



Strictly Confidential

THINK FAMILY REVIEW FOR ALAN & BRENDA

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THINK FAMILY REVIEW

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1.0 Introduction

Safeguarding is about protecting human rights, enabling children and adults to live life free from harm, abuse and neglect. Safeguarding is intrinsic to high quality health and social care. It is about ensuring that both commissioners and providers within a local area have effective systems and processes in place to safeguard children, families and communities. Section 16F of [Children and Social Work Act 2017](#) requires safeguarding partners in our local area partners to identify serious cases which raise safeguarding concerns of importance to the local area and for those case to reviewed under their supervision. This is one such case, determined by the One Panel to meet this criteria and which also raised matters of importance for the local area. Serious child safeguarding cases are those in which abuse or neglect of a child is known or suspected and the child has died or been seriously harmed¹. This case was very unusual for both Waltham Forest and nationally. When the review was completed the child A and B were asked their opinion about publication and they both agreed to the review being published.

In [Working Together to Safeguard Children-2018](#) the threshold for serious harm includes serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. Its scope includes impairment of physical health and professional judgment should be exercised in cases where impairment is likely to be long-term, even if this is not apparent from the outset.

2.0 Family Background for this review and circumstances leading to the initiation of the review

This reviews is about a family of 7 (2 parents and 5 children). The review will mainly focus on both parents and child A and B. The older siblings of child A and B who are now adults will be referred to in this review but will not be the main subjects within the review. These are referred to within the review as (C,D, E and F).

In June 2018 Child B, aged 14 made contact with the National Society for the Prevention of Cruelty to Children (NSPCC) and disclosed that neither he nor his older sister who was 16 years old at the time had ever been to school or received home schooling. Child B reported that he and his sibling were confined to the house and allowed out to the park only outside school hours. According to the Children's Social Care (CSC) record/child B's account the children were told to hide when professionals visited the family home. They lived with their parents and mother was reported to have a number of co-existing physical health problems as well as anxiety and panic attacks and has been supported by the District Nursing Service since 2016.

Police and Children's Social Care visited the family home following the Child B's call to the NSPCC and described the children as being pale and with their appearance suggestive of being malnourished. The children were reported to be happy to be able to leave the family home and have been thriving in foster care to date.

¹ HM Government (2018). Working together to safeguard children – A guide to interagency workig to safeguard and promote the welfare of children.

In response to a referral to the One Panel from Children's Social Care (CSC) and notification of the incident to the National Panel. Local agencies provided information to support the Panel's decision-making, as to whether to commission a SCR, discuss with the Independent Chair of WFSCB the potential scope and methodology of the review, timelines, engagement with the family and with professionals involved in the case.

3.0 Purpose and rationale

The purpose of this Review is to identify improvements which should be made locally to safeguard and promote the welfare of children and families which would prevent and reduce the risk of recurrence of similar cases. This requires establishing whether there are lessons to be learnt from the case about the way in which local organisations worked together to safeguard and promote the welfare of children and young people.

4.0 Terms of Reference

At the One panel's request, the question to be answered by the review is :

What does Child A and Child B's experience tell us about how local systems work together from a 'Think Family' perspective?

The aim is to look for areas that relate to systemic issues, which will lead to changes in practice and service improvements.

In the selection of reviewers the One Panel ensured that there was no conflict of interest which could or would limit the objectivity, actual or perceived ability of reviewers to identify improvements impartially¹. The reviewers were tasked with completing the review report and publishing it as soon as possible, but no later than six months from the date of the decision to initiate a review, which was 1 August 2018¹.

Scope

The key focus is on learning together from a non-blame perspective. Two Lead Reviewers were appointed by the One Panel to conduct the review, following the rapid case review and the notification to the National Panel. These two reviewers were also members of the One Panel but were deemed to have had no links to the case. The Independent Chair of the Waltham Forest Children's Safeguarding Board (WFSCB) supported the Panel's decision to undertake a local review, the potential scope and methodology of the review required relevant agencies to engage with the process due to their involvement with the case. The time period for the review is from **24 January 2002 – 6 June 2018**. Significant information from periods outside these periods is highlighted in the report. Understanding whether there are systemic issues affecting practice is critical to improvements and determines whether and how policy and practice need to change.

Key issues to consider

Understanding whether there are systemic issues affecting practice is critical to improvements and determines whether and how policy and practice need to change to achieve this.

1. Did all agencies work together effectively to safeguard the children subject to the review? And do the policies that are in place support practitioners to do so?
2. Were the safeguarding procedures followed appropriately for both children and adults?
3. Were the children's voices heard, listened to and acted on throughout agencies involvement?

Agencies Involved in the case

- LBWF agencies - Adult Social Care, Housing, Behaviour Attendance and Children Missing Education
- Primary Care - WFCCG
- NELFT, District Nurses, and School Nursing, and Health Visiting
- Barts Health – Midwifery, Whipps Cross Emergency Department and Children's Safeguarding Team
- Hornbeam Academy - Hospital and Home Teaching Service
- Police – local officers and Specialist Crime Review Group
- National Society for the Prevention of Cruelty to Children (NSPCC)

5.0 Methodology

In order to have the ability to analyse frontline practice and as well as the effectiveness of organisational systems as recommended by the Munro Review², a systems methodology and also the learning from the Triennial Reviews³ was adopted. This was to promote learning linked to the findings that will ultimately improve outcomes for children and families. Embracing the model of pathways to harm and protection, advocated in the Triennial Review³ moved the focus away from blame to affirming good practice and identifying opportunities for learning and improvement.

As such, the One Panel agreed to use a hybrid methodology that ensured active involvement from front line practitioners and senior managers from the agencies involved. The review has also taken a system wide approach that analyses practice to understand why things happened in the way they did. Broadly this means using the framework of 'pathways from harm and protection' to make this case a window on the system.

The process included:

² The Munro Review of Child Protection: Final Report: A Child Centred System (May 2011).

³ The Triennial Analysis of SCRs 2011-2014 -Pathways to harm and protection (DFE,2016)

- (i) All relevant agencies submitted a chronology
- (ii) A workshop of senior managers and front line practitioners was convened to explore the key issues raised by the integrated chronology.
- (iii) A review team of managers were identified from the workshop to comment on the draft report.
- (iv) Semi-structured interview with HV Safeguarding Supervisor/Team Leader.

The reviewers analysed relevant documents and information such as assessments, policies and procedures to develop an understanding of what was known and when. Data sources included chronologies, documents, interview data, workshop discussions and email correspondence. Given the passage of time and organisational changes there is an acknowledgement that there will be loss of organisational memory in relation to historical systems, staff retention, processes and policies. The final report was quality assured by the One Panel prior to submission to the Waltham Forest Safeguarding Children Board for consideration.

Review and follow-up Workshop Participants included representation from:

- LBWF agencies - Adult Social Care, Housing, Disability Enablement Service, MASH
- NELFT, District Nurses, School Nursing, Health Visiting
- Barts Health – Whipps Cross Emergency Department and Children’s Safeguarding Team
- Hospital and Home Teaching Service
- Primary Care
- Police – local officers and Specialist Crime Review Group

6.0 Family Composition

Member	Name	Age	Subject
Mother		50yrs	yes
Father	Mother’s current partner	47yrs	yes
Son	Alan (child A)	14yrs	yes
Daughter	Brenda (child B)	16yrs	yes
Daughter	Christine (C)	26yrs	no
Son	David (D)	27yrs	no
Step-Daughter (father)	Esmeralda (E)	31yrs	no
Step-Son (mother)	Frederick (F)	n/k	no
Maternal Grandmother		deceased	
Maternal Grandfather		n/k	
Paternal Grandmother		deceased	

7.0 Appraisal of Practice – Preventative and Protective Actions to Prevent Harm

Areas for consideration – What was the lived experience of this family?

The review group consisting of both frontline professionals and managers from the relevant agencies reviewed both the timeline and the integrated chronology, this enabled them to contribute their perceptions of the family's lived experience.

Waltham Forest context

Waltham Forest is a rapidly growing borough⁴ during the ten year period of 2001 to 2011 the population grew by 17 per cent from 222,782 to 260,397. In comparison, the changes in population for other Local Authorities in London during the same period ranged from a growth of 29.6 per cent in Tower Hamlets to a decline of 0.2 per cent in Kensington and Chelsea. The 2015 mid-year population estimates by the Office of National Statistics, indicate a local population of 271,200 people. This is an increase of 3,150 residents than the previous year and a gain of 13,000 since the 2011 Census. In response to the needs of the growing population, private rented housing has been the fastest growing housing tenure in Waltham Forest in the past decade. According to the 2011 Census, about one in four households in Waltham Forest (26 per cent) now live in private rented accommodation, which is up from 16 per cent in 2001. This is in line with the London average (25 per cent) and higher than the national average (17 per cent). The total number of private rented sector households in the borough is now 25,100, nearly double that in 2001 (14,100).

Family Context

From the information gathered it would appear that mother had her first child at the age of 19, who is the step daughter of her present partner. The current partner of mother is the father of D who was 20 years old at the time of D's birth.

Mother and her present partner (father) have had 4 children together and the oldest is D now aged 27 yrs, she had another child, C a year afterwards. C is a child with complex health needs and learning difficulties. There is a gap of 10 years before the birth of Child B, with Child A being born two years after. Father has a child (F) with a different partner, who is a step-son to mother. There is limited information in relation to F and his age is not known. Such a complex family is also sometimes referred to as a blended or reconstituted family. This describes a family where one or both are step-parents to children within the family unit and also includes kinship arrangements where care is provided by a grandparent or aunt/uncle such as in this case. Although there is nationally reported data on blended families, the 2016 Labour force survey reported highlights a growing trend of multiple family units from 0.2% of the population to 0.3% of the population⁵.

⁴ <https://www.walthamforest.gov.uk/content/statistics-about-borough>

⁵ <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/2016>

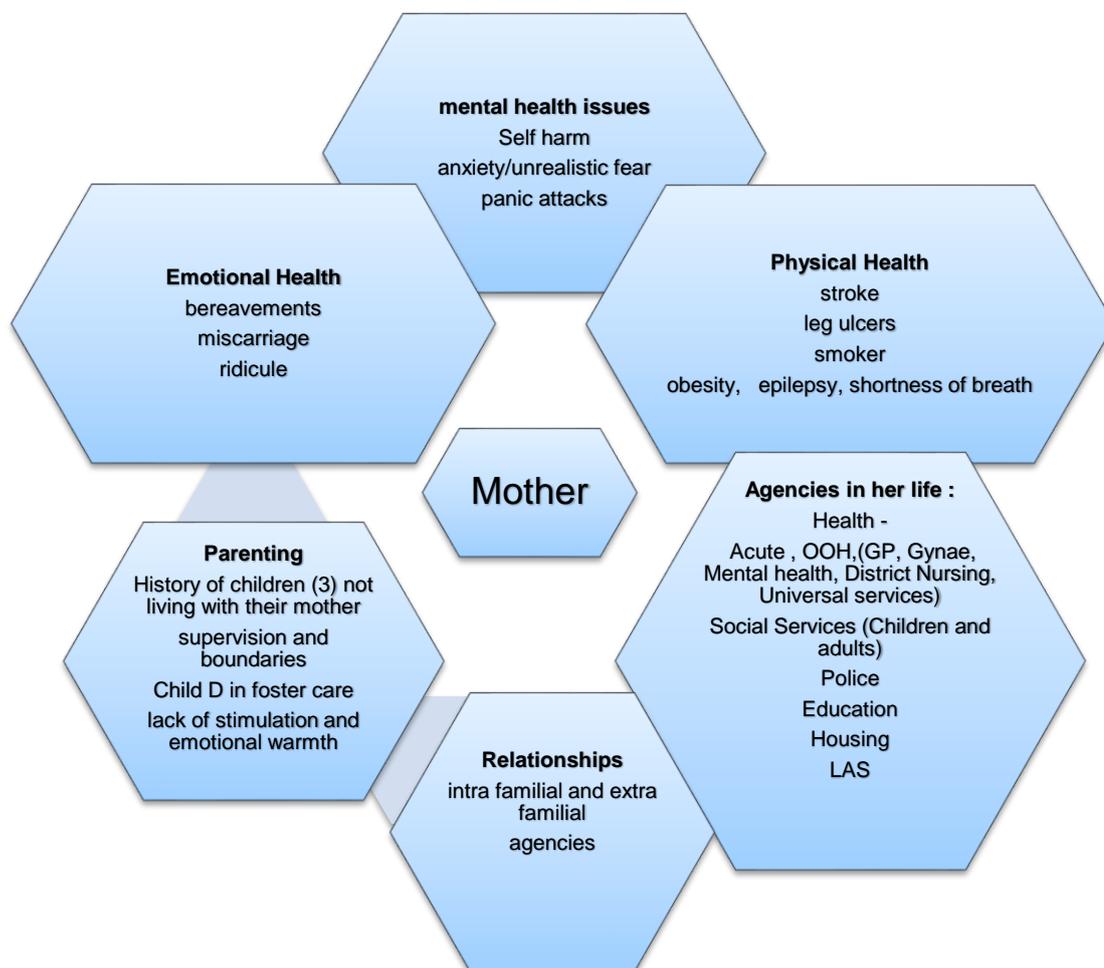


Figure 1- Mother's known past & present history

The diagram above regarding mother gives a sense of some of the challenges that mother in particular and the family encountered over this period. This may have impacted mothers parenting ability and perception of herself, family and wider society. This would have also impacted on her relationships with her partner and her children.

Father had also had some difficulties in his life and has had a recent bereavement in the last 2 years, and was the carer for his mother who died in 2016. He is also reported to have had some medical problems. He also has been the main carer for the children A and B at some point in their lives as well as the care of child C at the time of her residence within the family home.

E now aged 31 yrs lived with the family till the age of 16 and left the family home after the birth of child A to live with maternal grandmother in Essex. It would appear that D also left the family home in 2003 at the age of 13, at the age of 16 the information gathered indicates that he went to live with an aunt (we do not know if this is maternal or paternal) in Enfield. He became homeless at the age of 17 and approached Waltham Forest Children Social Care (CSC) for assistance. C now aged 26 years was taken

into local authority care at 10 years of age for neglect in 2001. A contact order was in place which enabled her to spend weekends with her parents.

E attended a local secondary school while living with the family, but the information gathered would suggest that D and only stayed in education until the age of 12.

Historically there is a pattern of children not being brought to health appointments and no access for planned home visits for C, D, Child A and Child B and also for adults failing to attend multiple health appointments.

The family originally resided in the south of the borough during the period of the time C and D were growing up and when Child A and B were born. They were tenants of local housing association and lived in a large property with a lift to accommodate the needs of C. The family subsequently moved to a smaller property in the north of the borough during 2013-14. Child A and B were hidden from services until Child B made the call to NSPCC.

Known Past and Present history of mother and family at time of review

Mother at the the age of 34, disclosed her experience of emotional distress to the Health Visitor (HV) following a miscarriage in 2002, this occurred after the birth of Child B. She became pregnant soon after that miscarriage in 2003 and was initially ambivalent towards the pregnancy, but subsequently decided to continue with the pregnancy. Concern was expressed by the community midwife to the health visitor that mother had missed three antenatal appointments. She booked late at 22/40 weeks of pregnancy having requested an antenatal referral from her GP at 17/40. Mother however attended for her 24/40 scan and presented appropriately to the hospital when she experienced reduced fetal movements in the third trimester of pregnancy.

In February 2008, D attended a police station aged 17 years to report that he was homeless after mother requested him to leave the family home due to too many arguments. He had initially stayed with an aunt in Enfield but had been evicted by her as he was not contributing rent. D was then collected by the proprietor of a homeless hostel in Enfield who confirmed that he was working with CSC. The ensuing PAC Merlin document was shared with CSC and CSC completed a Housing Assessment with D. This incident was not triangulated with a further police incident which occurred two weeks afterwards when Child A was found wandering along the street on his own at 4 years of age. Triangulation of this information by agencies should have raised questions about parenting ability and possibly about the capacity of parents in relation to possible mild learning difficulties and/or their mental health.

Mother developed a number of comorbidities during the period under review. She became depressed after the loss of her mother in 2015 and was referred to Adult Mental Health and Brief Intervention (AABIT) service. During her telephone triage she disclosed to the mental health practitioner her difficulties with her loss and the impact of this in comfort eating. She also described the experience of being ridiculed by children in the neighbourhood due to her weight gain. She shared that she had not been in contact with her father since the death of maternal grandmother. Of note

mother did not inform the assessor that she had two younger children living at home with her and this information would not have appeared on the GP referral to AABIT as GP3 was also not told at registration by mother.

Mother's health appeared to significantly deteriorate in 2016 and she became a frequent attender at the Urgent Care/GP Out of hours service, she had several hospital admissions for serious health problems and investigations. In June 2016, mother was admitted with headaches and dizziness – LAS witnessed seizures in ambulance. Notes indicate patient had been a heavy drinker and smoker until a few years before this. Mother had not been attending gynaecology appointments, she was admitted for medical treatment and prescribed anti-convulsants. Mother was described as being housebound and while her case was discussed during the clinical multi-disciplinary meeting (MDT) due to multiple Emergency admissions and poor engagement with doctors, patient (mother) was described as not opening the door for home visits and was worried about having cancer as her mother died of a reproductive cancer. The plan was for a home visit to assess her mental state and address problems with engagement, it was not clear how this would have been achieved and the next steps if this plan did not succeed. There was no curiosity as to whether there was a parenting responsibility for younger children and no indication that this had been explored in relation to the impact of her health condition and non-engagement.

Learning point 1 : This was not recognised or identified as possible self-neglect by a vulnerable adult as a mental capacity assessment was not undertaken. The learning objective is to ensure that any care and support required by an adult is explored and consideration is given to key concepts of self neglect, the possibility of informal carers (family or friends etc - including young carers) within the family network. It is also important for professionals to explore the vulnerable adults mental capacity related to care and support decisions.

Where there are concerns of abuse or neglect towards the adult and the person alleged to be responsible for the abuse or neglect is a carer for the adult, we must consider the impact of the adult's reliance on the carer in terms of their care and support and therefore the adult may be more reluctant to accept support in relation to their care and support and/or the abuse or neglect due to fear or repercussion, undue pressure and/or coercion and control.

More recently in April 2017, there was an episode of police being called to the property after mother heard loud banging at the frontdoor. On arrival at the property police officers found that the story was corroborated by the children who were then aged 13 and 15 years, however, the family had been locked in. Father subsequently arrived with the two sets of house keys. The record indicates that the police described the situation to be 'strange' and 'odd' and queried whether the children actually attended school or had any contact outside the home address and this information was documented on an AN Merlin which was shared with adult services (ASC) and children's social care (CSC) or the Multiagency safeguarding children hub (MASH). This presented a missed opportunity to safeguard the children, as there does not appear to have been further intervention from CSC with the family.

In November 2017 mother disclosed to hospital staff during a hospital admission that she was self-harming and that her partner prevented her from attending health appointments. The Gynaecology registrar shared the disclosure with the GP regarding the reasons given by mother while on admission for her non-attendance at two previous appointments due to her partner preventing her from attending. In addition she revealed that she deliberately self-harmed herself and had not previously disclosed this to professionals. GP3 advised that she would review records for self-harm and safeguarding concerns. Mother subsequently also divulged to the GP that her partner threw away letters which included hospital correspondence regarding appointments. The GP then undertook to alert practice staff to telephone through future appointments to mother. **Learning point 2: However, the reasons for her partner's behaviour were not explored and they were not seen in the context of coercive and controlling behaviour and a safeguarding issue.** Neither was a further mental health referral considered.

Father

Father was aged 31 years in 2002 which is the beginning of the review period. During the period of health visiting (HV) contact with the family father was very visible and supporting with child care, including the care of C. There were no concerns identified by the HV regarding the care he provided to the children (A&B) or his interaction with them.

However, there is an entry from the Children with disability social worker, that the family were finding it difficult to juggle the care of the 2 younger children with that of visiting the disabled child and had requested a change to the schedule on 11.08.04.

During an incident in which mother called emergency services for assistance, the police on attendance at the property in February 2008, found themselves unable to gain entry as father had gone out while in possession of the two house keys. Father is described as being unemployed during this period. However, on 24.11.09 when he was aged 38 years he attended the Emergency department with an open wound to the left foot which he attributed to a work-related foot injury. He was diagnosed with fractured toes to the left foot. There was no indication as to the type of work and mode by which the injury was sustained.

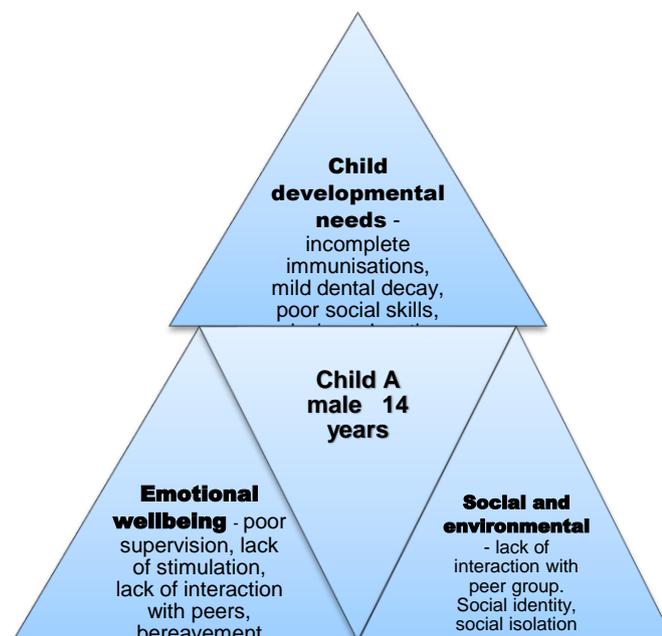
In 2017, mother described him as throwing away her letters and also preventing her from attending some health appointments, this had led to a suggestion of possible coercive control, although this was not explored by professionals. There is a growing body of evidence regarding the impact of coercive controlling behaviour on victims. Coercive control reduces a victim's power to make decisions, which limits the ability to exercise independence⁶. This highlights the need to explore father's behaviour in relation to this and other related episodes in the context of domestic abuse and coercive control. For instance, on 18.04.17 mother requested assistance from the emergency services but the Police on responding were unable to gain access/entry

⁶ Robertson K and Murachver T (2011) 'Women and men's use of coercive control in intimate partner violence'. *Violence and Victims* 26 (2) 208-217.

into to the property until father arrived with the two house keys. Notably, mother had reported to the police that she was prone to panic and anxiety attacks and denied being locked in the house with her children by her spouse. This should be considered alongside mother's claim in 2017 that father threw away some of her letters and also prevented her from some attending health appointments. In a separate event on 02.06.18 following the referral to the NSPCC, Child B advised Child A to be quiet as 'he' would be listening. The officers believe 'he' referred to father. Taken together these events would be suggestive of coercive control exerted by father and its impact on the family dynamics.

He also missed a number of hospital appointments with Ear, Nose and Throat (ENT) Team for a painful condition which required investigation and treatment this was over a period of 17.10.13, 12.05.14, 17.12.14 and 19.11.14.

Figure 2 – Child A



Child A was born in 2003 and was his mother's sixth pregnancy. This was a high risk pregnancy due to mother's multiple health problems, in addition mother expressed difficulty coming to terms with a miscarriage a few months prior to this pregnancy and had initially been ambivalent regarding continuation with this pregnancy. Mother registered with her GP at 17/40 pregnancy and was referred for antenatal booking with maternity services, which she attended at 22/40 of pregnancy on 14.06.03. Although mother attended for her 23/40 appointment with the midwife and her 24/40 ultrasound scan, midwife informed HV that mother had not been seen the initial booking appointments.

However, mother subsequently presented on the postnatal ward for the assessment for reduced fetal movements on 02.09.03. As mother failed to attend a midwifery clinic appointment on 08.09.03, a joint visit was planned by the community midwife and HV.

This plan was unsuccessful as the midwife had no access visit to the family. She described the windows being open and the car being parked in the drive outside the family home. Mother was then seen a week later by the midwife at 36/40, and no concerns were raised during this visit. The record highlights that there was a strategy meeting held under section of the Children Act 1989 in respect of the care provided by parents to C who was 12 years old during her weekend stays with the family. Child B was a 21 month old toddler at the time on 12.09.03.

Child A, was delivered after a second emergency caesarean section for mother during which mother was sterilised. This fifth baby was a good weight at 3570g and mother and baby were discharged home four days afterwards. By the time of the new birth visit E had left home to live with maternal grandmother in Clacton, while aged 16 years.

Confirmation was received from participants in the follow-up workshop that mother would have been screened antenatally for depression during her last two pregnancies. We were told that Health visitors (HV) also routinely screened for postnatal depression and would ask about domestic violence during the newborn visit. Mother was not seen during the new birth visit and subsequent follow-up visits on 5.11.03, 27.11.03 & 11.01.05 by the HV to the family home following the birth of Child A. On these occasions mother was reported to be resting upstairs and the children were seen with their father. Although the HV expressed concern and asked to see mother at the next visit, this appointment was cancelled by mother. Within a year of Child A's birth there had been 6 missed appointments for which the children were not brought and 7 appointment cancellations by either mother or father. Although this was discussed in supervision between the HV and her supervisor the non-engagement was not seen as a safeguarding issue at the time. **Learning Point 3 : This was a missed opportunity for escalation to the Named safeguarding Lead and for further exploration within the context of a professionals meeting.** As the chronology states that mother was not seen during the new birth visit there is no way for professionals to tell whether mother was hiding bruising and was told to hide by father.

The family cancelled 3 health appointments for D over a three month period in 2004, during this period mother was also de-registered by her GP for a "persistent failure to attend appointments for herself". Missed appointments by a vulnerable adult should not be reason for de-registration of that patient. A copy of a letter on D's file highlights that social worker had made 3 unsuccessful home visits to the family within a 2 week period also in 2005. The lack of information sharing with other professionals working with the family and siloed working during this period means that no agency had a full picture of the pattern of disengagement and disguised compliance.

In February 2008, a member of the public alerted the police when Child A was seen at the age of 4 when he was spotted walking along the street in his nappy and a t-shirt. This would have been winter and therefore quite cold. Police attended and began to make inquiries when father called to explain that the front door was ajar due to a gas board visit to the property. Father reported that he had started to search for him immediately he realised he was missing and had also called the police. From the information gathered there does not appear to be a record of father making contact with Police to report child missing. Officers on attending the family home reported that

mother was 'frantic with worry'. The police assessment is based on the report only and not from contact with practitioners given the historic nature of the incident and whilst it was referred to the local Child Abuse Investigation Team (CAIT) as the child was not known the case was referred onwardly as part of the procedure existing at the time. There is no record of the police requesting to see the other children in the household or liaison with other agencies. The Police shared the information with partner agencies, but this does not appear to have included the health visitor or GP.

Learning Point 4 – Following this visit information should have been shared with all agencies working with the the family. Checking the household composition and the safety of the remaining children in the household would have enabled a better identification of risk and a more accurate assessment of parenting capacity.

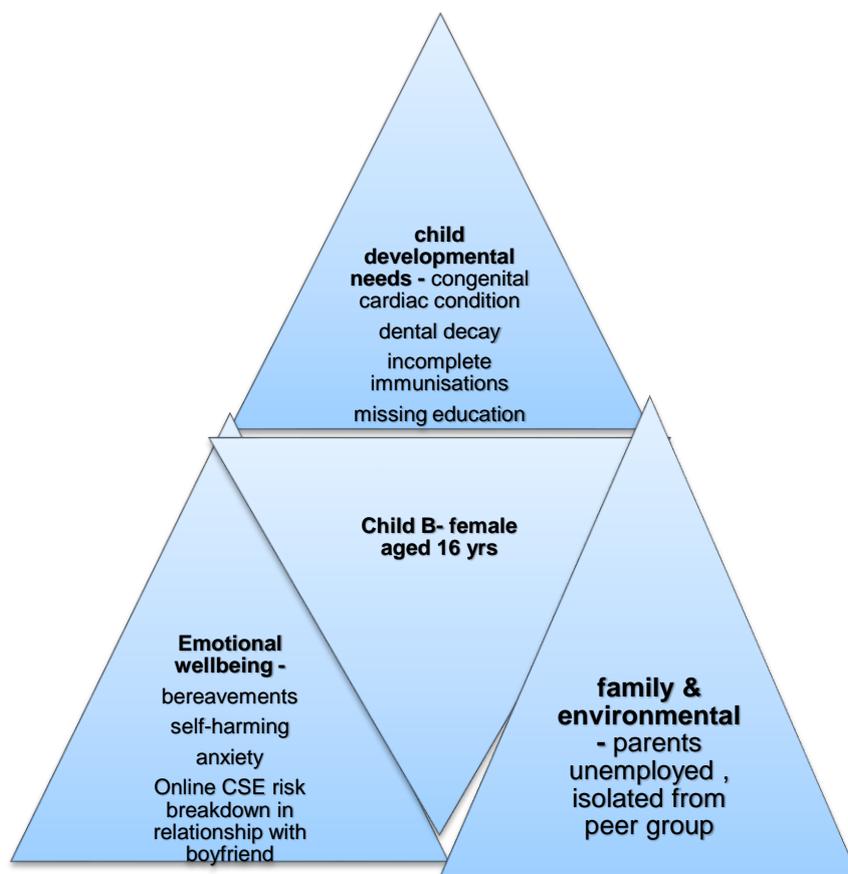
HV clerk sent a school inquiry letter to parents requesting information on Child A & B's schools, to enable the HV records to be transferred to the appropriate School Nursing Team on 01.02.13. The children's records were sent to Child Health on 13.10.14, as school address not known (ANK) following no method of successful contact with family to ascertain the schools attended. Of note the family moved to the north of the borough during this period.

Learning Point 5: The record does not indicate whether there was liaison with the GP to ascertain whether the family were still registered or had made any recent contacts with primary care. A lack of information sharing can lead to a loss of follow-up and invisibility of children at key transition points.

Child A contacted NSPCC for help in June 2018. He spoke to the NSPCC about family 'secrets' and not being home educated or in school. It is not clear what triggered the call. It is also not clear the nature of the relationship with father, as Child B was anxious that father would be listening –in on the conversation with the police officers. If the children were guarded in their responses due to their anxiety that the conversation could be overheard, could the interview not have been conducted a way from the home?

The children appear to have a close relationship with each other and have referred to their three family cats. Child A accessed social media platforms such as facebook, twitter and snapchat. He described being allowed out to the park outside school hours. Like his older sibling, at the point of entry into care in June 2018, Child A had an incomplete immunisation history. Child A could not recall seeing a health professional and had limited dental decay.

Figure 3 -What was known historically and at the time of the review about Child B



Child B was born by emergency caesarean section in 2002 due to elevated maternal blood pressure. She was described by HV at 14 days post delivery at the newborn visit as a healthy child and feeding well. Maternal grandmother was present and mother was pleased with her and handled her well. HV was worried about the large gap between Child B and her older siblings and requested mother to book for her postnatal examination with the GP. Family were still under the care of the Community midwife at the time of the visit. The birth notification for Child B highlighted that she was diagnosed with a cardiac disorder as a baby and was required to attend paediatric follow-up in the hospital at 6 weeks for 11.02.02. HV was sufficiently concerned to leave a message for the Paediatrician to confirm if an appointment had been booked by mother. HV attended the property on 25.04.02 for a planned follow-up visit and had no access. Mother later telephoned to apologise to the HV for forgetting her appointment for the home visit. HV organised and attended the home visit during which mother and baby were seen. Child B (at 4 months) was in the baby bouncer and there were toys on the floor. Mother explained that she had re-scheduled the Paediatric appointment for Child B. It is not clear from the record whether baby was taken to her re-scheduled Paediatric appointment in the hospital by her parents or whether this was followed up by the HV.

On contacting the GP surgery on 09.05.02, HV was advised that the family had no booked appointments and no recent attendance, Child B would have been 5 months

at this time. Two further telephone calls to the surgery by the HV on 14.05.02 and 28.05.02, elicited that Child B was brought to the surgery by her father. HV was unsuccessful at arranging a visit to monitor Child B's growth as mother informed her that the family were visiting maternal grandmother in Clacton for a holiday. The record does not give an indication of the duration. If this was for an extended period there was scope for the Waltham Forest HV to liaise with her counterpart in Clacton to initiate a contact with the family.

A visit was agreed for 12.08.02, this was 3 months after the previous contact. However, E at 15 years of age telephoned HV on behalf of mother to cancel the planned visit on the day of the scheduled visit. The information gathered does not explain whether the couple were actually married and who held parental responsibility for the children. It is not clear why a 15 year old cancelled an appointment on behalf of her parent. Where was mother and why could she not make the call herself and why this was not challenged?

At 7 months of age Child B had not had her second primary immunisation which was due at 2 months in the schedule. A home visit was finally undertaken by HV at 9 months to undertake Child B's 8 month developmental review on 13.09.02. Mother, E and Child B were seen at this visit. Child B was weighed and her height measured by the HV. The record indicates that there were no concerns with growth, vision, fine and gross motor skills or communication which were all assessed as being age appropriate. However, Child B still had 2 outstanding immunisations and needed to be taken to the GP for this.

During this visit mother disclosed that she had a recent miscarriage which she found very difficult. Mother advised HV during a telephone contact that Child B finally had her 3rd primary immunisation, this would have been at 14 months, which was rather late. HV had a further no access visit on 18.03.03 for a previously agreed visit. She received a further telephone cancellation from mother for a subsequent planned visit.

On 16.05.03 mother attended the GP surgery (GP1) at 17 weeks of pregnancy to request an antenatal referral to maternity services. Mother and Child B were subsequently seen at an opportunistic home visit by the HV. Child B was noted to be healthy and HV described good interaction between mother and baby. The children were reported by father to have gone to maternal grandmother for holiday and there was a plan to schedule an 18 month developmental assessment for her return. On 2.10.03 parents did not attend the agreed appointment with HV for Child B.

Child B was also offered a nursery place during their tenure in the south of the borough and was due to start in September 2005. There is nothing in the record to evidence that she actually took up this place. **Learning point 6: Child B's development was described as age appropriate and HV had no concerns regarding her interaction with mother during this period. However, her immunisations and developmental reviews were completed late and there were multiple occasions during which Child B was not brought to health appointments. From the information gathered it is not possible to determine if or when Child B was taken to her paediatric**

follow-up appointment in the hospital. Even though there was contact with the GP Practice in relation to the child not being brought to appointments there was a lack of awareness that this constituted medical neglect. Sidebotham et al (2016)⁷ propose that an alteration to the term DNA (did not attend) to WNB (was not brought) would help 'maintain a focus on the child's ongoing vulnerability and dependence, and the carers' responsibilities to prioritise the child's needs'. Evidenced from themed case reviews indicates that the use of chronologies can assist in providing a historical overview and evidence of past parental behaviour and experience, including possible former instances of disguised compliance, non-engagement with services. This supports professionals in their analysis in understanding and recognising patterns of parental behaviour which assists with their decision-making when working with complex families. This can help in recognising and understanding further incidences of disguised compliance and medical neglect. A reduction or downgrading of professional concern can lead to drift, thereby missing the opportunity for timely interventions. It is important to record these incidents from a child's perspective rather than focussing solely on the parents capacity and engagement to maintain the perspective of the professional on the impact and measurable outcomes for a child.

In 2016, Child B (at the age of 14) was seen by GP for minor ailments, blood tests were requested to investigate complaints for dizziness and GP1 completed a cardiology referral due to the examination findings. However, she failed to be brought to her hospital appointments and the practice made numerous attempts to follow up with the parents, in line with their practice policy for 'DNA'/'Not brought to appointment'. There is no record of a discussion with the Practice Safeguarding Lead, Named GP for Safeguarding or a referral to CSC. A choose and book outpatient appointment was made for Child B. The initial referral had been made by the GP on 11.04.16 as child was having 'near blackouts' but had not actually passed out. The GP requested for child to have an assessment of her symptoms and cardiac murmur. A further appointment was going to be offered in a couple of months. Links were not made between mother's previous pattern of non-attendance/missed appointments which had resulted in her de-registration from the practice in 2004 and fathers own behaviour in missing his health appointments (as he remained registered with GP1) whilst mother was registered with GP3 and the patterns with D also not being brought to appointments. This historical information would have precipitated a different response.

Child B was seen by the GP1 for a routine check-up and subsequently referred by the GP to the Emergency Department (ED) as she had a rapid heart rate and episodes of feeling faint.

Child B attended ED with her father. During this hospital presentation in May 2018, Child B consented for the Doctor to see her with her father in attendance and she also gave consent to be seen on her own with the Doctor whilst the father stepped out of the room. The Doctor's impression was that child appeared anxious and nervous but

⁷ Triennial Analysis of Serious Case Reviews (2011-2014): Practice briefing for health practitioners. Research in Practice (2016).

said that there were no problems at home. This contradicted her assertion to the doctor that her mother and father often argued at home. However, this was not explored in relation to how it impacted on her, neither was this challenged.

Child B told the Doctor that she has been upset since her grandmother died 3 years previously as she was very close to her. She also disclosed to the Doctor that she had recently broken – up with her boyfriend but she said that she was on good terms with him and they were still friends. How did she meet this boy? What was his age? Did they meet in the park or was this encounter online? Child B made further disclosures to a hospital doctor whilst she was on admission for a cardiac complaint. She revealed that a man had exposed himself to her on social media. Child B divulged that she had 5000 friends on facebook. She also reported accessing twitter and Instagram. She was clearly able to seek advice from mother who advised her to block the contact. The doctor explored this further with Child B and sought advice appropriately from the Hospital Safeguarding Children Adviser (SGA).

Even though, Child B demurred against a MASH referral, the doctor decided to make a referral but this was not completed. Further scrutiny of the hospital records indicate that a decision was made not to make a MASH referral to CSC after discussion with a social worker. However the decision was made to notify the Children Missing from Education Team as there were concerns in relation to Child B not attending school. This notification was emailed to the Children Missing from Education Team by the Safeguarding Children's Advisor. Participants to the SCR workshop noted that there is a difference between a telephone inquiry to ascertain if a child is known to MASH and making an actual referral. The Safeguarding children adviser (SGA) also alerted the Safeguarding Lead within the Hospital Home Teaching Service (HTTS).

Child B has expressed that she had never been to school before or received informal education and was not able to read or write. According to the record Child A and B were allowed to go to the park outside school hours. It is not clear how much social interaction she had with her peers and how this affected her development or emotional wellbeing as she disclosed episodes of self-harm the most recent being in May 2018.

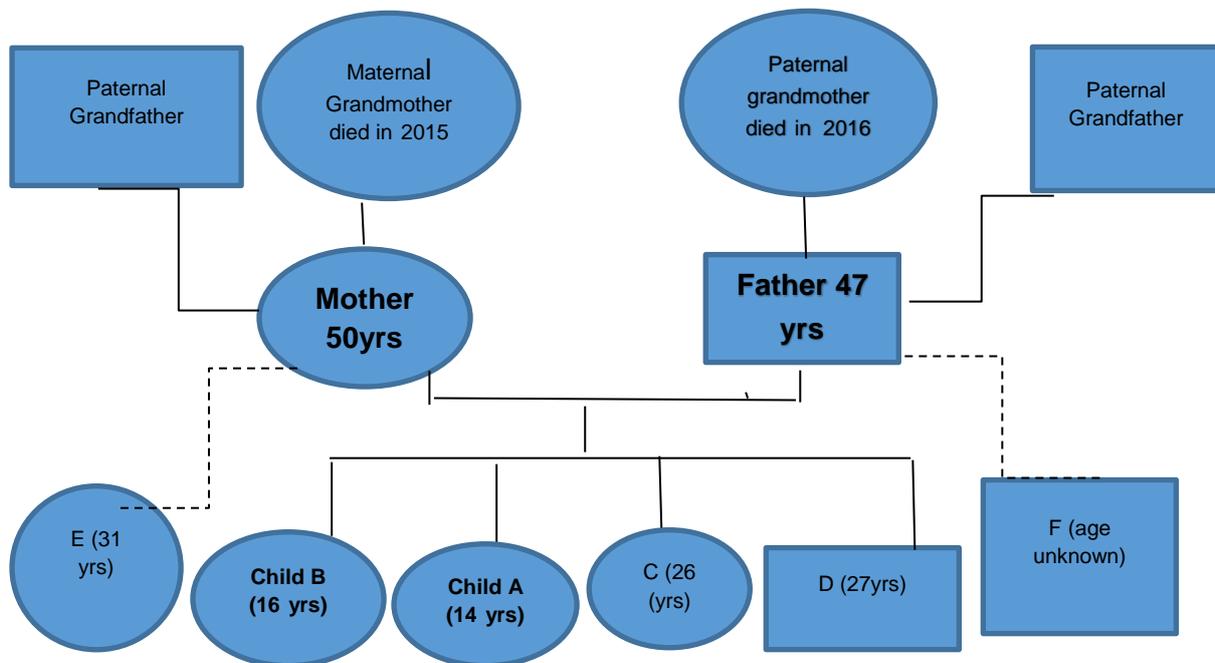
At the point of entry into care in June 2018, Child B had an incomplete immunisation history at 16 years of age, which would suggest that she had not received her full schedule of immunisations. This could partly be attributable to not being in school and not being known to the school health service as some of the immunisations such as the school age booster and Human Papilloma Virus (HPV) are administered in school. Child B has significant dental decay and it would appear that she was registered with a dentist and received some dental care prior to being taken into Local Authority care. **There is a missed opportunity during this contact for the dentist to have explored the level of dental neglect and also her school status.**

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. Emotional trauma in childhood can affect health due to Adverse Childhood Experiences (ACEs) such as neglect, these affect physical and mental health over the longer term. Attachment difficulties and the experience of ACEs can manifest through social, emotional and learning difficulties. The parent's decision to prevent their children from attending

school may mean that these children have missed out on the development of crucial skills for life and learning such as social and friendships skills, and the ability to control their emotions and impulsiveness. This potentially has significant implications for a child's ability to engage and trust in new relationships, for example with teachers and school staff, and may result in difficulties with processing information; the ability to organise self and work; transitions and working with others. This may then lead to poorer educational outcomes, risky health behaviours and social problems⁸.

Child A and B reported that their parents advised them to hide whenever the district nursing professionals (ICT) attended the flat. The ICT Nurse observed that there were no toys, children's clothes or evidence of the presence of the children. During the workshop the participating ICT Nurse described that on visiting the home to attend to mother's pressure ulcer care, she would be met by father at the door and directed up the stairs to mother's room. As the bathroom was adjacent to this room she did not have the opportunity to explore or access any other parts of the accommodation. Father also remained during the nursing procedures, leaving limited opportunity for direct conversations with mother on her own. The GP3's record shows that on registering with the practice in 2016, mother then aged 48 years only made reference to her older children. Child A, B and D remained registered with GP1. Of note even though Child B disclosed a safeguarding concern suggesting possible online grooming by an unknown adult, she did not tell the doctor that she had a younger sibling (Child A).

Figure 4 - Relationships within the family - Genogram



⁸ <https://youngminds.org.uk/media/2142/ym-addressing-adversity-book-web.pdf>

Both mother and father had one previous child each before they had their first child as teenagers. Father would have been 16/17 whilst mother was 19/20 years. It is indicated in the notes that mother and father are not married and described as partners. This flags the question of 'parental responsibilities'.

In another incident police were called to the property by mother, after she heard banging on the front door (this was verified by the children) but could not open it as the family had been locked in by the father, who had taken both keys.

We know that the ambulance service and police were called out when mother, who had multiple co-morbidities, fell out of bed. When mother called the London Ambulance Service (LAS) and they sought assistance from the police to enter the property. Mother was in a lot of pain on the arrival of LAS and was subsequently admitted to a hospital. This raises questions as to whether mother called for help and was not heard or was there another explanation?

Child B discouraged Child A from talking to the police for fear that their father would be listening in. Indeed, Child A informed the NSPCC that there were other 'secrets' in the family. What were these secrets and why were the children hidden from the view when professionals visited the home?

On registration with the new GP (GP1), mother did not disclose that she had younger children and only referred to her older children. What was the reason for this detachment?. Did professionals miss indications that the mother might have been coersively controlled by the father?

Summary

F (age n/k)	E (31yrs)	D (27yrs)	C (26yrs)	B (16yrs)	A (14yrs)
No details available from information gathered	Attended local secondary school while living at home with parents	Stayed in education until the age of 12.	CSC input, subject to a CP plan under the category of neglect in 2001.	Not clear whether child accessed nursery placement offered at the age of 3.	No record of being on roll of any local school.
	Left home to after the birth of B at the age of 16	Left the family home in 2003 aged 13 after birth of A.	Taken into local authority care with a contact order in place for weekend contact with parents.	No record of being on roll of any local school.	Not home educated.
	Lived with maternal grandmother in Essex from the age of 16.	Went to live with aunt in Enfield from the age of 16. Became homeless at the age of 17 and approached CSC for assistance.		Not home educated.	

There is evidence to suggest that working with complex blended families provide challenges for professionals and the wider system⁹

These bullet points from the information gathered provides a snap shot into the relationships within the family:

- It would appear to be supportive in as much as father cared for the children whilst mother was unwell or unable to do so.
- Mother rang the ambulance service on one occasion as she fell out of bed, and was unable to reach father and children to support her.
- There is a report that on one occasion father locked mother and children at home.
- Children told to hide when professionals were around – this was also not explored by professionals in receipt of this information.
- Child A and B were neither on the school roll nor were they being home schooled.
- Thoughts around what triggered Child A to contact NSPCC – this was not explored by professionals in receipt of this information.
- Who in the family cared for mother? Could these children have been ‘young carers’?
- Repeated missed appointments for all – who was responsible for bringing the children for their appointments?

Immediate Family

We also know that there was a change in housing status and the family had to downsize to a smaller property in another part of the borough. Father was also unemployed during the period of Child A and B’s births. The GP records also indicate an awareness of benefits entitlements, as mother was attempting to renew her Personal Independence allowance (PIP) with father’s input. Parental and environmental risk factors in relation to domestic abuse, learning difficulties, substance misuse, coercion and mental ill health are noted in the Triennial Review, but also include adversity in parents’ own childhoods and social isolation. It is not known to what extent any of these factors influenced their parenting abilities as the scope of the review did not enable inclusion of this historical information. However, there is evidence to suggest that the family experienced social isolation. From a contextual safeguarding perspective it is important to understand what and if environmental factors existed and presented as risks and threats to the children’s safety and welfare.

The Triennial Reviews highlighted that the most serious and fatal maltreatment takes place within the context of the family. Infants and adolescents can be at risk for a variety of reasons. Disabled children are particularly vulnerable as signs of abuse and neglect may be obscured or misinterpreted due to their underlying impairments. The impact of having a disabled child within the context of this family cannot be fully

⁹ Serious case review: Martin. [Unnamed local safeguarding children board] (2017) NSPCC Online Library - INQUIRIES/2017

explored, as there are limited records for the period within the scope of the review. However, what is clear is that parents felt overwhelmed and the impact of the child being taken into care would have been difficult for the family to accept.

The parents expressed to the social worker that they felt blamed for the poor management of C's seizures and reduced their supervised contacts to C as a result. They also asked for changes to the care arrangements to enable them to participate in C's care. There was a view that the parents struggle with the care of the disabled child who had complex health needs may have affected their self-esteem. However, consideration needs to be given to the fact that if one child had needed to be taken into care, should not professionals have had heightened awareness of the other children's needs when working with the family? Mother would have been 34 years and father 31 years at this time.

D had a history of not being brought to medical appointments and as a result missed a number of health appointments when living with his birth family. During the time the family resided in the south of the borough information on the School Admissions database shows D attended two primary schools in Waltham Forest. As the record is disjointed, it is not clear whether D was actually being home-schooled from the age of 12 or what level of supervision or stimulation he received. An entry in the record would suggest that he left the family home at the age of 13 to live with an aunt in Enfield?? Or was it with someone else??

There is also an entry in is correspondence between Children's Social Care (CSC) and Probation, Corporate Parenting and Special Guardianship/friends/family Assessment Team stating in February 2008 that D (then aged 17) advised his social worker that mother had said he could not live with her due to her illness, but this was felt to be contradictory to what mother had said to professionals the day before. There is also a reference to an aunt in Enfield, with whom D stayed following the breakdown of his relationship with his parents.

Extended family support

Workshop participants noted that non-engagement with services became particularly apparent following the demise of the maternal grandmother, who had played an active role in the family. The family took regular holidays with her in Clacton. E (now an adult) also left the family home to live with maternal grandmother at the age of 16. No explanation is provided for this decision. D also presented at Social Services with a request to be re-housed after a breakdown in his relationship with an aunt living in Enfield, when aged 17.

The role of bereavement cannot be under-estimated in the family. Mother suffered loss following a miscarriage after child B's birth. She expressed to the health visitor that she had encountered difficulty in coming to terms with this. It is not clear what support was offered and what pathways were in place for such women. This emotional turmoil continued with the subsequent pregnancy for Child A, during which the mother was initially ambivalent as to whether to continue with the pregnancy. Of note, mother was not seen at the new birth visit conducted by the health visitor in the home, during which

the children were seen with the father. Although no concerns were identified with the care and presentation of the children, the mother was reported to be at home upstairs but was not seen for 3 subsequent visits.

The record highlights the significant impact of maternal grandmother on this family as a caregiver. This was demonstrated through practical support with child care, as well as for emotional support. Child B acknowledged this support and closeness. There are indications of a strained relationship between the mother and the maternal grandfather after her death but the reason for this is not known.

The record also highlights that father also lost his mother a year after and told his GP in December 2016. He also reported to GP1 that he was his late mother's carer.

8.0 Pathways to Prevent Harm – Thematic Analysis of Findings

Strategies within 'Pathways to Prevention and Protection' include hearing the voices of the children and families and listening and acting in response to them. Recognising the importance of the voices of adolescents and attending to 'silent' ways of communicating; crucially professionals need to maintain attitude of respectful uncertainty, professional curiosity and challenge.

Parenting capacity

There were sufficient concerns about parenting ability in 2001 when C was taken into Local Authority care due to neglect. However, this did not translate into further support for the family or closer monitoring with the arrival of Child A, more so after the incident on 6.9.03 when C lost consciousness while in the care of parents and their delay in seeking urgent medical assistance during such an event.

The information gathered indicates that foster carer stated that whilst C was having a home visit on Saturday 06.09.2003 she received a phone call from father stating that C was floppy, requesting that she visit to check on her. It would have been expected for the Foster Carer to advise the parents to call an ambulance instead of the family waiting for her to arrive at the home and assess C's condition before calling the emergency services for assistance. On the foster carer's arrival she found C unconscious in a chair and called for the London Ambulance Service. C was admitted to hospital and discharged to her foster carer the following day. The Social Care referral highlighted that E (aged 16) was currently living with maternal grandparents, and that D (aged 13) was also not living at home. Child B was aged 1 year and Child A (unborn child) was due in one month.

A strategy meeting was convened on 12.09.2003. It was documented that the Social Worker (SW) intended to visit the family prior to the strategy meeting. The strategy meeting was attended by police and ASC. It is not clear from the chronology why CSC

and HV were not invited to participate in the strategy meeting. The incident was discussed by the professionals present and they agreed that the care provided by father was inadequate but did not reach the threshold for criminal neglect and therefore social services would be dealing with the case as a single agency to facilitate the onward care for C. It is not clear whether this information was shared with the HV or indeed the Midwife who had concerns that mother had failed to attend three antenatal appointments. Curiously, there was no additional social work input to support the family at the time when there were additional stressors, neither was the GP alerted. Therefore, based on the above it would appear that agencies did not provide support for the family.

There was no record of liaison with the Health Visitor by the Social worker to alert her to these concerns. Neither was there curiosity about the younger child and the ability of parents to care for the unborn child, particularly as father appeared to be the main caregiver when Child A was born. The CRIS report was marked as 'no crime' and closed with no further police involvement. This strategy meeting represented a missed opportunity for preventative multiagency work¹⁰ to safeguard the Child B and her unborn sibling (Child A) as the focus of agencies was solely on C and not on the wider impact of the concern for neglectful parenting even though this had not reached the threshold of criminal neglect¹¹. In effect, the 'think family' model was not considered or applied to the risk assessment or consequent decision-making.

Parenting capacity is the ability to provide 'good enough' parenting in the longterm¹². Parenting capacity has been identified to have three core inter-related elements such as child developmental needs, wider family and environmental factors based on the assessment framework. Poor or deficient parenting is not always unintentional as may have been the case for this family.

The longterm impact on the emotional, social and psychological wellbeing of Child A and B is not known. Neither is it known whether a capacity assessment was ever undertaken for either parent during their contact with agencies during statutory assessments. Other complicating factors which impact the ability to parent were the family's limited social networks, particularly after the family bereavements of matriarchal figures¹³. There were also changes in the family's circumstances such as a loss of employment for father and also having to downsize in accommodation and the relocate to another area in the borough.

The records from London Ambulance Service (LAS) on 09.02.16 indicate that mother had been a heavy drinker and smoker until recently. It is not clear how this would have impacted on parenting capacity. What was the emotional and psychological impact on children living in such a home environment?

¹⁰ <https://www.gov.uk/government/publications/protecting-disabled-children-thematic-inspection>

¹¹ Growing up neglected: a multi-agency response to older children July 2018, 180023

¹² Conley, C. (2003). A review of parenting capacity assessment reports. Ontario Association of Organisational Neglect of Children's Aid Societies Journal, 47 (3):16-22.

¹³ [Childrensociety.org.uk/lutonscbreport](http://childrensociety.org.uk/lutonscbreport)

Professional curiosity /missed opportunities/management of missed appointments/child not brought

The strategy meeting held on 12.9.03 presented a missed opportunity for services to safeguard Child B, given the serious concern regarding father's parenting ability. The lack of a joined up approach meant that no additional safeguards were put in place to monitor or support the care of Child B and Child A who was expected to be born on in a few weeks time.

No linkages were made even when the Health Visitor shared concerns regarding lack of engagement with health appointments by the family with D's social worker and this did not result in a further referral to social care. There is no record of professional challenge being provided in this situation or escalation via supervision to the named safeguarding professional for advice to both supervisor and supervisee.

Most serious case reviews (SCRs) flag the issue of inadequate information sharing and ineffective work with colleagues and other agencies. Incidents where the family came into contact with statutory services were treated as separate episodes by professionals and not linked to provide a growing picture/chronology of cumulative concerns. For instance on 28.02.08, Police were called by a member of the public who saw Child A (aged 4) walking up and down the street on his own wearing only a t-shirt and nappy in winter. Police attended and began to conduct enquiries until a call was received from the father. This incident did not appear to be linked to the strategy meeting held in September 2003, which was convened a month before Child A's birth where there were concerns of parental neglect. The use of significant event chronologies would have highlighted this episode⁷.

When Child B was seen by GP1 and sent to ED, there were questions raised by staff, asking CSC if she was known to the service. It was noted that asking if someone is known to CSC is not the same as asking if they have a concern about the person. There is therefore a need for clarity regarding the purpose of a contact or telephone inquiry. There was a gap in the information on Child B's discharge summary from hospital, which referenced domestic violence and exposure to online exploitation and abuse. The hospital record states that following discussion with a social worker the professional did not complete a referral to MASH. There is no evidence around professional challenge and escalation around this decision, although the concerns were communicated within the discharge summary. There was no ownership and a lack of clarity regarding each professional's role in relation to how the safeguarding concerns were going to be resolved beyond the referral to the children missing education team to close the safeguarding loop. The statutory guidance, Working Together 2018¹⁴ highlights the need to avoid role ambiguity if children are to be safeguarded effectively. This also relates to the use of universally understood terminology within inter-agency communications.

¹⁴ **Working together to safeguard children** - Statutory guidance on inter-agency working to safeguard and promote the welfare of children. HM Government (2018).

Hidden children/Home schooling

In England, the responsibility for a child's education sits with the parents. Education is compulsory in England, however, school is not. Article 2 of Protocol 1 of the European Convention enshrines the rights of children to receive an education that equips them for adult life and enables them to contribute productively to the community in which they live. Parents have a duty to secure an appropriate full-time education for their children. Some parents choose to do this by educating their child/ren at home. Parents must comply with notices and orders served by the LBWF under Section 437 of the Education Act 1996, if it appears that parents are not providing a suitable education. This will apply where no evidence is provided by which the local authority is able to judge progress and that appropriate provision is in place.

However, in this instance parents did not notify the local authority of their intention to electively home educate (EHE) their children. If parents had fulfilled this legal duty it would have provided the opportunity for appropriate monitoring in accordance with the local EHE Protocol. As the onus on the parent to notify authorities of their intention to home educate, how confident are we that parents were aware of this obligation? How is this information made accessible to parents with mild to moderate learning difficulties, language barriers and/or literacy problems? All these considerations would impact on a parent's ability to make informed choices and discharge this legal duty.

Children can sometimes be vulnerable if not in school due to their 'invisibility' to their peer group and professionals, they can also experience social isolation. For children who are already in school there can also be an impact from managed moves across schools on established relationships. On 01.02.13 the HV clerk sent a school inquiry letter to parents requesting information on Child A and B's schools. It could not be ascertained/verified from other sources if they ever went to primary or secondary school. Learning lessons from the Laming Inquiry, a child registered with a GP who has no school history should have been referred to MASH. **Learning point 7 : At this point they should have been flagged as missing children to enable the BACME processes to be followed and child missing inquiries to be made via MASH. On registration of children all GP Practices should inquire for details of the school attended, where this information is not forthcoming they should refer to MASH.**

RIO records indicate the family moved addresses from the south to the north of the borough during 2013 and 2014, raising the possibility that the family did not receive the letter from school health. In 2014 records for both children who were of school age were sent to Child Health for archiving, as their schools were not known and there appeared to be no method of successful contact with family to ascertain information regarding schools attended by the children. This was to enable the HV records to be transferred to the appropriate School Nursing Team.

It should be noted that parents did not inform education authorities of an intention to home school which is the legal requirement. However, we cannot be certain that they were aware of this legal obligation. As there was no school history for either primary or secondary education for children registered with a local GP and with a local address this should have merited further exploration and escalation. This was clearly a family

who created a concern for the HV service as evidenced by the level of supervision received, therefore indicating a corresponding need for such a vulnerable family to be handed over to school nursing either formally or via a transfer summary.

A separate entry on 05.02.13 from D's Adult Social Care (ASC) record indicates that D who is now an adult, approached CSC at the age of 17, seeking accommodation as a homeless teenager under the Southwark judgement¹⁵. Records indicate that D claimed that he did not attend school from the age of 12 and informed social workers at the time of his homeless presentation. How did he become lost to follow-up? Why was there no curiosity regarding his transfer from primary to secondary school as his younger sibling C attended a special school in the borough while in care.

Neglect

From the information gathered, there was evidence of neglect from early on in the lives of Child A and Child B. This is reflected in the significant delays in health assessments and immunisations, multiple cancellations of appointments and children not being brought to appointments and adults themselves not attending important health appointments. For instance, mother did not attend for her cervical smear test, even though there was a strong family history of reproductive cancer. Mother later disclosed to a mental health worker that she was afraid to attend the appointments due to a fear that her symptoms were due to a similar cancer.

Father had a painful ear condition but still failed to attend the appointments, which were scheduled to alleviate this condition. The reasons for these failed appointments and cancellations were not fully explored.

On 28.02.08, Police were called by a member of the public who saw Child A (aged 4) walking up and down the street on his own wearing just a t-shirt and nappy in the winter. Police attended and started to conduct enquiries when a call was received from the father. Father stated the gas board were at the home address carrying out some work and the front door was left ajar to facilitate this. As soon as father realised Child A was missing he started to search for him calling police. Officers attended the home address where mother was described as frantic with worry. The home address was described as clean and tidy. No other concerns were reported by Police. A PAC Merlin was documented and shared with partner agencies. As this information did not appear on the HV record, it is not clear whether Health agencies (HV or GP) were informed of this incident. There is also the possibility that CSC were not informed.

Children rely on their parents and carers to take them to medical appointments so missed appointments are always a cause for concern. Failure to attend medical appointments is recognised as a child protection issue within statutory definitions of neglect. It may also suggest that services are difficult for vulnerable families to access. Serious case reviews criticised the practice of simply recording missed appointments, but not analysing the records for patterns and trying to find out why a child might not be brought to appointments. They criticised the system of flagging non-attendance at medical appointments as Did Not Attend which in many cases actually leads to a withdrawal of services. The Did Not Attend category does not recognise the real issue which is children not being taken to appointments, a potential indicator of neglect.

¹⁵ <https://publications.parliament.uk/pa/ld200809/ldjudgmt/jd090520/appg-1.htm>

Adolescent neglect can be difficult to define, Child A and B were isolated from their peers, as they experienced educational neglect due to a lack of either formal or home education. Children may react or respond differently to neglect and can either internalise or externalise their symptoms in a somatisation of their problems. Child B presented as overly anxious on attending hospital with her father².

For instance there was:

- A fear/mistrust of professionals
- Child A and B were missing education (educational neglect)
- Child A and B had dental decay (neglect in relation to basic care)
- Children hidden or told to hide from professionals (ICT nurses)
- Child A disclosed that there were secrets in the family
- Professionals not being told that there were younger children in the household
- Children were not taken to some medical appointments (medical neglect)
- A lack of supervision (supervisory neglect).

In some cases, fragmented recording systems predisposed professionals to view each family member's behaviour in isolation, rather than in the context of the family. **Learning Point 8: It is important for professional systems available to be fully utilised to link families together, to enable information to be shared in context and to provide a holistic view of the impact of changes within the family on children and vulnerable adults within the household.**

Self-neglect/mental capacity /competency

Self-neglect¹⁶ involves any failure by an adult to take care of him or herself, which causes or is reasonably likely to cause serious physical, mental or emotional harm, or substantial loss of assets. In mother's case the home was described consistently in the records as clean and tidy by professionals visiting. Self-neglect is often defined across three domains – neglect of self, neglect of the environment and a refusal to accept help.

However, we need to consider the mental capacity of the adult to understand the implication of non-attendance and also discount the possibility of a physical impairment which precluded his attendance.

In this case it could also refer to non-attendance at health appointments by an adult with care and support needs due to their co-morbidities/complex health needs. Mother attended the Emergency Department (ED) with a complaint of a leg ulcer on 09.02.16 and was subsequently referred to the Integrated Community Team (ICT) who provided a District Nursing Service. The records from London Ambulance Service (LAS) indicate that mother had been a heavy drinker and smoker until recently. Antenatal records also stated mother was offered smoking cessation advice/support at that time, although there is no further reference to this in the health record until this point.

¹⁶ https://search3.openobjects.com/mediamanager/walthamforest/fsd/files/lbwf_multi-agency_self-neglect_policy_final_21_12_16.pdf

There is also an element of organisational neglect in relation to the development of a grade three pressure ulcer while on admission to hospital in December 2017 a few weeks after the ulcer was described as healed. A safeguarding alert was passed to the social work team in hospital. The case was assigned to a Safeguarding Adults Enquiry Officer and a Safeguarding Adults Manager in the Adult social work team in the hospital. There was a query by managers as to why the pressure ulcer occurred in mobile patient and a request made by the Social Work manager and hospital safeguarding Lead for a community Tissue Viability Nurse to review. There is no record on Mosaic (Social Care IT system) of this intervention occurring or if the pressure ulcer was hospital or community acquired. This safeguarding adult concern was not progressed as per process and remained outstanding until 25.06.18. This represented a delay of six months from when the alert was first raised and constituted a missed opportunity to safeguard an adult with care and support needs under the Care Act 2014.

Communication/Telephone consultations/Transfer of records

Good information sharing is essential to identify and support vulnerable families. In this case the Health Visitor shared her concerns with the GP, Social worker and Midwives regarding attendance at appointments. However, this was not replicated during other encounters the family had with other professional groups. For instance, although the HV persisted in sharing her concerns with the Team Leader of the Children with Disability Team (CDLT), he declined to elaborate to the HV the reasons why C was no longer being cared for by the family at weekends. This information would have assisted the HV in her risk assessment and response to the multiple cancellations of appointments by the parents and parents either failing to bring children to appointments or be inaccessible for planned home visits. CDLT also experienced difficulties in gaining access for home visits.

Police attended the family home after being called to assist by London Ambulance Service (LAS) on 29.12.14, because mother had fallen out of bed and had requested assistance from the emergency services. She reported that she was unable to get up following the fall, and partner was asleep in another room but answered the frontdoor to Police and LAS. Mother was taken to another East London hospital. A Merlin was raised detailing the reason for the call out and medical issues experienced by mother. The Merlin also noted in their record that there were two children in the household both of whom were asleep and unaware of incident, this was subsequently shared with Adult Social Care (ASC). Police officers did not identify any other concerns. This information was recorded on the ASC system on 20.1.15, three weeks after the incident. The Merlin rated as green and there was no record of ASC follow-up or liaison with either Children's Social Care or universal children's services to alert the school nurse or HV as appropriate. GP was also not made aware of this incident. **Learning Point 9: This presented a missed opportunity, siloed working which did not enable a 'Think family ' perspective , an absence of respectful questioning, professional challenge, professional curiosity and inadequate information sharing.**

GP de-registration

NHS England policy book (2015) sets out that when removing a Patient from a Practice List, the practice must normally provide the reason for removal in writing to the patient. Removal may normally only be requested if, within the period of 12 months prior to the date of the request, the practice has warned the patient in writing that they are at risk of removal and reasons for this have been stated. Circumstances where a written warning may be justified include a change of address outside of the practice area including where de-registration will be harmful to the physical or mental health of the patient or put at risk one or more members of the practice team.

However, the practice must record in writing either the date of any warning given and the reasons for such a warning or the reason why no such warning was given. This should also include the reasons and circumstances of the removal and this record must be made available to the Commissioner should it be requested. The Commissioner must refer to the relevant Regulations/Directions (set out at in Part 2 of Schedule 6 of the GMS Regulations; Part 2 of Schedule 5 of the PMS Regulations; the APMS Direction do not require APMS contracts to have provisions relating to patient lists – the Commissioner should refer to the wording of the relevant APMS contract).

GP Practices may remove a patient with immediate effect where the patient has committed an act of violence or behaved in such a way that the contractor, practice staff, other patients, or those present at the place the services were provided have feared for their safety. The incident leading to the request for immediate removal must have been reported to the police. It is highly likely that there are different ways in which violent patients are managed nationally as services were commissioned in different ways under a violent patient directed enhanced service scheme. For this reason the Commissioner must refer to the relevant Regulations/Directions and current guidance for managing violent patients.

As patients may experience difficulties in registering where they have been removed from a practice list, although, (other than on the grounds of violence or threatening behaviour), this should not ordinarily be a factor considered by practices when approached by new patients. It should also be noted that patients have the right to choose to move from one practice to another, even within the same locality, without providing grounds for doing so.

The Laming review of the Victoria Climbié case in 2003¹⁷ led to a greater awareness of child abuse and resulted in profound changes in practice, and increased acknowledgment of the role of the medical profession as whole in safeguarding. Furthermore, Lord Laming's review highlighted the pivotal role of the role of General Practice in safeguarding, due to their position of trust and also as gatekeepers to secondary care. As such the Royal College of General Practitioners endorses good registration practice, and GPs now have systems that link adults in a household with the children. The GP Safeguarding Toolkit also recommends coding of factors that

¹⁷ Laming, Lord (2003) The Victoria Climbié inquiry. Report of an inquiry by Lord Laming. Cm 5730, London: TSO.

increase the risk of child abuse—such as substance misuse, mental illness, and domestic violence, all of which are used as alerts to highlight safeguarding concerns within families¹⁸ and to make practice colleagues aware of such patients.

Mother was de-registered by GP1 on 15.03.04, although father and the remaining children remained registered with the GP Practice1, although C registered with the Practice a month later on 25.04.04. The reason given for mother's de-registration was "persistent failure to attend appointments for herself".

The record on mother's attendance at the GP to request an antenatal booking referral to the maternity service referred to father as her 'partner' and not husband, it is therefore not clear whether he had joint parental responsibility with her for the children¹⁹. This would be relevant in respect to the adult providing consent for medical procedures and interventions such as immunisations for the children. In addition from a safeguarding perspective having a mother registered in a separate practice to her partner and children would make it difficult for a GP1 to make links between parental health issues which would potentially impact on parenting ability as they would not have access to the records of GP2 who was in a separate Practice.

Although there is no legal requirement it is good practice to register a family with one GP Practice and to link the family records to enable wider safeguarding patterns to emerge. Crucially, the children and father remained registered with GP1²⁰. The guidance states that where parents or carers have been removed from a GP list due to aggressive and or violent behaviour a risk assessment should be completed to identify any risk to their children and the appropriate referrals made. However, in this instance there was no report of violence from mother to trigger a de-registration.

Maternal Mental Health

GPs have a key role in safeguarding children and vulnerable adults, mother referred to Waltham Forest Access and Brief intervention (AABIT) service by her GP following mother's refusal to attend gynaecological appointments for investigation of health symptoms. AABIT is a mental health single point of access and provides a signposting service to other services when referrals do meet threshold criteria. Under the Care Act 2014, a competent adult is allowed to make unwise decisions. This decision was not seen in the context of her parenting responsibilities as GP3 was not aware of their existence.

Two weeks after the GP referral a screening appointment conducted by AABIT service via telephone. Mother informed the mental health practitioner that she was finding it difficult to come to terms with the death of her mother, which occurred two years previously. Mother also reported that as a result of this she had gained a lot of weight due to comfort eating. Maternal grandmother was reported to have died of cervical cancer and both had a close relationship. Weight gain was adversely affecting her

¹⁸ BMJ 2014; 349 doi: <https://doi.org/10.1136/bmj.g5898>

¹⁹ <https://www.legislation.gov.uk/ukpga/1989/41/section/3>

²⁰ <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/01/patient-registrations.pdf>

mood and she reported being verbally abused by local children. She also reported a sleep disturbance and worries about her physical health.

Mother disclosed that she avoided attending her hospital investigations due to her fear that her symptoms could be due to a cancer. She had a residual left sided weakness following a stroke and denied having suicidal thoughts. Mother informed the AABIT worker that she had two adult children who did not live with her and three grandchildren. She reported that she lived with her partner and had broken contact with maternal grandfather since her mother's death.

Mother agreed to take antidepressants and access bereavement counselling. However, she did not disclose to the mental health worker that she had two younger children. It is not clear whether at that time RIO functionality allowed the adult mental health staff to access the universal children's record. The family records were unlikely to have been linked as this preceded the implementation of RIO in 2007. As mother was de-registered by her original GP in 2004, it is also not clear whether GP2 was aware that she had two younger children as they together with father and D continued to be registered with GP1. Mother on registering with GP3 did not disclose the existence of her two younger children. The reason for her decision is not known.

The telephone assessment was discussed two days later at the AABIT Team meeting. The outcome was to refer to bereavement counselling services and consultant psychiatrist recommended commencing anti-depressant medication. The outcome of this AABIT Team discussion was to refer to bereavement counselling services and the consultant psychiatrist recommended commencing anti-depressant medication. There was no follow-up to ascertain whether mother accessed the counselling support or took the anti-depressants. Conversations with the provider have established that the service is not commissioned to follow-up the outcome of cases signposted to other services. Best practice would indicate that the referrer (GP) is informed to follow this up with the patient.

Impact of family bereavement

The impact of bereavement on the the emotional wellbeing of the family unit was not recognised or explored due to the family being registered with two different practices G1 and GP3. GP3 had referred mother to the AABIT due to concerns with her mental health and Child B had expressed sadness at the loss of her maternal grandmother. The ability of professionals to provide support to the children was hampered by mother not disclosing to GP3 and AABIT service that she had 2 younger children. It is not clear whether mother's previous GP records from G1 and GP2 were retrieved and read by GP3. If this had been the case GP3 would have been aware of mother's grande multiparity.

Impact of a child with disability on the family

The Children with Disability Team Leader is recorded as encountering difficulties in gaining access to see the family. The entry in the social care record for the Children with Disability Team indicated that parents felt they were being blamed for C's epileptic seizures and withdrew from contact visits. C continued to experience seizures and the record shows that these were the subject of ongoing investigation. The social worker

also reminded the parents that during telephone conversations he had gained the impression that parents wanted to reduce contact with C due to the increased demands in caring for two young children. However, when given a choice parents requested to have the opportunity of providing day care to C. This would suggest that parents felt overwhelmed with the competing demands of caring for a baby, toddler and a disabled child, in relation to limited quality time C would have had with her younger siblings. There is insufficient information within the integrated chronology to understand the impact on Child A and B of having a disabled sibling.

The information gathered shows that C underwent a child protection medical conducted by 2 doctors on 01.01.06 as staff in a respite placement noted bruising in the groin, vagina and thigh area. Although there was no evidence of sexual assault and the bruising was attributed to the tight application of continence products there is no record that this was followed up with additional support or training for the foster carer to assist with C's care and management.

Supervision

The relatively newly qualified family health visitor received a combination of regular managerial supervision and periodic safeguarding supervision from her Team Leader. There is evidence to the effect that she found this to be supportive. Good supervision is crucial to provide professional challenge and to encourage critical reflection.

It is not clear from the information received that historical information was considered in supervision by the Health visitor and her supervisor as this would have informed decision-making and the health response to non-engagement. As a consequence of this gap in information, no professionals meeting was convened after the birth of Child A when it became apparent that the main caregiver was father and mother was not seen at the new birth visit and subsequent follow-up visits. HV's plan following managerial supervision was to write to the Team Leader for the Children with Disability Team requesting further information after parents failed to bring Child A for his third primary immunisation at the GP Practice and the HV had encountered difficulty in engaging the family. It should be noted that parents have a right to decline immunisations for their children, but this was not the case for these children.

The record shows that the HV initiated telephone liaison with the Team Leader of the Children with Disability Team. The Team Leader informed the HV that he was also experiencing difficulties in getting to see family members, but had managed a recent contact. He also advised HV that C was now subject to a full care order. The HV's plan after this contact was to write to the Team Leader of the Children with Disability Team to request more information and to arrange an eight month developmental review for Child A. When parents failed to bring the child to the appointment, there was no evidence of escalation or follow through with the letter. Father however, brought Child A to the GP for his delayed third immunisation a week after the missed appointment. **Learning point 10: This represented a missed opportunity for the GP or Practice Nurse to explore the reasons for the delay in bringing Child A to the appointment with father. A child not brought to appointments may be an indicator of a parent struggling and can also point to neglect.**

9.0 Findings - What does Child A and Child B's experience tell us about how local systems work together?

Communication within the system was not functioning as well as it could. Even though, information was shared between some agencies, no agency had a full picture of the concerns as a professionals meeting was not convened. In 2003 a strategy meeting was convened regarding concerns of possible criminal neglect of C while in her parents care. Unfortunately, health professionals were not involved in the strategy discussion or meeting. These represented a missed opportunities for agencies to work together to safeguard and promote the wellbeing of the children who remained in the care of the parents.

Incidents where the family came into contact with statutory services were treated as separate episodes by professionals and not linked to provide a growing picture/chronology of cumulative concerns. Green Merlins were not shared with Children's Social Care (CSC) or universal children's services (HV or school nursing), neither was this brought to the attention of the GP. This was a missed opportunity, current changes in practice now ensure that there is a think family approach and such Merlins undergo a dual process. Discussion with the Service Leads suggest that this may point to human error or a limitation in the older version of the Merlin system to be able to dual process at the time.

The New MASH system, has incorporated a Daily Risk Meeting (DRM) into the MASH operational function which has had a positive impact on the ability to manage Safeguarding risk for Children and Families in Waltham Forest. The DRM meeting provides the framework to allow timely information sharing and action planning to safeguard high risk cases being received into Waltham Forest's front door, by ensuring that action regarding high risk cases and overnight critical incidents is taking place and is co-ordinated. The incorporation of the DRM process into the daily functioning of the MASH team has improved joint working between the Health, Children's Social Care, the Police, and partner agencies including education. This has enabled a robust multi-agency response where it is believed a child, young person or adult may be at risk of significant harm, particularly those who are at risk of CSE, Missing, Gangs, High risk DV and radicalisation. The DRM review intelligence gathered on these young people and adults (across the agencies) and strategy meetings are being held where appropriate. The new system enables a more effective way of managing cases as meetings are daily and adopt a think family focus. These systems are however managed by humans and therefore at risk of human and/or cognitive errors.

Changes to child health system occurred following the introduction of the new Child Health Information System (CHIS) function and platform in London. CHIS provides an automated movers in and out report. This report is based on the updates to the system which is largely dependent on both Universal Childrens services and Primary Care/GPs updating information in real time. Even though there have been major strides with technology during the review none of these changes have resulted in system-wide integration and therefore IT systems remain siloed. However, professionals still have options of email, telephone or face to face contact to share concerns and intelligence.

The review also identified that particular age groups can become invisible to professionals and services due to the unintended consequences of the universal child health programme²¹. Children can be hidden in the system once health visitor involvement ceases after the completion of the primary immunisation schedule and universal health surveillance conclude during the first 18 – 24 months window. In this review those age groups were identified to be from 2-5 years and 18 – 50 years. The same applies to school age children not in education and not being home schooled, as parents and carers hold the responsibility to notify the local authority of their intention to educate their children or wards at home. Feedback from the professionals who attended the workshops was that during these transitional periods there was a greater likelihood for minimal contact with GPs, school nurses and HVs giving rise to situations for vulnerable children and adults to be hidden or missed if not in early years provision, school or if not actively seeking health care. School nurses are mandated to make contact with children in reception year and this is a key performance indicator (KPI) for the service, but this is only applicable to children who are enrolled in school. There is a gap for those children not enrolled in schools, who may or may not be home schooled. There is now a school nurse with a designated role to work with school age children who are not in mainstream provision.

The BACME process is now well established and robust. The partnership may wish to consider whether when school details are not known to enable the HV service to forward those details with the child health records to school nursing, whether linking with the BACME team may add additional levels of safeguards for such children. This could also be piloted where GPs are unable to obtain school information for families registered with their practices.

10.0 Analysis and issues for consideration – Pathways for prevention and protection from harm.

In analysing the themes from the review it is important to understand the complex context within which the family lived and the reasons for professional responses to opportunities to safeguard the children and mother who was a vulnerable adult. In utilising the framework of pathways of prevention and protection from harm in this review the information gathered highlights the predisposing factors to vulnerability and risk (Figures 1, 2 and 3 and Table 2). These include maternal mental health, a mother with ambivalence in early pregnancy for child A, following a miscarriage, a mother with multiple chronic health problems, an isolated family, and safeguarding issues in respect of coercive control, self neglect and mental capacity. In critically reviewing the harmful actions or omissions of the parents within this framework these are in the main child neglect, encompassing the domains of medical, supervisory, emotional and educational neglect. Although there are unusual features to this complex review child

²¹ Public Health England (2018). Best start in life and beyond – Improving public health outcomes for children, young people and families.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/686928/best_start_in_life_and_beyond_commissioning_guidance_1.pdf

neglect has been a dominant feature for SCRs conducted within the borough since 2014, pointing to the need for a better understanding across the system.

A prevailing culture in which there was a lack of professional curiosity during contacts with the family and in response to missed appointments and children not brought to appointments contributed to a lack of follow-up and the invisibility of child A and B over a significant period of time. Effective pathways to prevention and protection require sustained and robust professional challenge, reflective and challenging supervision, good communication between professionals and agencies as well as open and meaningful relationships with families which maintain the focus on children. These elements are necessary to promote the development of a resilient system as a whole and effective pathways for prevention and protection within it.

From the information gathered it has become apparent that the system does not lend itself easily to professionals joining the dots to have a full picture of a family, more so in the case of a complex and blended family unit, where mother had five children over an extended period of time. This feature may have made it harder for professionals to retrieve historical information, emphasising the importance of having a chronology that highlights significant events within a family. The reference to blended families is also relevant as clinical practice and IT systems need to adapt to accommodate these emerging societal changes. IT systems need to be adaptive if they are not to hinder preventative and protective actions of professionals to safeguard children and vulnerable families. Conversely, professionals require to be fully trained to maximise the safeguarding features within these IT systems in linking families and also accessing significant events chronologies as good practice. These factors need to be considered during registration and de-registration of members within a family unit.

Another emerging theme for the system was in relation to business continuity when services are recommissioned or reconfigured. Two key agencies which experienced one or more episodes of restructuring during the period within the scope of the review are housing and the community health provider another is to do with the phasing out of paper records and the accessibility of archived material. Missed appointments for vulnerable adults and children not brought to appointments is another major theme. In the context of this review this was a feature of child neglect and self-neglect associated with issues of either mental capacity and/or coercive control. These themes of children not brought to appointments/ and their association as an indicator of neglect are reflected in reviews nationally and have been identified by the local Neglect sub-group as well as in the triennial reviews³.

a. Did all agencies work together effectively to safeguard the children subject to the review?

During the review there were occasions when the opportunity to work together effectively to safeguard the family were missed due to a number of factors. These included human factors and cognitive errors, stop start syndrome where historical information was not accessed and each episode was seen in isolation. This manifested in a lack of professional curiosity and a lack of escalation. There was a lack of awareness of professional boundaries and remits and absence of professional challenge. The voice of the child was not evident at some encounters, there was a lack

of follow-up of actions or plans. The impact of this was that children were missing in the system.

b. Were the safeguarding procedures followed appropriately for both children and adults?

A six month delay in responding to an adult safeguarding alert raised while mother was on admission in hospital. This delay meant that it was not possible to identify where the pressure ulcer originated either from the hospital or from home. This demonstrated a lack of professional curiosity.

c. Were the children's /service users voices heard, listened to and acted on throughout agencies involvement?

The review highlighted a number of occasions when service users voices were responded to by agencies. This is demonstrated by the persistence of the health visitor in her multiple attempts to engage with the family and the reflection of the voice of the child in her records. But this did not translate into professional challenge, voice of the child is to be heard, listened to and acted on by all agencies. Child B received dental treatment for significant dental decay and there was a lack of professional curiosity about the school status which was a missed opportunity to safeguard Child B.

There are other instances such as when the hospital doctor who supported disclosure from Child B and who responded immediately to safeguarding concerns shared by her during her hospital admission.

GP3 was also sufficiently concerned with mother's non-attendance at agreed appointments and referred her to the AABIT service. However, GP3 did not follow-up the outcome of this referral.

d. Is this is an isolated case and have local systems and processes have moved on?

In relation to ongoing and recent work across the local safeguarding system a number of initiatives are being progressed from a Think family perspective , these include but are not limited to the following:

- MASH has now introduced a whole family approach, with establishment of the daily Risk Management Meeting. The RIO system allows practitioners to know which professionals and agencies are working with a family. The health role in MASH also supports such inquiries.
- Antenatal questions are supplemented by electronic records from previous births. There is also a Miscarriage Pathway in development with commissioners.
- The 'was not brought' video was circulated by the Strategic partnership in June 2018. The neglect sub-group undertook a piece of work with Health providers

- in relation to their Missed Appointment/Child Not Brought policies in August 2018.
- Professional curiosity is promoted across all services in the community and acute provider through safeguarding training.

The BACME process is now well established and robust. The partnership may wish to consider whether when school details are not known to enable the HV service to forward those details with the child health records to school nursing, whether linking with the BACME team may add additional levels of safeguards for such children. This could also be piloted where GPs are unable to obtain school information for families registered with their practices.

11.0 Summary and Recommendations for the Board

The recommendations from the review incorporate lessons to be learnt and are linked to findings of the review. These findings and questions for the WFSCB are aimed to promote a reflective response and action plan to address the learning points for the wider system. The summary booklet highlights the case specific learning identified within the review which can be addressed in training and supervision by all agencies. The systems issues for consideration by the WFSCB have been included within the recommendations for the Board.

Case for change

Consideration should be given to the emotional impact on families following the removal of a child. This should include work done with parents whose children are taken into Local Authority care to improve the parenting of subsequent children.

Taking hold of opportunities to learn and improve

1. Is the Board assured that the recording systems and practices within agencies are sufficiently robust to enable practitioners working with families to understand the whole family make up and therefore consider historical involvement and issues in their work with the family?
2. During the period within the scope of the review the acute and community health provider, education and housing agencies underwent reconfigurations and some services were recommissioned as part of this process. The impact of this is evidenced in the review as well as in other national cases as the changes have not been unique to the local area. As commissioning arrangements for children's and adult services are going through a period of transformation, how can the WFSCB assure itself that business continuity is maintained during these changes and that archived records are retrievable to support statutory reviews?
3. Missed appointments (DNA/Not Brought) is a common issue in cases referred to the One Panel locally, is the WFSCB assured that partner agencies have appropriate processes around these that support good safeguarding practice? Even though some work has been undertaken locally in relation to children not brought and adults missing appointments. This still remains an issue,

is this considered as part of a risk assessment within agencies in contact with families?

4. Hidden children is an emerging theme in national and local cases. The review highlights issues regarding pathways for prevention and protection for children who are not in mainstream education or not electively home educated. Waltham Forest has significantly improved local process and responses in relation to children missing from education. **The partnership may wish to explore whether this can be built on for children whose primary or secondary school destination is not known to health services.**

APPENDIX 1 – Timeline for SCR A and B Review



R&J timeline.pdf

APPENDIX 2 –Glossary of Terminology and Abbreviations

Abbreviation	Terminology/Word	Meaning
AABIT	Access and assessment and brief intervention Team	The access and assessment service is for adults aged 18 and over needing community mental health services in the London borough of Waltham Forest. The service provides an initial mental health assessment.
ASC	Adult Social Care	
ASW	Adult Social Worker	
BACME	Behaviour Advice and Children Missing Education	
CDLT	Children with Disability Team	
CSC	Children Social Care	
DRM	Daily Risk Management Meeting	
ED	Emergency Department	
EHE	Elective Home Education	
GP	General Practitioner	
HV	Health Visitor	
ICT	Integrated Community Team	Provides District Nursing Service
KPI	Key performance indicator	
LBWF	London Borough of Waltham Forest	
LD	Learning Difficulties	
MASH	Multiagency Safeguarding Children Hub	
Merlin		Police referral form
Mosaic		IT system previously used in Social Care
NSPCC	National Society for the Prevention of Child Cruelty	
One Panel		The One Panel is an amalgamation of the Local Safeguarding Children Practice Review Panel, Safeguarding Adults and Domestic Homicide Review Panels and leads on statutory reviews on behalf of the Strategic Partnership Boards.
RIO		IT system used in NELFT
SCR	Serious Case Review	
WFSCB	Waltham Forest Safeguarding Children Board	

