**Local Child Safeguarding Practice Review: Executive Summary**

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**Family CC**

November 2023

**1. INTRODUCTION**

* 1. This review was commissioned by the East Sussex Safeguarding Children Partnership (ESSCP) who decided to conduct a Local Child Safeguarding Practice Review (LCSPR) following a serious incident involving the neglect of a large group of siblings.
  2. The review was conducted using a systems methodology to identify learning across the whole safeguarding system. A key part of the methodology was contact with frontline professionals who had been involved with the family. It was not possible to involve the family until after the criminal proceedings were completed, so a draft of the final report was provided to family members and comment invited.
  3. This is an executive summary of the full report which focuses on the lessons learned about the wider safeguarding system. The ESSCP Independent Chair and statutory safeguarding leads have agreed that the full report should not be published to protect the identity and wellbeing of the children in the family.

**2. LESSONS LEARNED ABOUT THE WIDER SAFEGUARDING SYSTEM**

**2.1 Working with highly resistant parents**

2.1.1 In their work, professionals sometimes have contact with families whose compliance is not genuine, or who are more obviously reluctant, highly resistant, or sometimes angry or hostile to agency approaches. The term “highly resistant” sits on a continuum. At one end there may be a certain degree of reluctance on the part of many parents who may know they need help but find it hard to accept. At the other end there may be highly manipulative parents who are very accomplished at misleading practitioners. The following types of uncooperative behaviour can be displayed by parents and carers:

* **Ambivalence**: can be seen when people are always late for appointments, or repeatedly make excuses for missing them; when they change the conversation away from uncomfortable topics and when they use dismissive body language.
* **Avoidance:** a very common method of uncooperativeness, including avoiding appointments, missing meetings, and cutting visits short due to other self-reported important activity. They may have something to hide or resent outside interference.
* **Disguised compliance:** Some parents/carers may give the appearance of cooperating to avoid raising suspicions and to minimise agency intervention. Some families may deliberately sabotage efforts to bring about change. Parents/ carers may make unfounded complaints or unnecessary requests for a change in worker. This can mean that practitioners may fail to recognise the true areas of concern.
* **Confrontation**: involves parents challenging practitioners, provoking arguments can involve extreme avoidance and often indicates a deep-seated lack of trust leading to a ‘fight’ rather than ‘flight’ response to difficult situations. Parents may fear, perhaps realistically, that their children may be removed, or they may be reacting to them having been removed.
* **Violence:** threatened or actual violence by a small minority of people is the most difficult of uncooperative behaviours for the practitioner to engage with. Violence can include verbal intimidation.[[1]](#footnote-1)
  + 1. This review has identified that Mother and, to a degree, Father 2 presented most if not all these behaviours. The review has also shown that whilst some professionals were aware that Mother’s behaviour was indicative of resistance, this was not understood by others. The social worker, school and Elective Home Education workers were very aware of Mother’s ambivalence, avoidance and disguised compliance which is why they were all concerned at the Child Protection Review Conference about her capacity to maintain the improvements in the home if the plan was ceased. This understanding was not reflected across other agencies and was not acknowledged at the review conference. It does not appear that these issues were raised at the core group, and it is possible that if the issue of ending the plan had been discussed at these meetings there could have been a debate which may have led to a clearer understanding of the risks prior to the review conference.
    2. It is not unusual for there to be such contradictions. Working with resistant families is extremely difficult and is known to present challenges to the professional safeguarding system. It is also not a new phenomenon. In 2013 Vic Tuck summarised the issues in the following way: -
* *‘Working with resistant, hostile, and non-compliant parents is a key feature of everyday child protection work.*
* *There are a range of sources which draw attention to the issue and point the way for practitioners in identifying and assessing the phenomenon.*
* *There are a range of strategies and tactics which can be utilised to manage the problem. These need to be grounded in authoritative child protection practice and an appreciation of the lived experience of the child.’[[2]](#footnote-2)*
  + 1. His explanations for why professionals have such difficulty in working with these families include:
* Anxiety over a potential conflict with the notion of partnership with parents.
* Sensitivity of practitioners to the impact of the intrusive and deeply difficult child protection processes on families.
* The prevalence of the ‘Strengths-led’ approach; and
* Ambivalence about the use of authority, control, and imposed change.

2.1.5 The review suggests that some, if not all, of these factors may have been relevant in explaining how and why the professionals working with this family did not effectively address the risks and failed to fully protect the children. Certainly, the focus in recent years for all professionals working in the safeguarding field has been on the importance of building relationships with families, understanding their experience of alienation within the child protection system, focussing therefore on the positives in their parenting trying, if possible, to achieve a negotiated change. Such an approach is laudable but while *‘Building strong relationships with families with compassion is crucial to reducing maltreatment … trust needs to be placed with care [and] with due demonstration of respectful uncertainty and curiosity in the narratives of parents and carers’* and furthermore such an approachassumes *‘a belief that the individuals with whom professionals come into contact are essentially rational and inherently reasonable beings. Moreover, if practitioners would only apply the correct principles of working with families and find the most appropriate forms of engagement then children would be properly safeguarded’.[[3]](#footnote-3)* This did not apply in this case and does not apply to all families.

2.1.6 Vic Tuck’s suggestion for strengthening practice with resistant families is to improve the focus on the ‘The Lived Experience of the Child’ identifying what it is like for children to live in the household; assessing parents’ capacity to empathise and understand the child’s experience and ensuring that there is sufficient contact with the child to enable an understanding of what sense they are making of the life they are living. This was difficult with this family because Mother placed barriers to professionals having contact, however that should have been an indicator that there were problems. This approach is particularly important when addressing problems such as neglectful parenting as it is notoriously difficult to identify specific incidents and issues and often there is a need to build a picture of the overall impact on the child of the various deficiencies in the parenting.

2.1.7 This review has identified that in this case professionals struggled to work with parents who were resistant and on occasions duplicitous. Working with such parents is always complex and difficult but they are not unique and discussion with professionals at the workshop indicated that they recognised the challenges of this type of work and thought that the Partnership should consider how to improve support for professionals engaged in it. Otherwise, there is a risk that professionals feel helpless in the face of such behaviour and are unable to effectively safeguard children.

**2.2 How to safeguard children who are electively home educated in the context of neglectful parenting**

2.2.1 In this case, the Elective Home Education (EHE) team worked well within the limitations of their legislative framework to protect the children. There is work ongoing at a national level to consider how the law can be further developed to better protect children who are electively home educated and where there are safeguarding concerns. The Partnership may wish to consider contributing the learning from this review to that process.

2.2.2 A significant feature of this case however was that the elective home education was occurring in a context of neglectful parenting which was evident to some professionals. This raises the question as to whether the current approaches to assessing neglect needs to place greater focus on the extent to which the education provided to such children is fully meeting their ‘*basic emotional, social and educational needs’.[[4]](#footnote-4)* The EHE team in their referral to Children’s Social Care (CSC) suggested that the education being provided to the children was ‘not meeting East Sussex County Council guidelines’ and they ‘were not at the levels that they would be if in a school environment’. This suggests that there should have been an assessment to consider whether this was sufficiently poor as to constitute neglectful parenting. CSC’s inaction may have been for other reasons, but it does suggest that there may be scope for examining policy, procedures, and training to check there is sufficient emphasis on neglect where it relates to emotional, social, and educational development.

**2.3 Relevance of neglect/abuse of animals when assessing risks to children**

2.3.1Research has shown that neglect and/or abuse of animals is a known risk factor for abuse or neglect of children. If a child is cruel to animals, this may be an indicator that serious neglect and abuse have been inflicted on the child. There is also some evidence that households where animals are abused are often more violent and furthermore that where animals are abused there may be risks of physical harm to the children.[[5]](#footnote-5) Practice in this case suggested that the links between animal abuse and risks to children were not well known and discussion with professionals at the workshop suggested that there was little joint working between the Royal Society for the Prevention of Cruelty to Animals (RSPCA) and local safeguarding services. This may be an area the Partnership wish to consider developing.

**2.4 Relevance of history when screening for service delivery**

2.4.1 While conducting the review it became apparent that despite this family having been well known to a range of agencies over a significant period, and the children having been the subject of Child Protection plans on two occasions, professionals were unaware of significant elements of the family history. This meant that repeatedly when agencies were screening referrals, or initiating assessments, they were reliant on the information provided by either the referrer or the family. Reasons for this varied, in many cases the information was held by the agency but could not be quickly or easily obtained. Sometimes there was information held on the system regarding one child but there was no mechanism for cross-referencing that with other children, even though they were all living at the same address. It was acknowledged that much of the information was held in child protection conference records, but these were not considered to be easily accessible. It was also reported at the workshop that different agency thresholds for sharing information, and a lack of time to review past records, meant that the history of families was often unavailable.

2.4.2 This is a serious limitation as it is well known that a person’s past actions are a useful predicator of future activity. Mother had clearly shown, in the past, aspects of disguised compliance and resistance to change, and perhaps if there had been better access to previous records this behaviour might have been better understood. This issue was particularly apparent in health agencies although the school also had limited information, mainly because of poor transfer of files from primary schools. Professionals at the workshop reported that these issues were generic and not limited to the work on this family, however the Partnership may wish to further explore through auditing the extent and degree of the problem.

**2.5** **Role of voluntary sector agencies in providing support to vulnerable families**

2.5.1 Another factor highlighted in this review, that would benefit from greater analysis, is the nature of the relationship between community and voluntary sector (CVS) organisations supporting families and the statutory agencies responsible for safeguarding. This family were assisted by two local CVS groups as well as being given significant support from a third. All these agencies may have had relevant information they could have shared with the professionals who were working with the family. There was however, limited communication and a degree of confusion on both sides as to their roles and responsibilities. Direct communication about mutual roles and responsibilities may have led to better outcomes for the children.

**3. VIEWS OF FAMILY**

3.1 It was not possible to involve the family until after the criminal proceedings were completed, so a draft of the final report was provided to family members and comment invited. The older children were offered the chance to contribute to the review, but this was declined.

3.2 Mother provided detailed feedback on the report which included some aspects of factual accuracy which led to amendments being made. She was very unhappy that the report had a significant focus on her actions. Mother cited caring responsibilities, an abusive relationship, and COVID affected her ability to care for the children.

3.3 Father Two reported that he felt the report was broadly accurate. Father Two stated he would have spoken to professionals if he had been able to do without Mother overhearing.

3.4 Father One considered that the report was an accurate and fair reflection of circumstances as far as he was aware however, he was clear that although he saw his children regularly, they visited him, so he was unaware of the home circumstances and his children did not discuss the situation with their mother with him. He also confirmed that this remained the case and that the older children had not discussed anything in detail with him and did not want to contribute to the review.

**4.** **CONCLUSIONS**

4.1 This review was concerned with the significant neglect of a large sibling group by their parents and the reasons why the professionals, working with the family, failed to intervene successfully to prevent the children experiencing significant harm. The most significant factor that the review has identified is that the parents, particularly the mother, were highly resistant to professional intervention and sabotaged efforts to bring about change. She showed limited engagement with further follow up and interventions which were offered to support the children. Whilst some professionals working with the family had some understanding of the issues, there was no consensus in the multi-agency safeguarding team, leading to the premature ending of the child protection plan. This coincided with the COVID-19 pandemic and meant that professionals had very limited contact with the children for over a year, during which time conditions in the home deteriorated significantly. During that time there were referrals raising concerns about the care of the children, and family pets, however these did not trigger interventions until eventually the Police undertook a home visit in response to a different matter and the home conditions were revealed.

* 1. The case review has identified the need to strengthen some aspects of the multiagency safeguarding procedures and processes regarding the functioning of core groups and the auditing of child protection conferences. It has also shown the importance of all professionals focussing on ‘the lived experience of the child’ when assessing neglect. A significant feature was that the younger children were being electively home educated which affected the contact that professionals had with the children. There was some evidence that the education the children was receiving was failing to meet their social and emotional needs and the review has identified that this is an area where the processes, procedures and training around neglect could be developed.
  2. The review also highlighted that the assessments undertaken by health professionals had insufficient direct contact with the younger children and did not fully consider fabricated illness in their work. Furthermore, all professionals failed to involve and assess the fathers appropriately.
  3. Another factor affecting professionals capacity to work effectively were the limitations of recording systems and in particular their capacity to enable a full understanding of the history of the family and to cross-reference the records of different children in the family.
  4. Finally, the review also showed that involvement of the voluntary sector in the multiagency safeguarding system could be strengthened.

**5. RECOMMENDATIONS**

**5.1 Recommendation 1**

That the Partnership and all agencies review the training and support processes available for professionals working with resistant parents ensuring that they place sufficient focus on understanding the relevance of family history and the lived experience of the child. Furthermore, the Partnership to request that health agencies consider the issue of fabricated illness in this context and to require all health professionals to ensure that when assessing the medical needs of the child they do not rely solely on evidence reported by parents.

**5.2 Recommendation 2**

That the Partnership requests that CSC adapt its audit processes so that any child protection plan that ends after three months (at the first review), is audited by a senior manager. Furthermore, that CSC develop a system whereby when a child protection plan ends when the allocated social worker has recommended its continuation, this should be reviewed by managers.

**5.3 Recommendation 3**

That the Partnership review the practice and procedures regarding core groups to require that there be consideration by the core group of whether the child protection plan should continue prior to every review conference meeting.

**5.4** **Recommendation 4**

That the Partnership develop the neglect policy and training for all professionals to consider the needs of children who are electively home educated. This to include the requirement that there be consideration of whether the parents can provide EHE effectively; and that if there are concerns, this could trigger an assessment of parenting skills with an assumption that a failure to provide suitable EHE is neglect of basic emotional, social, and educational needs.

**5.5 Recommendation 5**

That the Partnership request all agencies to review their recording systems (including IT systems) to ensure that workers screening referrals/and or starting assessments are able to review the wider family history and any previous agency involvement and understand the importance of taking this into account when responding to a new referral or undertaking an assessment.

**5.6 Recommendation 6**

That the Partnership consider how to better involve voluntary sector agencies in the multi-agencysafeguarding processes**.**

**5.7 Recommendation 7**

That the Partnership consider whether as part of their routine audit programme they should consider whether multi-agencysafeguarding assessments have sufficient focus on fathers and other significant males.

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1. Working with Uncooperative and Hostile Families Practice Guidance: Darlington safeguarding Partnership <https://www.darlington-safeguarding-partnership.co.uk/media/1760/working-with-hostile-families-july-2019-dsp-1.pdf> [↑](#footnote-ref-1)
2. Resistant Parents and Child Protection: Knowledge Base, Pointers for Practice and Implications for Policy Child Abuse Review Vol. 22: 5–19 (2013) Published online 8 October 2012 in Wiley Online Library <https://onlinelibrary.wiley.com/doi/abs/10.1002/car.1207> [↑](#footnote-ref-2)
3. ibid [↑](#footnote-ref-3)
4. <https://sussexchildprotection.procedures.org.uk/page/glossary?azid=N> [↑](#footnote-ref-4)
5. Understanding the links: child abuse, animal abuse and domestic violence. Information for professionals NSPCC <https://bswccg.nhs.uk/for-clinicians/safeguarding/child-safeguarding/287-understanding-the-links-child-abuse-animal-abuse-and-domestic-violence/file> [↑](#footnote-ref-5)