of immediate concern for the children's health and wellbeing. They did not realise that the doctor was also concerned that the children might have been exposed to trauma. It is notable that the doctor's observations of the children's behaviours were similar to those which had been described by family centre workers when they visited.

3.85 At the child protection strategy meeting, there was a full discussion of history and recent circumstances although, as noted above, information from substance misuse service was missing. It was agreed that an initial child protection conference would be arranged. Following the strategy meeting, social workers went to the family home to tell MC about the outcome. From that point, events began to move quickly; as social workers became increasingly alarmed about the twins' presentation, while the adults looking after them (MC and FF) appeared to have been using illicit drugs.

3.86 CSC concluded that action was required to remove the children from what were the immediate dangers of this situation. In anticipation of problems which might arise, the police were called to assist at the family home. In the event, police officers secured MC's consent to allow the local authority to accommodate all three children. Martha and

Mary were appropriately placed with foster carers, while Ben remained with the relative in whose care he was already living.

3.87 Three days later, all three children were made the subjects of interim care orders. Hair strand drug tests were undertaken during the course of proceedings: those confirmed that the children had been exposed to significant levels of drugs during the previous six months.

4. Key lines of enquiry

a. How effectively was the children's mother's vulnerability assessed?

4.1 Although, in the learning event, professionals working with the family could identify MC's vulnerabilities without difficulty; throughout the course of the review, the significance of those vulnerabilities was not adequately assessed. MC was often (but not always) described as having learning difficulties, but the nature of those disabilities and their impact on her everyday life were never clearly established. Although she was known to have attended special school as a child, the details of her assessment of special educational needs were not sought. MC and MGM gave different accounts of how MC's learning needs affected her abilities to read and write. This was not clarified.

4.2 It was known that MC had been the subject of a child protection plan but the nature of the concerns and the outcome were not ascertained. MGM was said to have been a long term drugs user with mental health problems: there was no understanding of the impact that this had on MC's childhood experience or assessment of how this might have affected MC's capacity to care for her own children. There were reports that the person who sexually assaulted MC was a visitor to MGM's home, but the circumstances of the assault and their significance were not explored. CSC and community health workers were unaware that details of the incident, gathered contemporaneously, were held in hospital records.

4.3 Allegations had been made that MC had been sexually exploited by family members. MC's denials appear to have been accepted without further question and details were not sought of the rationale for finding that the allegations were unsubstantiated. At the same time, there were professional suspicions that MC might have been involved in sex work during the period of the review, but these were never clearly articulated or discussed with MC.

4.4 Importantly, the nature of MC's relationship with GUC was unknown. There was a clear reference on MC's midwifery record to MC having said that she was sexually abused by her uncle, but the review has been unable to establish what action was taken as a result of that allegation having been made. MC has consistently denied having made such an allegation. MC's denial was effectively accepted, although doubts remained.

4.5 At the same time, there was no consideration of the nature of the continuing relationship between GUC and MC. Their living arrangements were unusual, but there is no evidence that GUC was asked why he was living in the same household as his niece and her young children. MC's description of his being a source of support appears to have been generally accepted at face value.

4.6 It was known that GUC had a history of drugs use; mental health problems; violence including domestic abuse; and, criminality. The possibility that GUC might be controlling or exploiting MC was not, however, developed as a working hypothesis, despite MC's

recorded vulnerabilities, including to sexual abuse. Insufficient information was gathered about important aspects of their living arrangements and daily life to determine whether GUC was exercising coercive control over MC. Over time, professionals appear to have become more accepting of their relationship; on occasion, for example, suggesting that GUC might help her by reading her post to her.

4.7 MC appears to have had no friends or support other than from MGM or GUC. One or other or both were generally present when visits to the family home took place. MC was rarely seen alone. In addition, as is acknowledged in the CSC IMR; all three adults could become challenging and aggressive when difficult issues were raised and this was often in the presence or hearing of the children. As a result, these conversations were often terminated either due to workers' concerns about the children's safety or their own. The only other 'family friend' who was seen by professionals was F, who appeared after GUC was arrested. His reasons for being present are unknown.

4.8 Health visitors routinely asked MC about her emotional health and wellbeing and findings were recorded: MC's responses did not give cause for concern. The record suggests that MC's physical appearance had deteriorated over time; losing weight, with thinning hair and skin lesions. There was, however, little professional enquiry about this. Towards the end of the review period, MGM suggested that MC's GP had said that MC was suffering from stress. Information from MC's personal medical record has not been obtained as it has not been possible to secure her consent.

b. How effective was the provision of support for the family?

4.9 The effectiveness of family support is predicated on there being a good understanding of the nature of the challenges the family faces and that account has been taken of the views from family members about what they think would be helpful.

4.10 In this case, MC, GUC and MGM generally denied that there were problems that would require professional intervention; they acted to impede professional efforts to gain insight into their family life; and, when professional concerns were identified, they did not accept their validity. This made for a challenging environment for professionals who were not always equipped to respond adequately. Most professional contact was focused on MC, who, as the children's mother and the only person with parental responsibility, was assumed to be the principal care giver and decision maker in respect of Mary, Martha and Ben.

4.11 MC did not, on the whole, seek help. In the early period of the review, she sought some support from SR and the children's centre, but this was mainly for financial or material help. SR and the children's centre tried to build on the rapport that SR had established with MC. In trying to promote learning activities that involved children and adults, they took into account MC's practical circumstances with three small children. But, from February 2015, MC withdrew from contact with SR.

4.12 During the brief period of CSC's first involvement, there was no multi-agency planning and, as noted, the case closed without a formal support plan being agreed. The involvement of the local authority family centre with its experienced family support workers had been proposed as part of the strategy meeting, but this did not happen.

4.13 Efforts continued to make it possible for MC to take the children to community resources. These varied from encouraging suggestions; delivering newsletters and invitations to attend; home visits; support for settling in sessions; and, personal interventions when MC had let places go or had not applied as she had said she would.

4.14 From around five months old, Martha's weight was faltering and was recorded as falling below the 0.4th centile. Advice was given to MC about feeding, vitamins and weaning. This did not, however, lead to improving her rate of growth. The community health IMR suggests that there was insufficient assessment of the twins' feeding history and unsatisfactory follow up and referral to GP, paediatrician and dietician.

4.15 As the pattern of MC's non-compliance for attendance at health appointments became entrenched; health visitors offered advice about the importance of taking the children to appointments; reminded MC when appointments were due; and, made new referrals when appointments were failed. Again, these actions had little impact in bringing about change.

4.16 The CSC IMR acknowledges that during the period that the children had Child in Need plans, support and intervention did not address concerns or improve outcomes for the children. Some very small improvements were made but not sustained. Then, MC's eventual refusal to engage led to case closure, despite the previously agreed contingency of progressing to child protection enquiries.

4.17 CSC was aware, by this stage, of GUC's involvement with substance misuse services but there was no communication with the agency. As a result, their concerns about his health and wellbeing were unknown and the impact of his drugs use on MC and the children was not assessed. No formal continuing support plan was put in place before the child in need plan ended.

4.18 Within a short time of CSC ending its involvement, there were new concerns about the children's welfare and about illicit drugs use in the family home. Ben's living arrangements were unclear. The situation quickly became critical and, in less than 2 weeks, all three children became looked after.

c. How effective was the assessment of the risk of harm to the children?

4.19 The risk of harm to the children was not effectively assessed. The assessment of the likelihood of harm requires an evaluation of the combined effect of both positive features of family life and of factors which increase risk. In this case, the home conditions and Ben's chatty, engaging personality had a powerfully reassuring effect on professionals

working with the family. Practitioners also noted warm relationships between MC and the children. GUC was seen to attend to their needs.

4.20 At the same time, when the children were first referred to CSC, a range of risk factors were identified, including: the children's ages and the twins' prematurity; MC's vulnerabilities (and possible drug use); GUC's history; and, the nature of the relationship between GUC and MC. However, the assessment was curtailed and the risk of harm was not adequately evaluated. In addition, professionals from partner agencies were not sufficiently consulted or involved. Poor feedback in respect of decision-making in CSC meant that partners were uncertain as to why enquiries had been concluded identifying no child protection concerns. Despite this uncertainty, however, partners did not challenge the validity of CSC's findings or decisions. As a consequence, professionals working with the family, from that point, appear to have assumed that the concerns identified at the strategy meeting had diminished or had been resolved.

4.21 Before the twins were born, MC already had a pattern of reluctant involvement with health professionals, as was evident from her previous contact with maternity and health visiting services. When the twins were discharged from hospital, this pattern became ingrained and many important health appointments were missed. For example, in the early weeks of their lives, in addition to MC's cancelling or rearranging community health appointments, Mary and Martha missed all but one of the out-patient appointments that were offered to ensure that there were no new or continuing effects of the their prematurity. In addition, Mary was not taken for an appointment in relation to a squint. It should be noted that squints, if untreated, can lead to complications, including to the loss of sight in the affected eye[5]. MC would have been aware of this as the referral letter for Mary stated that MC had a squint and sight loss in one eye.

4.22 The reasons why MC did not take the children for follow up appointments were not understood and the implications for the children of not being taken were not clearly articulated. Both the GP IMR and the community health IMR acknowledge that the risk to the children of persistently not being taken for hospital appointments should have been addressed in a timely way and should have led to a consideration of whether MC was neglecting the children's twins' needs[6].

4.23 Although, for a period, a degree of regularity in health visitor contact was achieved; overall, the pattern of 'no access' visits continued for pre-arranged appointments. In addition, Ben was not taken to several rearranged out-patient appointments, despite his showing signs of chronic constipation, including frequent soiling. There was a suggestion this was one of the reasons he was still in nappies, aged 4. Martha also missed appointments relating to her faltering weight before the second CSC assessment began. There was no evidence that the children had been registered with a dentist.

[5] RNIB: Childhood Squints

[6] Was Not Brought - Take Note! Think Child! Take Action! Child Abuse Review Vol. 26: 165–171 (2017) Published online in Wiley Online Library (wileyonlinelibrary.com) DOI: 10.1002/car.2476

4.24 In the meantime, the family's and the children's social isolation continued. Children have a right to play (Article 31 of the Convention on the Rights of the Child). In its Declaration on the Importance of Play (2014) , the International Play Association describes how play has an intrinsic value to a child, in terms of the enjoyment and pleasure it affords. Play with other children also encourages the development of personal and social skills and contributes to all aspects of learning. Having the opportunity to play in this way is also a form of participation in everyday life. In addition, for children who may be at risk of harm or neglect, being visible to other people, outside the family, can also be a protective factor.

4.25 In this case, health and community professional focus had been on trying to persuade MC to take the children to nursery and the children's centre. When their efforts were not successful, however, health visitors questioned whether non-attendance could be considered an indicator of neglect, given that parents can chose not to make use of these resources. Yet, despite MC's denials, there was no evidence that the twins, in particular, were being taken out of the family home into the wider community or that they were having the opportunity to mix with other children. Indeed, the evidence was that Martha and Mary were spending all their time in one bedroom. They were quite hidden from professional and community gaze. It was in the context of that wider isolation, therefore, that the risks to the children of not attending children's centre and nursery needed to be seen.

4.26 CSC undertook a second assessment but the complexity of the family circumstances were not explored. Safeguarding concerns were not sufficiently recognised and, although practitioners thought neglect might be an issue; they did not use the standardised tools available. As already identified, there was no communication between children's services and adult substance misuse services. The substance misuse services had not considered whether GUC's drugs use posed any risks of harm to children as they were unaware of the children in his household.

4.27 Although Martha had been seen by two paediatricians during this period and Mary by one; paediatricians were not invited to contribute to the assessment. It was generally understood that Ben was not always being cared for by MC, but as he was now attending nursery; his living with MGM was viewed relatively positively, despite MGM's history as a care-giver. As noted earlier, the plan to undertake child protection enquiries was not enacted. Partners did not challenge this CSC decision. The community health IMR states that thought should have been given to discussing the case with the Safeguarding Children's Specialist Nurse for consideration to escalate concerns to CSC.

4.28 The question of MC's neglect of Martha's health needs was raised again following Martha's attendance at A&E with a dental abscess. There is evidence that the paediatrician and the GP were concerned but, although health records refer to communication with the health visitor and MASH, there is no record of referral to CSC.

The GP services IMR author has provided an update which states that the GP 'attempted phoning for two days and had not been able to speak to anyone that could help'.

4.29 In the meantime, CSC's focus was on events in the family house, following the police search of the premises. The decision in MASH not to hold a strategy meeting impeded both the evaluation of new and historic information and the development of a multi-agency plan to assess the risk of harm to the children. Although there was an early decision within CSC assessment service to hold a strategy meeting, it was set for a date 12 days after the police arrested GUC. The CSC assessment, therefore, began without a sense of urgency or clear direction.

4.30 Soon after assessment visits began; concerns about the twins' wellbeing increased as MC and MGM revealed more about drugs use and family circumstances. Social workers were most concerned about the twins' presentation and, as they suspected that they might be suffering from exposure to illicit drugs, a child protection medical appropriately took place. As noted earlier, the medical was inconclusive in relation to exposure to drugs, but an opportunity to gain an understanding of the wider risks to the children was lost when there was no joint consideration of the implications of the paediatrician's observations of the twins' 'freeze/flop' reaction. Ben's wellbeing did not form part of practitioners' immediate concerns, as he was not often present when they visited.

4.31 The day after the child protection enquiries began; the children became looked after, when MC agreed to them being accommodated. Care proceedings followed. This was a rapid development in the levels of intervention. Medical examination, just over 3 weeks later, concluded that Martha and Mary had been exposed to extreme neglect and were at risk of developmental/neuro-developmental delay and learning difficulties. Ben's initial health assessment for looked after children concluded that he had age appropriate social and dressing skills with delayed toilet training. Effects of his chronic constipation were still evident. All three children had been exposed to drugs.

d. How effective was the communication between disciplines, agencies and organisations and across geographical boundaries?

4.32 The communication between professionals from different disciplines, agencies and organisations was variable, as was the communication across geographical boundaries. Throughout the period of the review, there were only 7 multi-agency meetings: 2 strategy meetings and five Child in Need meetings. Most recorded communication between professionals from different disciplines or agencies was, therefore, written or by telephone.

4.33 At the point that MC came to live in Sefton with Ben, the health visitor was alerted to MC's mild learning difficulties; her volatile relationship with MGM; and to the history of involvement with children's social care. Reference was also made to the unsubstantiated

allegations that MC was a sex worker. As a result, the health visiting service offered an additional targeted visiting schedule above the core national healthy child programme.

4.34 As noted earlier, midwifery services identified various medical and social risks in respect of MC and her twins. A range of referrals for support and specialist assessments were made, although the twins' early birth meant that some of these were redundant. An appropriate referral was sent to CSC. CSC followed up the referral by seeking further information from the midwife. CSC also sought information from the neighbouring authority about their contact with MC and family members. The information which was provided identified a range of relevant concerns but it was generally superficial. The local authority's understanding of context into which the twins had been born would have been enhanced by further reference to the record.

4.35 The NICU was made aware of the child protection concerns which had been expressed, particularly in respect of GUC and of the allegations that MC had been sexually exploited by family members. Staff at the hospital were not entirely satisfied with CSC view that there was no reason to restrict GUC's visiting the twins so they informed the neo-natal consultant of the circumstances. He advised close supervision of GUC and to await further guidance following the strategy meeting which was due to take place two days later. The maternity hospital IMR acknowledges that this was good practice, but suggests that it would have been more appropriate to seek guidance from safeguarding practitioners who could have acted as a conduit between the hospital and the local authority. Had the safeguarding team been made aware of the concerns, they might also have been in a position to attend the strategy meeting on behalf of the hospital. The hospital was not aware that the local authority understood that the twins had suffered 'withdrawal symptoms' at birth.

4.36 In the two weeks following the strategy meeting, as has been noted earlier, communication between the maternity hospital and CSC was affected by limited availability of CSC staff during the Christmas and New Year period. The decision by the local authority to end child protection enquiries without reference to partners and the lack of formal challenge have also been discussed above.

4.37 The absence of a formal discharge plan in respect of the twins has already been identified and the current improved practice acknowledged. Despite there being no formal support plan for MC and the children, at that point; good communication has been reported between the health visiting service, the children's centre, and the school readiness service during the time prior to Child in Need plans being established.

4.38 Referrals for investigation or services formed a considerable proportion of written inter-disciplinary and inter-agency communication. There were also examples of what the children's hospital refers to as 'DNA' responses. The children's hospital IMR indicates that clinicians adhered to the 'Pan Mersey DNA Pathway' and that they reviewed the children's records after each failed appointment. When the decision was made to discharge the children because they had not been taken for appointments, the GP was

always advised in writing. As already described, this was acknowledged by the GP IMR but, in the surgery; there was no equivalent enactment of the pathway, so that alerts were not logged and acted upon. Remedial action was recommended by the GP IMR and it has been reported that recommended measures have been implemented.

4.39 The hospital IMR also refers to evidence of good verbal communication between the health visitor and the paediatrician who was reviewing Martha's growth. The health visitor was copied into hospital letters to the GP with outcomes of out-patient reviews; Martha's attendance at A&E; and, the children's child protection assessment.

4.40 Health visitors twice made what they assumed would be accepted as referrals by MASH. On both occasions, there were problems in creating referrals which were only identified when the health visitors requested an update about progress made.

4.41 Levels of communication between professionals involved in the Child in Need plan appears to have been good, although the assessment and interventions were limited. As noted above, the failure to follow up contact with the substance misuse service in respect of GUC was a significant gap.

4.42 As before, CSC made the decision to close its involvement without reference to other practitioners. And again, this was not formally challenged. Discussion with practitioners about this suggests that, for some, there was a sense of being in a hierarchy of perceived competence in safeguarding and that their personal/ professional point of view was less valuable or valid than the social work opinion.

4.43 The communication between professionals towards the end of the review period is generally covered in the sections above.

4.44 Frustrations were also expressed during the course of the review about differing expectations of what information can be shared with other professionals, in the contexts of confidentiality; consent; data protection; and the appropriate timely sharing of information in order to safeguard and promote the welfare of children.

4.45 Specifically, while MASH had little involvement in this case, a number of concerns were raised by professionals either individually, through records or during practitioner learning event. These included: the difficulty getting through on the phone; restrictions on the availability to the Assessment Team in CSC of information collected during MASH enquiries; and, not getting back to referrer.

4.46 In respect of the reported difficulty in getting through to MASH on the phone; the CSC SCR Panel representative noted that the current communications system in MASH should ensure that there is a quick response to callers who have been unable to speak to a MASH worker on their first attempt. The MASH team manager will, however, monitor the effectiveness of these arrangements in practice.

4.47 The CSC SCR Panel representative has reported that the issue of sharing information collected by the MASH team with CSC assessment teams is currently under review.

4.48 In relation to measures to ensure that referrers are given feedback as to the outcome of referrals; the SCR Panel noted that this has been highlighted previously by health organisations as an issue. The CSC SCR Panel representative reports that there have been changes to administrative personnel within the MASH team and that the lead administrator will ensure that all staff are aware of their responsibilities in terms of feedback to referrers. As there have always been clear processes in place, however, it is likely that barriers to compliance are more complex.

e. How was the lived experience of the children understood?

4.49 It is clear from the review that the lived experience of the children was not understood. The children lived with their mother and the person who was legally their maternal uncle but who might also have been their father. Although his paternity cannot be confirmed, his everyday relationship with the children appears to have been parental. MGM was a frequent visitor to the family home. Ben appears to have been living with MGM and, possibly his maternal aunt, at different times throughout the period of this review.

4.50 The family lived in private rented accommodation in an area of Sefton characterised by high levels of deprivation. The household income was not established and financial arrangements between the adults were unknown. MC seems, however, to have been without funds at different times.

4.51 The family was socially isolated. The children were not seen out and about in the local community. There is no record of the family referring to any social activity. The curtains in the house were kept closed 'against nosy neighbours'. Professional contact and assessments did not reveal details of the family's daily routine: their living; eating; and, sleeping arrangements were unknown. MC's reporting of the children's diet and dental care routines were not consistent with the evidence of the children's presentations. The roles that MC and GUC had, separately and together, in caring for the children were not established.

4.52 The relationships between the children and the adults in their lives were observed at different times to be warm: the adults were kind and appropriate and Ben, in particular, was responsive to them. On the other hand, neither Martha nor Ben was taken in a timely way for medical help when they must clearly have been suffering pain and discomfort. Mary was consistently noted to be markedly bigger than Martha in all ways; but it was not known whether they were treated differently.

4.53 As time went on, the twins' distress prevented professionals from engaging with them. Ben was not spoken to alone and he was less frequently seen at the family home. As a result, his thoughts and feelings were not explored.

4.54 All three children were known to have been present when the adults in their lives were displaying anger and aggression. The children's reactions were observed at different times; their reactions suggest that this was a common experience for them.

4.55 The family appears increasingly to have lived upstairs. At the end of the review period, the twins had a small table and chairs in their mother's bedroom where they ate. They seem to have slept in her double bed. They were not being offered the kind of stimulation they needed and they were exposed to adults' illicit drug use.

5. Lessons learned from this review

5.1 Lessons have been learned at different levels throughout the course of this review. Practitioners took advantage of structured conversations to reflect on their individual experiences in this case and to highlight the factors which contributed to the decisions they had made and the actions they had taken. The information they provided in structured conversations provided a depth and colour which was absent from the combined chronology.

5.2 In addition, bringing practitioners and managers together in the multi-agency learning event offered further learning opportunities both for individuals and for groups of workers. Again, their joint learning has influenced the findings of this SCR report.

5.3 The Individual Management Reports which were prepared as part of the SCR process each addressed the key lines of enquiry as they related to their agencies and organisations. They subsequently identified the lessons they had learned and drew up related recommendations. Reference has been made to some of those lessons and recommendations throughout this overview report. The IMRs have made a considerable contribution to the learning from this review.

5.4 Central to professional reflection and examination of practice, however, is the knowledge that Martha, Mary (and Ben?) were found to have suffered severe neglect, despite their being known to services as vulnerable children throughout their lives. They had previously had multi-agency support plans (Child in Need plans) but the extent to which their needs had been neglected had not been recognised prior to their becoming looked after. The children had not, for example, had child protection plans at any point. The most significant feature of this SCR review is, therefore, neglect.

5.5 As can be seen from Sections 3 and 4 of this report, there were significant shortcomings in single- and multi-agency practice throughout the period of the review. In particular, there was a tendency to focus on what was observable, rather than taking a more analytical approach which would have involved active hypothesising about family functioning.

5.6 There was limited evidence of professional curiosity about the dissonance between what was being seen on most occasions and what was seen when family members were challenged or taken unawares. There was little exploration of the link between the individual and joint histories of adults involved in the children's lives and their capacity to keep the children safe and to promote their welfare. MC's denials that she had been abused by GUC or that she had been sexually exploited were effectively accepted at face value. The nature of the relationship between MC and GUC was not understood.

5.7 While professionals were concerned both about MC's failure to take the children for medical appointments and about the children's social isolation; there was no evidence of reflection on why this was happening, either within the practitioner group or in

supervision. There was no recognition of the impact of high levels of hostility and aggression from the adults on practitioners' capacity to challenge the ways in which the children were being cared for. There were clear shortcomings in decision-making in CSC; but when decisions were made, they were generally accepted without challenge. In circumstances where there were barriers to spending time with the children; there is little indication that practitioners attempted to view family life from their perspective.

5.8 The interrelated features of practice and management suggest that the identified shortcomings are unlikely to be limited to this single case. The nature of the issues which have been identified suggests that they are established characteristics of local practice and that enduring change is only likely to be brought about through a 'whole systems' approach.

5.9 As a result, the contribution that can be made through this SCR is likely to be limited, at least in its immediate effect. For that reason, lessons identified in this section will include a number where remedial actions could produce 'quick wins', where proposed changes are relatively easy to implement and anticipated improvements delivered within a short time. Where pertinent, recommendations for action will link work already being undertaken by the LSCB, the local authority and partner agencies.

a) Strategy meetings and child protection enquiries

5.10 Lesson 1: Child protection strategy meetings are fundamental to good safeguarding planning and practice. Child protection enquiries should not be ended without taking into account the actions agreed at strategy meetings.

5.11 In the early stages of this review, concerns were raised that the children might be at risk of significant harm of abuse or neglect. The nature of that harm was not clearly articulated but a multi-agency child protection strategy meeting agreed that, as part of child protection enquiries, two specific assessments should be completed; relating to both MC and GUC. As has been noted earlier, a decision was made to end CSC involvement without there being an adequate consideration of the risk of harm to the children. This decision had a serious and continuing impact on the progress of the case.

5.12 For that reason, when contemplating closing child protection enquiries with no further action; reference must be made back to the strategy meeting. Where actions are outstanding, explicit consideration must being given to the potential impact on the child/ren of those actions not being completed. This is particularly important when no formal support plan is to be offered, as 'there may be no further contact and so no chance of realising that judgement on safety was wrong'[7].

[7] Munro Effective Child Protection: Second Edition Sage Publications

5.13 The views of professionals from partner agencies should also be taken into account. The rationale for the manager's decision-making should be clearly recorded and shared with other safeguarding professionals working with the family.

5.14 The factors which contributed to the decision to end child protection enquiries in this case are acknowledged in Sections 3 and 4.

b) Identifying indicators of neglect and taking action

5.15 Lesson 2: There were shortcomings in the early recognition and identification of the signs of neglect and a subsequent delay in efforts to provide the family with the right help at the right time.

5.16 Neglect is the most common form of child maltreatment in England. Tackling neglect is strategic priority for Sefton LSCB[8]. The strategic plan has been active for three years. It identifies eight priority areas which are supported by detailed actions, many of which have been completed.

5.17 Yet, despite high levels of activity across the partnership, this review has found that a significant proportion of practitioners, from all disciplines, would identify with the statement that 'it is extremely difficult for professionals working with families 'to identify indicators of neglect; to assess whether they need to take action; and, to decide on what the best action would be'[9].

5.18 Brandon, Glaser, Maguire et al (ibid) describe some of the characteristics of neglect which may make it harder for professionals to recognise that a threshold for action has been reached. Two in particular were features of this review:

i. the chronic nature of neglect leading to professionals becoming 'habituated' to the child's circumstances and failing to question a lack of progress; and,
ii. the experience of neglect rarely produces a crisis that demands active, authoritative action.

5.19 Indeed, it is notable, that it was not as a result of their long term neglect that the children became looked after: rather it was due to concerns for their immediate health and welfare.

5.20 For the two years between 2015 and 2017, it was quite clear that MC and GUC were evading contact with services and that MC was not acting on health practitioners' advice. Despite increasing cause to believe that the children's health and development was being negatively affected by their circumstances, practitioners did not consistently identify MC's lack of appropriate action as a potential indicator of neglect.

[8] Sefton LSCB Annual Report 2015-2016

[9] Brandon, Glaser, Maguire et al Missed Opportunities: indicators of neglect – what is ignored, why, and what can be done? Department for Education Research report 2014

5.21 Similarly, although health visitors and family practitioners recognised that the children were not socialising in the community (despite advice and offers of support), they did not generally associate this with neglect.

5.22 There was no evidence that practitioners or managers lacked knowledge about how to make a referral for Early Help or to CSC. Staff and managers referred to Sefton's Level of Need Guidance and there was evidence of its use informing referrals. In some instances, however, practitioners described their reluctance to refer to CSC with certain issues of neglect, as similar referrals had been rejected in the past.

5.23 Discussion took place about what information should be provided to support referrals where early indicators of neglect had been identified. It was generally agreed that referrals should articulate the experience of neglect as actually, or likely, to be perceived by the child. As noted in the community health IMR, 'this will help ensure that important information does not become lost when shared between multiple agencies (NSPCC 2014)'.

5.24 Factors which contributed to inconsistent responses by health practitioners and family workers in this case are acknowledged in Sections 3 and 4.

5.25 Since 2017, The National Institute for Health and Care Excellence (NICE) has produced two sets of guidance and guidelines which might have assisted practitioners in the case. The first, Child Abuse and Neglect, helps identify features that should alert practitioners to the possibility of neglect. It also provides an analytical framework to support thinking and decision-making about what to do next[10]. The second, Faltering Growth[11], covers recognition, assessment and monitoring of faltering growth in infants and children. It includes a definition of growth thresholds for concern and identifying the risk factors for, and possible causes of, faltering growth. It also covers interventions, when to refer, service design, and information and support.

c) Assessing need where neglect is an issue and offering services

5.26 Lesson 3: Where neglect is an issue, Child in Need assessments and plans are likely to be enhanced by the use of the Graded Care Profile.

5.27 Lesson 4: The decision to end Child in Need plans must be made in a child in need meeting to allow professionals from partner agencies to contribute to the decision-making.

5.28 Lesson 5: In circumstances where consensus among agencies cannot be gained to ending a child in need plan, consideration should be given to using the LSCB conflict resolution/ escalation procedure

[10] Child Abuse and Neglect: Guidance and Guidelines NICE 2017
[11] Faltering growth: recognition and management of faltering growth in children NICE 2017

5.29 As noted earlier, the assessment of need which was undertaken by CSC in 2017 did not sufficient take account of the complexity of family circumstances. The indicators that the children might be experiencing harm as a result of neglect were not adequately explored.

5.30 As part of its neglect strategy, Sefton has collaborated with the NSPCC to trial the Graded Care Profile 2 (GCP 2) as the recognised method for helping practitioners to assess family circumstances where neglect is thought to be a feature.

5.31 GCP2 is a tool for the multi - agency assessment of neglect which can be completed by all suitably trained members of staff from all agencies working with families where neglect is an issue. It is most effective in the early detection of neglect. The GCP2 is designed to be completed collaboratively with parents. Its use encourages openness between parent and practitioner, and so, can help develop trust and more effective working relationships.

5.32 For those reasons and in line with current LSCB expectations, consideration should always be given to employing the GCP2 in such assessments and support planning. Where there are indications that its use would not be appropriate, these should be discussed in the multi-agency group and with the parents. The rationale for not using the tool should be clearly recorded on the child's file in all agencies working with the family.

5.33 In this case, it has not been established why no consideration was given to employing GCP2 in the early stages of the assessment and support planning. With little new information being gathered and in the absence of a new perspective, as has been noted was essentially 'more of the same'. Nevertheless, as has also been acknowledged, child in need plan ended, despite as described in the CSC IMR 'concerns were arguably increasing, outcomes were worsening for the children and child in need planning had been ineffective in securing any positive change'.

5.34 A CSC's single agency recommendation is that 'any decision to close a case due to non-engagement by adults, where outcomes are not improving, must include a multi-agency meeting chaired by a team manager in CSC to support decision-making'.

5.35 Where agreement about ending child in need plans cannot be reached and there is recourse to the LSCB escalation process; records of discussions must be maintained by all the agencies involved throughout each stage of the escalation process. The LSCB has published an Escalation Flowchart which identifies timescales.

d) Working together with substance misuse services when children are vulnerable and/or may be at risk of abuse or neglect

5.36 Lesson 6: The impact of drugs' use is a significant aspect of assessment of need and risk of abuse or neglect. Where previous or current involvement with substance misuse services is acknowledged, there should be appropriate information sharing between the two services.

5.37 It is not suggested that all parents who use illicit drugs are unable to provide their children with the care they need. Parental substance misuse can, however, have a negative impact on children at each stage of their development. Additional factors such as domestic abuse, parental mental health problems or learning disabilities also increase the likelihood that children will suffer significant harm.

5.38 In this case, despite being aware that GUC was a methadone user, the impact of this on family life was not explored and no contact was made with the local substance misuse service as part of the assessment which being undertaken in CSC. At the same time, the risk assessment in the substance misuse service was overly narrow in its form and professionals were insufficiently curious about the impact of GUC's problem drug use on MC and on his relationships with other members of his family.

5.39 Had the connection between the two services been made, it would have revealed that GUC's drugs had become more chaotic and that he had been experiencing physical ill health. Frank discussion about drugs' use in the household, if this could have been achieved, might also have encouraged MC to disclose her own drugs use at an earlier stage.

5.40 Many serious case reviews have identified the importance of closer working relationships between children's and substance misuse services where drugs' use is a feature of family life. The recommendations of the Advisory Council on the Misuse of Drugs (ACDM)'s report 'Hidden Harm: Responding to the needs of children of problem drug users'[12]are well known and have influenced safeguarding policy and practice in both agencies for fifteen years.

5.41 The substance misuse service IMR has recognised that in the assessments of adults' needs 'emphasis should be given to any caring responsibilities or impact of children living within the same household and not just assessing the risks to any biological children'.

5.42 When an adult in the household is known to use illicit drugs and there is reason to believe that children may be at risk of significant harm; a representative from the substance misuse team should attend the multi-agency child protection strategy meeting where the parameters of future involvement should be agreed.

e) Severe or extensive tooth decay as an indicator of potential neglect

5.43 Lesson 7: Where there is ready access to a free dental service, persistent failure to attend to children's tooth decay should alert health practitioners and dentists to consider neglect and to respond accordingly.

[12] ACMD Hidden Harm; Responding to the needs of children of problem drug users, HM Government 2003

5.44 A recent survey of the dental health of children in England that where children experienced severe or extensive decay this appeared to correlate with indices of multiple deprivation. Within that overall context, however, Missed Opportunities states that untreated dental disease is increasingly being recognised as an indicator of broader child neglect. It indicates that the 'wilful or persistent failure' to meet a child's basic oral health needs can result 'not only in the impairments of oral health but may also compromise the child's general health or development'. This is also recommended under NICE guidance and guidelines[13].

5.45 The Designated Nurse and member of the SCR Panel, reports that NHS England (Primary Care Commissioning) have advised that access to NHS dental services for children should not be problematic; although there can often be seasonal difficulties in getting a routine dental appointment. Access to dental services is monitored by Health Watch. CCG PALS (Patient Advice and Liaison Service) also receive complaints from the public; PALS has not identified access to an NHS dentist as an issue. It is acknowledged, however, that a child's being registered with a dentist does guarantee regular attendance.

f) Establishing the nature of a parent's disabilities and the implications for service delivery

5.46 Lesson 8: Professionals working with children and families must be cognisant of their own and their agency's or organisation's duties and responsibilities to parents with learning disabilities

5.47 Parents with learning disabilities can experience difficulties accessing services for their children and may require additional support to ensure that they are able to provide the care that the children need to support their development. When child protection concerns arise, parents with learning difficulties are also likely to need support to ensure that they are able to participate fully in that process. The problems experienced by parents with learning disabilities are likely to be compounded if their children are subjects of care proceedings as, indeed, the children went on to be. Those are among the reasons, that early identification of a parent's learning disabilities, and their impact on the individual's parenting capacity, is crucial.

5.48 Throughout the review period, professionals gained different impressions of MC's cognitive abilities and she, and family members, gave different accounts of how any impairment affected her life. It is acknowledged that MC was not cooperative with services and that she rarely sought support. At no time, however, was there any consideration of whether MC was entitled, for example, to an assessment of her own needs or whether MC could be a 'disabled person' under Equality Act 2010. No specific

[13] Child Abuse and Neglect: Guidance and Guidelines NICE 2017

adjustments appear to have been made to the ways in which services were offered or provided.

6. Recommendations

Recommendation 1:

Child protection procedures in relation to child protection (S47) enquiries should be amended to include:

- ***'S47 enquiries should not be ended with 'no further action' without:***
  - ***i. Evaluation of any outstanding actions from strategy discussion/meeting; and,***
  - ***ii. Taking into account the views of professionals from partner agencies'.***

Recommendation 2:

As part of their scheduled review of the implementation of the Neglect Strategy; the LSCB, local authority and partner agencies should take into account the findings of this SCR in determining how improved multi-agency practice can be delivered.

Recommendation 3:

Where there are issues of neglect in early intervention or working with children who may be in need:

i. **practitioners and managers must use the Graded Care Profile; and,**
ii. **a process should be established to monitor compliance and evaluate reasons for non-compliance**.

Recommendation 4:

a) **Revision of Child in Need procedures**

The LSCB has identified that existing multi-agency Child in Need procedures state that the recommendation to end a child in need plan must be made by the multi-agency meeting, for consideration by the CSC team manager. These procedures should be revised to include:

i. ***Where the evaluation of risk of harm is obscured by non-engagement by parents, that meeting must be chaired by a CSC team manager;***
ii. ***The meeting must address the impact of non-engagement by parents; and,***
iii. ***The rationale for all decisions and actions must be clearly recorded on the child files in all relevant agencies.***

b) **Measuring and improving decisions to end child in need plans.**

The LSCB should require an audit of decisions to end child in need plans with an accompanying action plan, if necessary, to secure improvement.

Recommendation 5:

LSCB agencies and organisations must ensure that professionals working with children and families are aware of the LSCB dispute resolution and escalation processes and that they are suitably equipped and supported to work within its provisions.

Recommendation 6:

In order to improve safeguarding of children where substance misuse is an issue, the LSCB should require CSC and the commissioners of the Substance Misuse Service to develop an information sharing protocol for all potential points of communication from general enquiries/advice to working together under child protection plans.

LSCB training programme should be informed by that protocol.

Recommendation 7:

As part of its review of the Neglect Strategy; the LSCB should ensure that there are specific actions in respect of the identification and assessment of dental neglect as a safeguarding issue. These should be linked to NHS England Direct commissioning team which is responsible for commissioning dental services both in the community and in secondary health services.

The LSCB should consider the merits of working on a pan-Merseyside basis in respect of this recommendation.

Recommendation 8:

In respect of parents with learning difficulties or disabilities, the LSCB should consider commissioning a 'task and finish' group to:

i. **review existing policy and procedures in the light of the current legal framework; and,**
ii. **to produce good practice guidance for professionals working with parents who may have learning difficulties or disabilities.**

The LSCB might consider the merits of working with neighbouring LSCBs on this.