# Serious Case Review of Family S
## Learning Briefing

## Introduction:

The East Sussex Local Safeguarding Children Board undertook a Serious Case Review (SCR) of Family 'S' concerning two children – aged 7 and 22 months – who experienced significant neglect.

The children were living with their mother in a privately rented flat where the home conditions were so poor that when professionals gained access to the accommodation it was deemed unfit for human habitation. Additionally, the older child was found to have a significant disability which had not been addressed and therefore means there will be a need for lifelong medical treatment.

A significant feature of this serious case review was the low level of contact that professionals had with the mother and children.

## Key features of the case:

The conditions in which the children were found to be living were truly awful and yet, even with hindsight, no professional could identify any evidence that would have suggested that their home was out of the ordinary. In part this is because the **parents were very adept at preventing professionals visiting the family home**. It is also likely that the children spent time staying with their grandparents.

### What is a Serious Case Review?

A **Serious Case Review** (SCR) is a locally conducted multi-agency **review** in circumstances where a child has been abused or neglected, resulting in **serious** harm or death and **there** is cause for concern as to the way in which the relevant agency or agencies have worked together to safeguard the child.

The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children.

The Review Team did investigate closely whether there were any indicators present that should have required a more proactive response by professionals however, despite some weaknesses in the safeguarding system being identified, **there were no obvious interventions that would have highlighted these children's predicament.**

Despite best efforts to engage the parents in the review work, it was not possible to meet with either parent or the grandparents. This has meant that the Review Team are still not clear **why the adults allowed their physical environment to reach the level of neglect that it did and what factors might have influenced this.**

As with all reviews, the review has identified some areas where safeguarding arrangements could be improved. **A significant feature was the absence of routine health contact with both children.** Child 1 was not seen by any health professional for over four years despite having a significant congenital health problem that was treatable, and Child 2 also had minimal contact with community health professionals.

It is known from information provided by professionals currently involved with Mother that she considers herself to be a **victim of domestic abuse and it is probable that substance misuse by the parents is also relevant.** There was some information known about the substance misuse issue at the midwifery stage but this did not lead to a more detailed assessment/additional support.

## Recommendations:

This SCR identified seven recommendations to strengthen safeguarding practice. These included:

1) CCG and NHS England to consider the feasibility of a system for raising alerts on children not registered with a GP for longer than three months.

2) East Sussex NHS Trust to provide assurance that the Midwifery Additional Support Form (ASF) is fit for purpose and is being used consistently with women who meet the criteria for its use.

3) East Sussex NHS Trust provide guidance to midwifery staff requiring that **all** women receive a post-natal visit at their **normal** address

4) East Sussex County Council, to provide assurances on the capacity and workload pressures experienced by the Health Visiting service. This report to address whether the practice of only visiting by prior appointment is universal or specific to that team.

5) East Sussex County Council to review the impact of the past IT difficulties within the health visiting service and report any actions needed to resolve the safeguarding concerns.

6) East Sussex County Council to establish a multi-agency working group to develop guidance regarding responsibilities for school attendance.

7) All agencies to provide assurance that their assessment processes enable the effective involvement of fathers, partners and other men within the household. And, where possible obtain independent verification of information rather than relying on self-report from service users.

## Action taken since the review:

Some of the systemic problems identified have already been addressed (e.g. changes to notifications of late starters at school) however some are likely to remain without changes in practice. To that end the Review Team has included some recommendations for action to be taken, either to reassure that practice has changed, or to achieve changes in systems to enable children to be better protected in the future.

Action already taken includes:

- The Health Visiting Service has reconfirmed that visits should not always be by routine appointments.
- LSCB Independent Chair wrote to NHS England raising concern about lack of national alert system for when children are not registered with a GP.
- Updated guidance issued to schools relating to link between school attendance and safeguarding issues.
- A process for regular documented clinical supervision for Health Visitors is in place, this includes a system to monitor compliance with Health Visitor visits

## Further Reading and Useful Links:

### Neglect toolkit

The East Sussex Neglect Strategy and Operational Practice Guidance (Sept 2017) and Neglect Toolkit and Matrix helps assist practitioners in identifying and assessing children and young people at risk of neglect. This guidance lays out identifying and responding to neglect across the Continuum of Need, assessment and care planning guidance, and threshold for step up. It provides guidance on the use of chronologies and discusses culturally competent practice.

### LSCB Multi-Agency Training on Neglect

The LSCB runs training for multi-agency professionals on neglect. The next one day course is running in November 2018. More details can be found on the East Sussex Learning Portal:

**www.eastsussexlearningportal.org.uk**


### Pan Sussex Safeguarding and Child Protection Procedures

When was the last time you used the Pan Sussex Child Protection and Procedures Manual? Why don't you refresh yourself! If you want to sign up for alerts when the procedures are updated please add your details on the website.
**http://sussexchildprotection.procedures.org.uk**

## Serious Case Review Briefings

The LSCB will be holding briefing sessions on the findings of this serious case review and other local and national reviews later in the year.

## Contact Us

**Telephone**: **01273 481544**

**Email**: **lscbcontact@eastsussex.gov.uk**

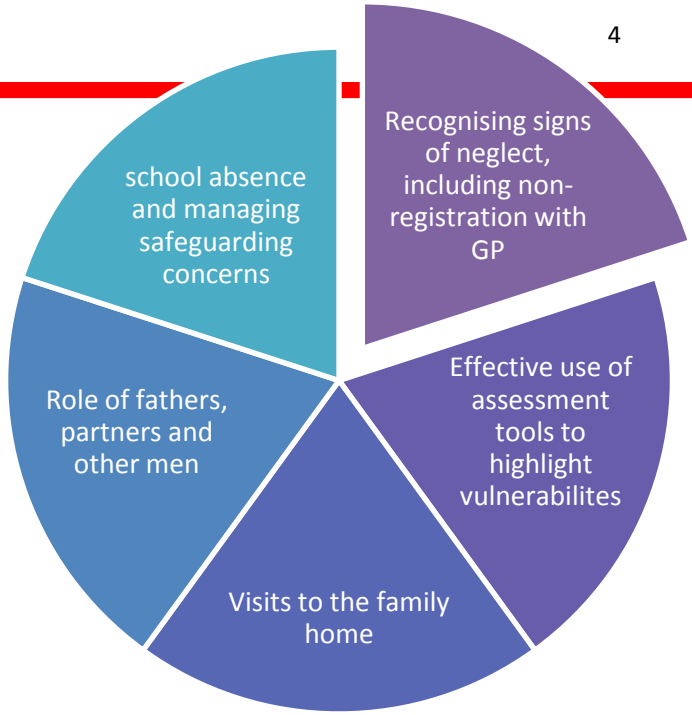
**Website**: **www.eastsussexlscb.org.uk**

**If you think a child is being harmed or may be at risk of harm**, please contact:
SPoA Mon-Friday 8.30am-5pm
**Phone**: 01323 464222
**Email:** 0-19.SPOA@eastsussex.gov.uk or 0-19.SPOA@eastsussex.gcsx.gov.uk

If you urgently need help outside of office hours you can contact the **Emergency Duty Service** for East Sussex and Brighton and Hove. Phone **01273 335905** or **01273 335906.**

# Learning for practice

The LSCB invite you to discuss some of the issues raised in this serious case review in your team meetings or during group supervision. We encourage your responses to be included in your team minutes and forwarded to the safeguarding lead within your organisation.




## Points for discussion:

**Signs of neglect**

- ✓ What are the signs of neglect that might have been evident in a family like this?
- ✓ How confident are you/your team at recognising neglect?

**'Hard to engage' families**

- ✓ How easy would it be for a family known to you to keep all professionals away from their home?
- ✓ What do you/your team do to challenge and support parents when their engagement is causing concern?
- ✓ How are concerns about a family's non-engagement escalated in your team?

**Professional curiosity**

- ✓ How are you professionally curious? How might you have been professionally curious with a family like this?
- ✓ What do you think would help you / your team to be more 'professionally curious'?

**Applying learning**

- ✓ What have you/your team learnt from this case?
- ✓ How might you/your team apply that learning?