# Rotherham Safeguarding Children Partnership
# OVERVIEW REPORT in respect of the CHILD SAFEGUARDING PRACTICE REVIEW for CR19 - Baby April

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## Executive Summary

### Pen Picture

This learning review concerns Baby April, a three-month-old baby girl who was taken to hospital by ambulance due to concerns that she had twice briefly stopped breathing during the evening. On examination Baby April had an enlarged head circumference which led to further investigations. A magnetic resonance imaging (MRI) scan revealed an acute haemorrhage to the brain as well as retinal bleeding. It was confirmed by the medics caring for Baby April that this presentation was likely due to a non-accidental injury consistent with shaking. No explanation for the injury was provided by either the Mother or the Father at the time of the injury.

Baby April had been born six weeks early and spent the first three weeks of her life in hospital. Initially due to her clinical presentation following her birth and then in order that a multi-agency discharge planning meeting could be convened. This was requested due to concerns about her mother's behaviour towards Baby April on the ward. Although the professionals who knew the family best were not present at the meeting, plans were agreed for her discharge and to continue to work with the family within Early Help as the threshold for 'harm' was not met.

There had been multi-agency involvement with the family from universal services as well as those described as being for children who were vulnerable or with complex needs since shortly after the birth of Sibling 1, seven years before. As Baby April's parents had separated several months before her birth, Baby April lived with her Mother Maisie and her three siblings aged from seven to two years old. The separation resulted in her father Paul suffering from a period of poor mental health which required hospital admission. However, at the time of the incident Baby April was spending time in the care of each parent in an informal shared care arrangement.

There were ongoing and long held concerns regarding endemic neglect of Baby April and her siblings as Maisie and Paul were not meeting their needs. This included basic care and hygiene needs for all the children, support for Sibling 1's physical disability and wider care and supervision of all the children. This neglect was in terms of both the physical conditions of the home which were described as extremely unhygienic and unsafe at times, a lack of appropriate care and supervision by both parents as well as a lack of emotional attachment by their mother. There were also concerns regarding possible physical harm and that the expectations placed on Sibling 1 by his parents, were inappropriate to his age in terms of his self-care and in caring for his younger siblings.

Practitioners held concerns that the children's mother may have a learning or literacy difficulty due to her perceived inability to meet needs, to take on board advice and engage with practitioners. She was also noted to be hostile towards practitioners when challenged about aspects of her parenting. However, there was no referral for assessment of her cognitive functioning related to her parenting capability during the period under review.

There were also concerns raised regarding the children being exposed to cannabis smoke, which the father was open about in terms of his long-term use. Practitioners saw father as the more proactive parent and attributed poor compliance with aspects of the children's care to a possible lack of understanding of expectations. However, this was not explored as whether causally linked to his mild learning difficulties, although it was known that he had attended a special school.

While there were appropriate referrals into the MASH and meetings held with other practitioners the family were often assessed as requiring help and that there was no evidence of possible harm to the

children. Therefore, during the period under review the family were predominately worked with under the auspices of the Early Help Strategy. There were two Single Assessments under section 17, Children Act 1989 as children in need. The family was assessed as not meeting the threshold for acute or statutory child protection services and the family were stepped down to Early Help.

While concerns were raised by practitioners regarding the outcome of assessments on many occasions the RSCP escalation protocol was not used. Nor was the Graded Care Profile used to benchmark the care given to the children and to evidence indicators of neglect. In addition to a lack of parenting assessment around learning difficulty for both parents, there was also a gap in the assessments undertaken regarding mother's own adverse childhood experiences and being a care experienced child.

It was not until the case entered family court proceedings, following Baby April suffering a likely non-accidental injury, that the possible effects of Maisie's own childhood trauma on her parenting capacity and emotional attachments to the children were explored and assessed. In addition the cognitive functioning of Paul was not assessed until a PAMS assessment was undertaken as part of the court proceedings. Therefore, there was no assessment of how these factors impacted on either parents' parenting capability or indeed on their care of the children during the period under review.

### Acknowledgements

As lead reviewer and author of this report, I would like to acknowledge the support of the Safeguarding Practice Review Group, RSCP officers and business unit staff. I would also like to express my appreciation for the insight of the practitioners who contributed their perspectives and enhanced the understanding of this case and learning from this review through an online practitioner event.

### Governance

I have considered the requirements for local reviewers as set out in Working Together (2018) and confirm that I have found no conflict of interest in completing this review, and that I am independent from the agencies and organisations within this review.

In preparing this report for publication, the details of the child and their family, and the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice. Working Together to Safeguarding Children (2018) states that the safeguarding partners are responsible for commissioning and supervising reviewers for local reviews.

The report has been commissioned by the RSCP and has been overseen by a multiagency Safeguarding Practice Review Group of local senior strategic safeguarding leads who have provided oversight and subject matter advice on a range of topics including working with disabled children, neglect, pre-birth assessment, vulnerable infants, substance misuse and adult learning disability. They have also quality assured the review report to ensure it is fit for purpose and suitable for publication.

## Learning points and recommendations

### Learning point one – Responding to the Voice of the child and their lived experience

The voice of the children was not always heard or responded to and was not always designed into assessment or delivery plans that were child focussed and considered all unmet need, and in particular Sibling 1's needs as a child with a disability.

### Recommendation 1

- The RSCP to seek assurance regarding how the lived experience and voices of children of all ages and ability are heard, reflected in assessments and plans and to address any gaps in practice particularly regarding children who have a disability or developmental delay.

### Learning point two - Recognition and response to neglect

This review has highlighted, where there is evidence of neglectful parenting or care, that practitioners need to routinely use the full range of tools available to them to effectively identify, benchmark, assess and respond to the presenting concerns in a timely way.

**Recommendation 2**

- The RSCP should refresh and relaunch its Neglect Strategy and promote the use of the tools to benchmark and assess neglectful parenting. Practitioners should also be equipped to recognise feigned compliance, over optimism and confirmation bias in in a competent and confident manner. The RSCP should seek assurance as to the impact of this on practice and in improving outcomes for children.

### Learning point three – The importance of consistent application of thresholds

This review has highlighted the importance of consistent application of thresholds and in ensuring early understanding of possible risks, as well as the level of support required by parents to ensure the future safety and well-being of children, including unborn siblings. There is a need to value the professional opinions of others in their application and to ensure children are safeguarded at the earliest opportunity.

**Recommendation 3**

- The RSCP should seek assurance that application of thresholds and the Step-Up and Step-Down within the Early Help Strategy is being applied consistently with appropriate and timely completion of Early Help Assessments by partner agencies. The RSCP should ensure that practitioners are alert to and routinely use the RSCP procedures and practice guidance for children in particular circumstances.

### Learning point four – Escalation and resolving professional disputes

Resolving professional disputes should focus on restorative practice principles that foster and enhances partnership working and a culture where respectful professional challenge is productive and welcomed.

**Recommendation 4**

- The RSCP should seek assurance that the systemic findings in learning point four are being addressed within their threshold document and the Step Up/Step Down process and includes restorative practice principles and problem-solving approaches to address them.

### Learning point 5 – Trauma informed approaches

The parent's own experiences in childhood were not always known or understood and therefore did not feature within assessments made around levels of need, risk and vulnerability. The likely impact of these experiences on the care received by the children was not known or understood.

**Recommendation 5**

The RSCP to ensure that practitioners can increase their knowledge, confidence and competence in trauma informed approaches and that its impact on practice is understood.

## Chapter One - Introduction

1.1 This Child Safeguarding Practice Review sets out sets out the findings of an independently led local safeguarding child practice review (CSPR) commissioned by the Rotherham Safeguarding Children Partnership (RSCP) in May 2020. The review concerns Baby April, who at the time of the incident was aged three months, and her three older siblings Sibling 1, Sibling 2 and Sibling 3 aged seven, three and two years old. At the time of the incident the family were working with universal, targeted and specialist services linked to parental mental health, substance misuse and disability.

1.2 Baby April who was taken to hospital by ambulance after her mother called 111 as Baby April had twice briefly stopped breathing that evening. On arrival at hospital, examination of Baby April showed she had an enlarged head circumference. Further investigations, including a magnetic resonance imaging (MRI) scan revealed an acute haemorrhage to the brain as well as retinal bleeding. It was confirmed by the medics assessing Baby April that this was likely due to a non-accidental injury consistent with shaking. No explanation for the injury was provided by either her mother Maisie or Father Paul at the time. However, it has been determined that this was a significant injury, which will have a substantial impact upon her future health and development.

1.3 As the statutory criteria for a serious safeguarding incident was met, in that abuse or neglect was known or suspected, and Baby April had been seriously harmed, Rotherham Safeguarding Children Board (RSCB) undertook a Rapid Review in line with Working Together (2018) and the National Panel CSPR Transitional Guidance (2019). All involved agencies provided a detailed and timely summary of their involvement covering a period of involvement spanning seven years. This was considered by the Safeguarding Practice Review Group on 17 September 2019, which concluded there were opportunities for learning to improve safeguarding across the partnership.

1.4 As the Rotherham Safeguarding Children Partnership (RSCP) was due to be established two days later, a recommendation was made to the Independent Chair to remit this case to the RSCP for consideration of a local CSPR instead of a Serious Case Review (SCR). This approach was agreed and confirmed with the National Panel: Child Safeguarding Practice Reviews. As such, the RSCP agreed draft Terms of Reference (ToR) in February 2020 and appointed the Independent Reviewer in May 2020. I have considered the requirements for local reviewers as set out in Working Together (2018) and confirm that I have found no conflict of interest in completing this review, and that I am independent from the agencies and organisations within this review.

1.5 The Terms of Reference agreed for the review reflect the overarching principles for CSPRs which include, that reviews should recognise the complex circumstances in which professionals work together to safeguard children; should seek to understand precisely who did what and the underlying reasons why; also avoids any hindsight bias and is reasonable and proportionate. The review approach was therefore to use a collaborative and analytical process which combines the analysis from the written agency rapid review timelines with a practitioner workshop and engagement with the family. The report therefore provides a summary narrative of the family circumstances and key agency involvement rather than a detailed chronology of events.

1.6 CSPRs are not investigations and do not seek to apportion blame or determine any culpability. This review is therefore written from a learning perspective and will make recommendations for practice improvement. It is also written in line with expectations within the Child Safeguarding Practice Review Panel: practice Guidance (2019) that Child Safeguarding Practice Reviews are designed to add reflection and learning into local safeguarding systems. The report 'must focus on... why do these themes keep recurring and what can be done to address them?'.

1.7 This CSPR also considers relevant information from the parallel processes in place such as the family court proceedings and criminal investigation. However but it does not stray into the territory of these separate statutory processes. Where findings indicate that individual practice calls professional conduct into question this will remain a matter for individual agencies and any relevant professional bodies to address as required. There have been no such findings in this case. The findings of this review therefore focus on appraisal of practice in general, systems learning, and any improvements required to strengthen the safeguarding system in Rotherham.

## Chapter Two - Background to the review

### Practice areas for consideration

2.1 The Terms of Reference identified the following overarching research question:

How effectively do multiagency practitioners recognise and respond to the impact of cumulative harm linked to neglect?

The following practice areas were also identified for consideration and analysis:

- How effectively did professionals understand the lived experience of each child and seek to revisit this understanding with each new contact / referral?
- How did we ensure that we considered the role of each parent, their individual needs and subsequent parenting capacity? This is particularly linked to the question as to whether the parenting received is around learning disability and/or a lack of emotional response.
- How can multi-agency colleagues, whatever their role, be supported to have their voice and concerns heard in multiagency decision making in order to safeguard children?
- Were there any contextual issues that can be evidenced as having a direct bearing on decision making?

2.2 Single agency timelines provided to the SPRG presented a comprehensive chronology of the key events, allowing for professional practice to be analysed within the rapid review. Examination of these key episodes shows the contact with agencies and practitioners and highlighted concerns included neglect, early life trauma, poor conditions within the home as well maternal ambivalence, relationship disharmony and paternal use of cannabis. These key practice episodes are detailed within Chapter 3, Appraisal of Practice.

2.3 The rapid review also identified that the family received a high level of support from the school, early help services and universal and specialist health. There was prolonged and sustained effort to engage with both parents and to support them to improve their care of the children and to compensate for the poor care of the children in areas where this was lacking. It was recognised that there was much effort across agencies to help this family and examples of good practice.

2.4 However, by January 2019, there was insufficient regard to the length of time this support had been going on for and the lack of progress made by the family and the cumulative impact of barely adequate parenting on the children. Assessments made gave a focus to the presenting issues rather than taking a longitudinal view of the lived experiences of the children and the risks from cumulative harm. Agencies held a view that more weight and consideration should have been given to the history of concerns at the MASH review and in the agencies individual perspective around the lived experience of the children. However, this lack of recognition of cumulative harm through neglect was not formally escalated and these themes are explored further in terms of context, rationale and systems learning within Chapter 3.

## Family Composition and Contribution

2.5 The family lived as a nuclear family from 2012 until February 2019, when Maisie and Paul separated at which time the children remained at home in the care of their mother. Their father Paul was homeless until April 2019 when they established an informal shared care arrangement:

- Subject Child: Baby April - aged 3 months
- Mother: Maisie
- Father: Paul
- Sibling 1 (aged 7)
- Sibling 2 (aged 3)
- Sibling 3 (aged 2)

2.6 The contribution of family members often proves invaluable in providing a different perspective or lens in appraising practice around the services provided. This together with the family view regarding what works well or could be done differently in future to achieve better outcomes enhances learning. However, I have not been able to meet with Maisie and Paul due to the ongoing criminal investigation into the injuries suffered by Baby April. However, it is hoped that following the conclusion of this parallel process both parents can be offered an opportunity to provide their views regarding the services offered to them and what they thought may have helped their family circumstances at the time. The children are making good progress in their placements but due to their young age, it is not felt to be appropriate to seek their views of the services offered them.

## Practitioner Involvement

2.7 A practitioner event was held for practitioners and managers from the involved agencies using an online videoing conferencing facility. The emerging findings from the rapid review and supporting materials and key practice episodes were shared with the group. The main purpose of the event was to build on the findings from the rapid review and to discuss the delivery of services to Baby April and her family without any hindsight bias.

2.8 Participants contributed to the learning from the review through identifying the points at which an action could or should have been taken and why they considered the rationale for decisions made. Good practice was also discussed and its evidence in aspects of current practice. Practitioners reflected on what had worked well or not, what could have been done differently or better, what enablers, challenges or barriers to practice had come into play and what would improve services for children in similar circumstances. There was much productive discussion held with excellent practitioner involvement which was fundamental to a successful review.

2.9 The agencies and services provided and considered in this review included:

| Agency | Services |
|---|---|
| Care Grow Live (CGL) Rotherham | Substance Misuse Recovery Services |
| Education | Primary School |
| Rotherham Clinical Commissioning Group | GP Services |
| Rotherham Metropolitan Borough Council | Children's Care, Early Help Services and Children's Centres, Housing and Estate Services and Tenancy Support |
| Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) | Adult Community Mental Health and Improving Access to Psychology Therapies |

| Agency | Services |
|---|---|
| The Rotherham NHS Foundation Trust (RFT) | Acute Services, Midwifery, Health Visiting, Neonatal Outreach, Orthotics and Physiotherapy |
| South Yorkshire Police | Community Policing and Multi-agency Safeguarding Hub |

## Other relevant contextual information

2.10. In 2017, the Ofsted Inspection of Rotherham Metropolitan Borough Council's services for children in need of help and protection, were judged to be 'good'. The report highlighted that 'The local authority has taken a systematic and rigorous approach to improvement' and 'Risks to children are recognised early and responded to, ensuring their safety.' The inspection did not make a judgement on the effectiveness of Rotherham Safeguarding Child Board as it was undertaken under the new inspection arrangements however, it recognised that: 'Strategic partnerships are much strengthened, improving the way in which children are helped and protected'.

2.11. Recommendations for the local authority were progressed and strengthened by the local authority involving the wider partnership in consideration of how they could support any improvements required and ensure effective multi-agency working as follows:

- Ensure that all assessments are meaningful to children and their families; reflect the changing needs of children; and effectively evaluate cumulative risks and their impact.
- Ensure that all plans: are clear about how children's and young people's holistic needs are to be met; have clear timescales; can be understood by families; and are always well informed by risk assessment.
- Improve the timeliness of the early help response to children, particularly those who have a disability.

2.12. In accordance with legislation and revised statutory guidance, Rotherham Safeguarding Children Partnership was abolished and replaced by their revised Multi-agency Safeguarding Arrangements on 19 September 2019. As part of these arrangements the three statutory safeguarding partners Rotherham Metropolitan Borough Council, South Yorkshire Constabulary and Rotherham Clinical Commissioning Group formed the Rotherham Safeguarding Children Partnership (RSCP) with the Independent Chair, Jenny Myers providing overview, scrutiny and objective challenge.

2.13. Two legacy Serious Case Reviews which appraised the multi-agency practice around neglect and pre-birth assessment were identified as having similar case characteristics or factors to this case. These reviews have been considered against the findings found within this review and a validation exercise undertaken in June 2020 confirmed these had been completed and demonstrated impact. However, this review has identified there remains a gap in multi-agency identification of neglect and consistent use of escalation processes.

2.14. The CQC carried out a focused inspection at The Rotherham NHS Foundation Trust on 7- 10 July 2020 to review the processes, procedures and practices for safeguarding children and young people using parts of the safe and well-led domains. Following the inspection, concerns were formally put in writing to the Trust with urgent actions requested to mitigate the risks to children and young people.

2.15. The CQC found staff understood how to protect patients from abuse. Most, but not all staff had training on how to recognise and report abuse and they knew how to apply it, but the systems and processes they used made this difficult. Leaders did not operate effective governance processes throughout the service and with partner organisations. Staff did not always take opportunities to meet, discuss and learn from the performance of the service.

## Limitations

2.16. As noted above there has been some limitations within this review due to the criminal investigation which has prevented liaison with family members. This would have assisted in providing a richer understanding of the family's experiences of the agency involvement and working together in receiving services from a range of universal, targeted and specialist services.

## Chapter 3 - Appraisal of Practice

3.1. The following sections are informed by the Rapid Review undertaken for this case which was comprehensive and thorough, and which extracted some immediate learning for the RSCP as well as identifying potential gaps in their understanding of practice which they wished to explore.

3.2. These documents build a picture of Baby April and her sibling's lives and lived experience. This together with the practitioner event assisted in understanding who was involved in their care, what actions and decisions they made and why. The information provided for the Rapid Review covered a period of over seven years going back to the birth of Sibling 1 and set a useful context to the family circumstances. However, the practice appraisal within the report focusses on a twelve-month period from August 2018 to August 2019.

## Relevant background

3.3. Paul attended a special school as a child due to a learning and physical disability. He self-referred to his GP for low mood and has been diagnosed with depression and was admitted to hospital but had sporadic engagement with Improving Access to Psychological Therapies (IAPT)[i]. The family were known to have significant debts and to be at risk of eviction. Despite the above factors Paul was seen as an active parent who engaged in the day-to-day care of the children and in attending meetings and appointments and as a more proactive and protective parent.

3.4. The children's father Paul was known to the Police prior to the period under review for unrelated offences and more recently for possession of cannabis. Paul was said to be open about his long-term daily cannabis use to most agencies and this was therefore known for a significant period. Prior to February 2019, Paul had not sought support for this or accessed any drug use cessation service. It was felt the relationship ending and his separation from the family was a precursor to this. Paul was frequently noted to smell of cannabis and on occasion the children were also noted to smell of cannabis, although he claimed to only smoke outside.

3.5. The children's mother Maisie was known to Social Care as she experienced a range of adverse childhood experiences. Maisie was a teenage mother, and neither she nor Paul had strong family support networks at this time. There was known relationship disharmony and parental conflict, and the records show that the parents relationship was inconsistent with several separations before the relationship ended in 2019. Maisie was said to be volatile as a teenager and young adult with the last known incident of violence being in 2014, when Sibling 1 was 2 years old.

3.6. All agencies noted that Maisie was reluctant to engage with services, refused or failed to attend appointments for herself and the children and reacted negatively or aggressively to any perceived criticism of care of herself or the children.

## Children's Lived Experience

3.7. Sibling 1 suffers from a condition which requires physiotherapy and medication to reduce painful muscle spasms as well as improving posture and mobility. Sibling 1 is required to wear splints and special shoes regularly to improve his muscle tone. The prognosis at the point of him coming into care was that he was likely to need surgery and potentially a wheelchair in future years but good compliance in his treatment regime will delay any deterioration. This medical view has been borne out as his mobility and muscle tone has reportedly improved due to good compliance while in foster care.

3.8. Sibling 1's parents failed to comply with most aspects of his medical care, having failed to follow his treatment regime and have missed important medical appointments for him on very many occasions. This is despite all agencies offered advice, encouragement, and various levels of direct assistance to his parents to improve compliance but with no sustained improvement. The school have compensated in part for Sibling 1's parents lack of compliance by ensuring wears the splints when he is in school. The physiotherapy services provided by Rotherham NHS Foundation Trust have been consistent in seeking the best outcome for him and seeking an improved regime of care through support within his school setting. However, this has not translated to referrals or assessment of as a child in need as a disabled child under section 17(1), Children Act 1989.

3.9. Sibling 1 has a cognitive developmental delay. There have been concerns throughout most of his childhood about the care he receives from his parents, including poor home conditions, unhealthy diet, delayed immunisations and consistently poor school attendance. He was also noted to be of unkempt appearance, wearing inappropriate clothes for the time of year and to have a lack of parental supervision, including spending excessive amounts of time online on interactive games. Sibling 1 has been expected to care for his younger siblings despite his developmental delay and physical limitations.

3.10. There have been several concerns raised by professionals regarding marks, scratches or bruises on Sibling 1 which were explained by their parents as accidental, but which could have been considered as evidence of lack of supervision and neglect. There was a report of excessive physical chastisement which resulted in a Child in Need plan. There were also concerns raised to the GP on one occasion as to whether Sibling 1 could have been abused after being in contact with a person who allegedly posed a risk to children. There was an anonymous referral regarding a neighbour witnessing Sibling 1 being hit around the head and in the groin as well as emotional harm and neglect by his parents, this was discounted based on the children's presentation and no further action taken.

3.11. There were several examples of where anonymous referrals were pre-empted by the parents, advising a family member would be making a referral as they had fallen out. These referrals were then considered with this context and discounted as being malicious. There were also concerns about expectations placed on Sibling 1 by his parents which were not age appropriate. Examples given included his parents setting an alarm for Sibling 1 to get up, get ready for school and wake his parents to take him to school while aged five.

3.12. Sibling 2 experienced slow weight gain as a baby, was exposed to poor home conditions and poor diet. Sibling 2 was not taken for specials appointments and their school attendance was poor. The reasons given for absence were often as attending medical appointments, but it is known that Sibling 2 was often not brought to them. During the wider period under review Sibling 2 was not brought for appointments on 7 occasions and there was not always sufficient follow up to this.

3.13. Sibling 2 suffered from respiratory problems, but her parents were not consistent in ensuring she used prescribed medication. Sibling 2 was admitted to hospital in 2018 with breathing difficulties and it was noted that parental smoking was a known factor. Maisie and Paul asserted that they smoked outside the home, but the home conditions and the smell of smoke and cannabis on the children and in the home would seem to refute this. There were concerns regarding lack of supervision due to reported accidental falls causing bruising.

3.14. Sibling 3 was also slow to gain weight as a baby and his parents did not take him to many appointments with the dietician and were not responsive to advice. He was admitted to hospital for breathing difficulties linked to a viral illness, but he had no on-going problems. At 10 months old, Sibling 3 said to have banged his head on a radiator and had a large bruise to his cheek and was vomiting after the fall. Two hours after the fall, his parents called 111 at 21.00 and he attended A&E by ambulance with his parents. Such presentations may also be of concern as research tells us, 'there was evidence of physical abuse for over a third of the children with a child protection plan for neglect (Brandon et al., 2013, p. 32)'. Sibling 3's immunisations were delayed on multiple occasions, he was exposed to poor home conditions and poor diet and had developmental delay including speech and language.

3.15. Baby April's pregnancy was said to have occurred at a point of time when her parent's relationship was in decline. Maisie appeared ambivalence throughout her pregnancy and was late attending antenatal services, she missed many appointments and refused important tests and treatments which were required to keep her and the baby in good health. During the pregnancy home conditions were observed to be 'very poor' and unsafe for a new baby.

## Key Practice Episodes

3.16. **Pre-pregnancy:** In the four months prior to Maisie's pregnancy there were seven medical appointments where Sibling 1, Sibling 2 and Sibling 3 were not brought by their parents. These included appointments for physiotherapy, dietician, ophthalmology or paediatric specialist appointments. One of these was a second missed specialist appointment within 6 weeks. As a result the children were discharged back to GP, and these episodes of 'Was Not Brought' were not always referred to Children's Social Care as required by the local protocol. However, the GP was noted to have followed up and re-referred the children to appropriate services. Maisie is reported to have again spoken to the GP about not wanting to get pregnant again.

3.17. During this period Sibling 2 was taken to hospital in respiratory distress where it is reported that her parents had lost the aero chamber required for delivery of her inhalers. During an Early Help visit with Paul, Sibling 3 is observed to be pale and looking unwell, Paul advises he has a sickness bug. The smell of cannabis is noted in the property. This was not addressed with Paul at the time but is raised with Maisie at a subsequent home visit where some improvement is noted in the home conditions. However Maisie is noted to be defensive when offered advice about Sibling 2 wearing earrings for nursery and still needing to see the GP for an eye infection.

3.18. During liaison with Early Help by the Health Visitor they expressed concerns regarding parental engagement, the home environment and missed medical appointments and it was agreed to arrange a team around the family meeting. Sibling 3 was taken to UECC by ambulance and admitted to hospital overnight with breathing difficulties related to Upper Respiratory Tract Infection. There are further concerns regarding Sibling 1 not being brought to his podiatry and orthotics appointment. At a Physiotherapy visit to the school Sibling 1 is noted to not have access

to his insoles and splints and that the parents are not compliant with his routine or medication required to ensure his development and keep him healthy. He is poorly presented, and his mobility has declined due to poor compliance.

3.19. Following an argument between Maisie and a family member the Police attend for a Domestic Abuse Investigation however, no action was required as her relative had left the property before their arrived. Home visits by professionals continue to note poor home conditions, exposure to smoke and the smell of cannabis within the home, concerns are expressed regarding parental engagement and regarding the home environment and parents not bringing children to medical appointments. There are also concerns regarding 'rough handling' [1]of Sibling 3 by Paul which was addressed by the Early Help worker.

3.20. Early Help support remains in place with team around the family meetings held during this period with involved practitioners. Sibling 2's parents cancel her 2-year assessment and Paul has sole charge of the children while Maisie goes on holiday. The children are said to be better presented in dad's sole care. The Team around the family meeting takes place at the school in while Maisie is on holiday, the longer-term plans for Sibling 1's mobility is discussed alongside concerns about lack of orthotics. Increased concerns were raised regarding Sibling 2's parenting capacity but a 'Step Up' to Social Care was not considered by the practitioners involved.

3.21. **Realisation of pregnancy** - In November 2018, Maisie attended the GP when prompted by Early Help, who confirmed the pregnancy. Maisie attends her midwifery booking appointment and concerns are raised re her low mood as she was not feeling like getting out of bed and had irrational thoughts around her eldest child's health condition. The Community Midwife provided information for IAPT and for a Consultant Obstetrician with an interest in perinatal mental health. Maisie attended out of hours with abdominal pain and missed appointments are noted and that she is not taking folic acid and has low mood.

3.22. There is poor compliance, and the Community Midwife made an unannounced home visit to repeat antenatal booking bloods as Maisie was 9 weeks pregnant and missed her appointment. Maisie was at home in bed, friends were staying on an airbed in the living room, the house was very cluttered, carpets and floor dirty, stairs cluttered with clothes, papers, dishes, the kitchen worktops cluttered, dirty with old food, dirty crockery and cutlery and cigarette tobacco on the table. There are a pushbike and suitcase overflowing with clothes in the kitchen leaving not much floor space, however the living room was not seen due to their guests sleeping there. Maisie refused to have the repeat bloods taken. The information was shared with the Early Help Worker.

3.23. An Early Help Home Visit is made, and a food parcel delivered. Since her last appointment Maisie has taken Sibling 1 to hospital and whilst there, she has made threats to staff. This is addressed with her and Maisie states that it was due to conflicting medical advice and worrying about Sibling 1 being made ill by the medication. This is despite the GP confirming that the medication is of benefit and does not cause bruising. It is noted by the worker that she does not feel that Maisie and Paul appreciate the importance of attending the appointments for Sibling 1.

3.24. Sibling 3 was brought to the walk-in centre by Maisie due to a high temperature and became abusive to staff, again made threats to staff and self-discharged without medical advice. This

[1] The risk associated with using this term has been identified in national Serious Case Reviews (Brandon et al, 2009) whereby its use had the effect of playing down concerns and delaying a protective response from professionals. Brandon et al (2009) went on to recommend that these injuries should be viewed as non-accidental, and professionals should not use the term, 'rough handling'. [SCR Rotherham & Doncaster 2009]

information was referred to the MASH who decided 'no further action' as the case was open to Early Help. However, this referral could have provided an opportunity to undertake a section 17, Single Assessment to collate and analyse the history of concerns and assess family functioning.

3.25. **Neglect of children and pregnancy** – In January 2019, the Community Midwife contacts the Early Help Worker concerned about home conditions after an unannounced home visit. Maisie and the younger children are still asleep on the settee in the afternoon. Maisie did not know where Sibling 1 was when she woke up. The HV also reports a smell of cannabis in the house. The Early Help Worker invites the Community Midwife to the next Team Around the Family (TAF) meeting. Maisie again refuses to have antenatal bloods taken, as she is experiencing symptoms of possible miscarriage.

3.26. An Early Help Home Visit takes place where there are again concerns about Sibling 1's presentation, but the other children were well presented. When asked about cannabis use Maisie says she does not smoke it and Paul only smokes it outside. Advice is given regarding the risks of second-hand smoke to the children. Sibling 1 is observed playing a gaming platform which is for age 12 and over. The Early Help worker feels this is a positive visit and that Paul shows insight by asking if she has concerns. Reminders are given regarding expectations and it is agreed to meet at the hospital for Sibling 1's appointment at Orthotics.

3.27. However, Maisie does not attend her planned appointments with the Community Midwife and Sibling 1 is not brought for his medical appointments. Although Maisie attended her next appointment with the Community Midwife, this is seen to be because she is brought to the appointment by the Early Help worker, rather than a recognition of the importance of antenatal appointments. She then fails to attend her GP appointment and 4 days later attends A&E in the early hours of the next morning with pregnancy issues after phoning 111. During case supervision these concerns are discussed and Maisie and Paul's feelings regarding this pregnancy. It is agreed that if Maisie refuses the next appointment a MASH referral will be made. However, despite the ongoing parenting concerns there is no record of consideration of commencing a pre-birth assessment due to neglect which could have provided insight into the care the baby may receive.

3.28. There are concerns re a domestic abuse incident between family members with none of the parties involved willing to support a prosecution. Concerns are raised that Sibling 1 has not had his medication for 2 months. A Team Around the Family (TAF) meeting is held where concerns are put to Maisie who appeared disinterested to workers. Maisie is advised to take Sibling 3 to the GP due to a recurring ear problem. Concerns were raised that Sibling 3 was being scapegoated by Maisie. The workers present discuss appropriate play and stimulation to support his development. When they suggested there may be an attachment issue, Maisie decline the idea and was hostile and reluctant to acknowledge this may be an issue with attachment.

3.29. Concerns were raised with Maisie that Sibling 2's school attendance was poor who was reported to have laughed and said, "she doesn't need to go". Maisie reported that Sibling 2 has been unwell with her breathing, but she has not taken her to the GP for this to be explored further. Paul was reported to be smoking cannabis regularly and the home smelt strongly of cannabis. Maisie was said to be very 'closed' and her responses were adversarial, she was advised to work with Early Help, or the case would be escalated to Social Care.

3.30. Concerns were raised at clinic that Sibling 1's prescription had run out two months ago, and the parents had not requested repeat medication. However, this was not viewed as possible evidence of neglect. In the second trimester Maisie is seen in clinic with abdominal pain and reduced foetal movement and she is discharged after review by a doctor. There are further failed appointments

and it is reported that Maisie and Paul 's relationship has ended. Paul attends A&E as he has collapsed after not eating and he self-discharges, and he returns the following day in a poor state and is admitted. The Early Help worker visits Maisie and finds other adults living in the home and is verbally abused and threatened by Maisie. The children are noted to be poorly presented and care has declined without Paul present in the home. Paul is homeless and sleeping rough or sofa surfing, his mental health and medication compliance is poor.

3.31. The school raise concerns regarding the change in circumstances and seek a referral to the MASH. The records show that MASH advises the school to produce attendance data and information about presentation and parental engagement. Paul refers himself to CGL Rotherham and requested support with his cannabis use. CGL start a personalised assessment in which he advised he was having no contact with his children. However, this information does not appear to be checked with Early Help. He is offered support in the form of structured psychological groups focussing on behaviour change.

3.32. An anonymous referral is made in February 2019 regarding Sibling 1, regarding inappropriate people within the home, that Sibling 1 had attempted to harm himself and that a possible sexual offence had been perpetrated. Sibling 1 was said to be very unhappy and distressed due to the separation of his parents and not having contact with his father. Information sharing took place within the MASH and Sibling 1 was spoken to by specialist officers. Following lateral checks, where concerns regarding poor parental mental health and failure to meet basic needs were noted it was agreed that a Single Assessment would take place. However, despite the continuing concerns and the seriousness of the allegations, there was no strategy discussion or section 47 enquiries undertaken and, as with previous referrals, the concerns were dealt with in isolation.

3.33. **Step up to Social Care** - in March 2019, the family is allocated a social worker who undertakes the Single Assessment. Liaison between the health visitor and social worker takes place. Paul discloses a habit of daily cannabis use and that this used to cause arguments between him and Maisie due to the financial burden this placed on the family. Maisie is said to be engaging with the assessment however there are significant concerns over her ability to prioritise the children's health and care needs and her inability to put the children before her own needs. During this assessment, the Graded Care Profile was not used to assess neglect and there was no consideration of a pre-birth assessment and liaison.

3.34. The health needs for all three children were discussed and the need for parents to take Sibling 3 to the GP regarding his persistent ear problem and for Sibling 2 to attend the GP due to her persistent respiratory problems. The parents assured the group that they are attending medical appointments and they understood they must meet the children's individual needs. Poor school attendance was therefore seen as the main concern for Sibling 1 and Sibling 2.

3.35. Paul was still homeless, but he had stated working with CGL re his long-term cannabis use. The school host a Child in Need meeting led by the social worker. Positives were noted in that the other adults had moved out of the family home and Paul was attending 'Change, grow, live' as support for his cannabis addiction. Paul 's health and homelessness was discussed, and support offered to obtain housing. Although some positive changes were noted there was still an issue with cleanliness of the house and rubbish, and it was agreed to support Maisie with a skip to facilitate rubbish removal. This would indicate that the conditions in the home were still poor.

3.36. The analysis in the Single Assessment indicated that the parents had complied with the issues raised during the assessment, such as asking the adult non-family member to move out of the family home. Maisie and Paul also provided reassurance regarding attending medical

appointments but without evidence of this. The social worker's analysis was that allocation of a new Early Help worker, would allow a fresh start with someone who can build professional relationships with parents and promote positive parenting. It was recommended that the case is stepped back down to Early Help Support. The case was then closed to CYPS and re-opened to Early Help without evidence of change or consideration of parental capacity to change.

3.37. Therefore, given the reoccurring nature of concerns around neglect and no evidence regarding the parent's explanations regarding the presenting issues, their unknown capacity to sustain good enough care, this outcome appears over optimistic and premature. Especially as Maisie was pregnant with Baby April, there were continuing concerns regarding neglect, the change in parent's relationships and paternal mental health and substance misuse, risk of homelessness and the lack of support network. All the children had missed many medical and dental appointments, including specialist appointments related to known medical conditions.

3.38. The threshold had been reached within the Rotherham Multi-agency Thresholds Document, and Children's Social Care Assessment Protocol for a Child in Need Plan to be put in place. This should have included use of the Graded Care Profile and a Pre-birth Assessment being undertaken to explore the presenting concerns, assessment of the parenting capacity of both parents and a clearer safety plan put in place. This would have ensured benchmarking of neglect, analysis of the care the new baby was likely to receive and pre-birth liaison between agencies to consideration of whether the threshold for significant harm was met before the birth of Baby April.

3.39. The practitioners and managers who worked with the family confirmed within the practitioner event that this may have been due to a confirmation bias regarding Early Help support being enough to bring the standard of care to the children to good enough. However, it was also recognised that while the previous Early Help worker had sustained a good relationship with Maisie and Paul for a significant period, this had only been sustained due to the skills of the worker and that when she exerted strong professional challenge, this had led to Maisie verbally abusing the worker and refusing to work with Early Help unless a new worker was allocated. The request was granted based on a new worker being able to start afresh with the family.

3.40. It was also highlighted in the practitioner event that had the Single Assessment been shared with the professionals working with the family who had contributed to it, they would have challenged the analysis of risk and vulnerability and the decision to close the case to CYPS. However, these are not routinely shared with involved practitioners although they contribute a multi-agency perspective of the family. This was agreed as a system learning point for Children's Social Care.

3.41. Maisie is seen on the Labour Ward at 28 weeks with abdominal pain and tightening, she is sent home with follow up and a prescription for blood thinning medication. However, this is not collected by her from the GP. Sibling 1 was again not brought to his audiology appointment. The Health Visitor therefore contacts the social worker and is informed there is a new Early help worker. Paul does not attend his GP follow up but does attend three group work sessions for substance misuse. Maisie fails to attend three planned antenatal appointments and concerns remain regarding her self-care, smoking and drinking energy drinks while pregnant. Practitioners still believe that the case is open to Children's Social Care.

3.42. **Step down to Early Help** - The Community Midwife makes several attempts to speak to the social worker and is advised that the case has been stepped down to Early Help. Although she discusses her concerns regarding this within the team, there is no formal escalation using the RSCP Practice Resolution Protocol: Resolving Professional Differences of Opinion in Multi-Agency working with

Children and their Families. This approach was identified as a systems issue within this review as

practitioners advised that they had not been aware until recently of this protocol and of the need to take a staged approach.

3.43. Paul failed to attend a second appointment at RDaSH with the Improving Access to Psychological Therapies team. Maisie is admitted for observation due to pregnancy issues and she advised she has not been administering the medication required to prevent clotting. There is a second episode the following week, when Maisie refuses to remain in hospital against medical advice. The hospital raises safeguarding concerns with the MASH which are passed to the Early help worker. Paul attends his GP appointment and advises he has not attended his RDaSH appointments due to caring for the children. The school raise concerns regarding the children's declining attendance, continued parental cannabis use, and a decline in Sibling's behaviour at school 'as a result of this traumatic time'.

3.44. **Birth of Baby April** - Maisie was admitted in preterm labour and Baby April was born 6 weeks early and remained in hospital for three weeks, initially as she was premature, then pending a second multi-agency discharge planning meeting with Social Care. Many concerns were raised by the hospital around Sibling 2's presentation, Maise's aggressive behaviour and attitude towards Baby April and wanting to get the baby delivered. This behaviour in the context of other longstanding concerns about the family, gave the midwives looking after Maisie significant concerns for the wellbeing of Baby April and they contact Children's Social Care.

3.45. Concerns were again raised regarding Maisie's mental health following the birth as she was said to be tearful and of low mood and her responses towards Baby April were limited with no eye contact initially and a reported preoccupation with her phone. Baby April who was considered extremely vulnerable as a premature newborn. Following birth, Baby April was admitted to the Special Care Baby Unit (SCBU) due to her prematurity and low birth weight. Maisie discharged herself against advice and due to her being tearful and having low mood a referral was made to peri-natal mental health team. Maisie was contacted by phone by RDaSH and she denied being depressed or of low mood and refused support. As a result of the concerns and Baby April's prematurity the hospital were unhappy to discharge Baby April without Children's Social Care being involved in a professionals' planning meeting and called the MASH. There is however no corresponding entry on their records until 12 days after her birth.

3.46. Following her self-discharge from hospital Maisie visited Baby April on the SCBU daily and was said to asked appropriate questions and spent time caring for Baby April. Early Help contacted the Out of Hours (OOH) team as she had seen a blister on Sibling 1's temple of unknown cause. OOH passed the information to MASH for review and a decision was made that as there is no evidence of intentional harm, and the case was to remain with EH. Concerns were raised via Early Help with a request for 'Step Up' to CSC and the hospital information is included in the request for a discharge meeting. This meeting was requested due to the concerns about Maisie's behaviour on the ward and possible harm to Baby April if she was discharged without assessment and support from Children's Social Care and other services.

3.47. A Discharge planning meeting was held without Children's Social Care present, due to the case being open to Early Help. Health professionals felt that it was unsafe to discharge Baby April without social care support. During the discharge planning meeting for Baby April, the Early Help worker reported the blister to the temple of Sibling 1. The school reported that Paul 's property smelt of cannabis when they attended to collect Sibling 1 although he was supposed to have been abstinent for a period of three months. It was agreed that a new referral would be made to MASH, to include Sibling 1 due to neglect and possible inflicted injury, learning difficulties in both

parents, the children not attending appointments and poor and unsafe home conditions. The meeting was reconvened as a professionals' meeting the following week.

3.48. While this ensured that Baby April was in a safe environment, it also meant that she remained in an acute setting while medically fit. The following meeting, although labelled as a professionals meeting did not include all the professionals who knew the family best. It was highlighted by during the learning event that this meeting focussed on discharge planning for Baby April and did not consider the needs of the other children or the wider history of Sibling 2's previous parenting and Paul's issues around cannabis use and mental health needs as might be expected. It also did not fully appreciate the implications of Maisie prioritising her own needs over Baby April's, not following safety or care advice when changing her. The outcome of the meeting was that the presenting features indicated 'help' not 'harm' and a Single Assessment would be undertaken.

3.49. Practitioners within the learning event indicated that the terms 'help' and 'harm' were not always well understood in the partnership with 'help' meaning Early Help instead of also including Section 17 - Child in Need. This reportedly led to an acceptance of Children's Social Care's view of the threshold for 'harm' as the agency responsible for assessing 'significant harm'.

3.50. It is identified as a learning point that the thresholds had not been correctly applied and reference to the RSCP Multi-Agency Threshold Descriptors and the RSCB Practice Resolution guidance would have been useful tools to evidence risk and support case escalation. It was also highlighted that where there are concerns of cumulative harm, it is not helpful to focus solely on the discharge of the subject child and the wider needs of the children and parents should be considered.

3.51. It was recognised as a practice factor that key professionals who knew the family best were not present and the longevity of the concerns and lack of sustained change were not considered in determining the meeting outcome of 'help not harm'. This is a further learning point when dealing with cases where there has been long held concerns, with barely adequate parenting and previous interventions have not sustained improvements in the care given to the children and their lived experience, that those who know them best professionally should be present and exert challenge where outcomes are not in keeping with expected practice.

3.52. **Escalation of concerns** -Three weeks after her birth Baby April was discharged into Maisie's care with support in place and a plan in place for the older children to stay with their father for three weeks. Intensive support was provided with home visits to Maisie and Baby April from Neonatal Outreach. Baby April had some feeding difficulties and severe nappy rash requiring treatment. Maisie had to be reminded of aspects of Baby April's care needs on many occasions during these visits. Given that Baby April was her fourth child, this lack of care was considered as possible evidence of a learning difficulty but was not assessed, despite being in the plan for the Single Assessment. Maisie did not register Baby April with a GP, nor arrange for her 6-week check or immunisation despite many reminders. Home conditions were described as poor and unclean throughout the following weeks and months.

3.53. Following the professionals' meeting the Health Visitor raised concerns that the blister injury to Sibling 1 's temple has not been investigated. As a result the social worker spoke to Sibling 1 alone, however this was 3 weeks after the injury was seen. Sibling 1 recalled the blister but could not recall what happened or how he got it. Paul had previously said it was sunburn, but this did not fit with the description of the injury. Sibling 1 's vague response was not questioned by the social workers and there is no evidence that a strategy meeting was considered or held to discuss the issue and no medical was undertaken. This lack of proper assessment is a feature of this case, and

evidence that the wider functioning within the family was not assessed and seen as a systems

issue. However, evidence has been provided by Children's Social Care, that this area of practice has since been strengthened by the addition of practice supervisors and regular audits.

3.54. Support continued through the multi-agency team around the family with regular visits from Community Midwives, Early Help, Health Visiting and support provided by RMBC Housing and Estate Services with housing and financial issues. Paul continued to attend sessions around his cannabis use at CGL Rotherham, but it is known that he continued to use cannabis regularly. Over this period there were continuing concerns regarding the presentation of Sibling 1, his attendance at school and poor compliance with his medical appointments and physiotherapy regime.

3.55. The Neonatal Outreach Team visited the home and Maisie was home caring for all four children. The home conditions were observed to have deteriorated further with leftover food on the floor, which was seen to be eaten by one of the children, the hallway was cluttered with unsafe access to the stairs. Maisie said the children could not play in the back garden due to a fire pit and ashes in the garden. Baby April's severe nappy rash had not improved, and Maisie was advised to take her to see the GP for a review.

3.56. Maisie attended A&E with Baby April in the early hours due to a choking episode the previous evening and stated she had been biting and bopping at feeds. Maisie reported that Baby April did not change colour but went floppy and it is not recorded why she delayed seeking medical attention. Health record checks were not made by medics in UECC which was noted as a single agency learning point by TRFT.

3.57. The Neonatal Outreach team make numerous attempts to contact Maisie as requested by the Children's Assessment Unit to ensure Maisie has Lactulose prescribed for Baby April and knows how to use it. They visit the following day and both Sibling 2 and Sibling 3 were asleep on sofas. At a further visit concerns were raised regarding lack of care and supervision of the children and physical fights between Sibling 3 and Sibling 2 resulting in Sibling 3 having cuts to his face. When concerns were raised Maisie was reported to have said to 'let them get on with it'.

3.58. There were further concerns noted regarding marks, bruises or scratches which were not referred on as the explanation given by the parent was said to fit their presentation. However, these should have been shared with children's social care for further assessment. As highlighted in the Graded Care Profile, these were also a possible indicator of a pattern of neglect due to lack of supervision but were not recognised as such by practitioners. This is a multi-agency learning point in relation to cumulative harm through neglect.

3.59. School received a report from a concerned person who witnessed Maisie holding Sibling 2 up by the arm and screaming at her. The school offered advice about making a referral to the MASH or calling the Police. The school then contacted the social worker by phone and email to share these concerns.

3.60. At a planned home visit by the Neonatal Outreach Team, as well as concerns about the poor home conditions and lack of supervision of the children, Baby April aged two months was noted to be in very poor condition as she was vomiting, very pale in colour and inactive. Baby April had also lost weight and a review was therefore arranged on the Children's Assessment Unit at the hospital. Concern was expressed that Maisie did not recognise how unwell Baby April was, and it was noted that Maisie was more concerned with her phone than Baby April. Baby April required respiratory support due to an apnoeic event and a spinal tap was carried out.

3.61. Due to Baby April's poor presentation staff were concerned she had sepsis, but this was ruled out. Appropriate medical treatment was given based on her presentation and symptoms. However, this was a second delayed presentation where Maisie had not sought timely medical attention with a possible apnoeic episode and her lack of care towards Baby April was of concern. The record notes that there are no safeguarding concerns, while also noting the name of the Social Worker, and that Baby April had still not been registered with a GP or had her six-week check. These were indicators of possible neglect, that required the possibility of child maltreatment to be considered as required by the NICE guidance 'Child maltreatment: when to suspect maltreatment in under 18s (updated 2017).

3.62. **'Help' not 'Harm' -** A discharge meeting was held, and the concerns reiterated regarding Maisie's inability to meet the needs of Baby April and to recognise how poorly she was. There were concerns about gaps in parenting ability and lack of insight especially from Maisie around the impact of her own behaviours. Given that Paul also cared for Baby April, there was a lack of consideration of Paul 's needs and the impact of these on his parenting of Baby April and the other children. The home conditions were still of concern and Maisie was struggling financially. However, the outcome was for 'help' not 'harm' and the threshold for Social Care intervention was said not to be met. Several practitioners who had been working with the family were not present, and the Community Midwife advised she would not have agreed to the plan to step down to Early Help if present at the meeting. The Single Assessment was concluded with a recommendation to Step Down to Early Help.

3.63. While Early help had a co-working arrangement with social care there had been episodic involvement with Early Help for a period of six years with no sustained success. Because the assessment determined that many of the concerns were historic and the main need for the children and their parents was for help to be offered, it did not effectively identify the potential for cumulative harm through chronic neglect. Given the significant concerns that had been voiced by professionals the week before when Baby April was so poorly this was a missed opportunity to test if the concerns were linked to parental capacity or willingness, and what support the children may need to prevent future harm through chronic neglect.

3.64. It also did not recognise that Baby April was inherently vulnerable due to her young age and prematurity. Her parents had separated and Paul who was said to be a protective factor, as care was better when he was present, was no longer living in the home. There was also the unassessed impact of Sibling 2's own adverse childhood experiences (ACEs). The decision to step down to Early Help was made too soon and meant the family remained in Early Help services too long.

3.65. There also needed for careful consideration around how the parents would respond to Early Help being offered and a renewed challenge on the presenting issues. The assessment references that Maisie is believed to have learning difficulties but does not identify the support in place to ensure she understood any advice or support offered or any assessments or liaison with adult services that may be required. It also does not explore Paul 's learning needs or cognitive functioning alongside his cannabis misuse. As such it does not demonstrate a wider professional curiosity and appears over optimistic in its outcome.

3.66. Throughout July and August 2019, the Early Help work continues with support including financial planning and tenancy support provided by Housing and Estate Services. Concerns continue regarding the poor conditions in home, parenting of the children and their physical presentation continued. Baby April continues to have severe nappy rash and Maisie was observed not to be following nappy changing advice. Baby April was not registered with a GP so had not received her immunisations. Neonatal Outreach made their final visit, and the Health Visitor visited the same

afternoon. They both raised concerns regarding the home conditions and the physical presentation of the children who were dirty and unkempt and not fully dressed. The toys and playmat were also dirty and the potty being used was not cleaned after use and very unhygienic. Use of the Graded Care Profile 2 would have indicated this was evidence of cumulative harm through chronic neglect.

3.67. Several specialist medical appointments for Sibling 1 were missed by Maisie so the Physiotherapist made a home visit to Paul to ensure he had the correct equipment and was able to apply Sibling 1 's splints and gaiters. The Early Help worker was contacted by the MASH to seek her views regarding whether the children were at risk of significant harm. They responded that they felt the case had been stepped down too soon and the children were teetering between adequate and potentially neglectful parenting.

3.68. Maisie and Paul contacted 111 as Sibling 2 was said to have bruised ear due to fall from a sofa on to a quilt. This information is shared with the GP following a MASH follow up meeting and due to an emerging pattern of further concerns, it was agreed for the case to remain in Early help for another 9-12 weeks to progress their work. However, given the heightened concerns it would have been beneficial to hold a strategy discussion to consider the threshold for 'likelihood of significant harm' before the decision to continue with Early Help was made. The school continues to have ongoing concerns regarding conditions in the home, presentation of the children, exposure to smoking, ongoing smell of cannabis and parenting of children.

3.69. Maisie contacts the Health Visiting Service and advises that Baby April's head looks too big for her body. She is encouraged to arrange a GP appointment as soon as possible. That evening Baby April is brought into hospital by ambulance and found to have an enlarged head circumference and a significant head injury, likely caused by non-accidental injury. The children were therefore removed into care and applications were made to the family court for interim care orders.

## Chapter 4 - Findings and lessons learnt with suggested recommendations for the consideration of RSCP

### How effectively do multiagency practitioners recognise and respond to the impact of cumulative harm linked to neglect?

4.1. This chapter outlines the findings and suggested recommendations identified from the analysis of the key events and professional practice. Baby April suffered a significant non-accidental injury which will have a substantial impact upon her future health and development and she and her siblings experienced care that was at best barely adequate but that was neglectful and likely to have a significant impact on their health and development.

4.2. The findings are produced for the consideration of the RSCP to reflect on and implement any learning from this Child Safeguarding Practice Review. The involvement of practitioners and their managers has been fundamental from the outset of the review, as has the support of the local Review Panel. The learning points set out for consideration by the RSCP reflect the collaboration and insight provided through their engagement and support.

4.3. The discussion of the key findings has been arranged around the central research question, key lines of enquiries and connected themes that seek to inform learning and improvement across the system. Reference is made to the literature, including other local reviews, inspection findings where relevant and to recent developments in improving the assessment and response to child

neglect and adverse childhood experiences. In delivering these findings consideration has been given to providing partners with a summary analysis that does not repeat information already being shared in other recent local reviews or as part of the wider work streams.

4.4. The review found that this family received a high level of support from universal services, targeted and specialist health services. There was prolonged and sustained effort to engage with both parents, to support them to improve their care of the children and to compensate in areas where care of the children was lacking. However, there was insufficient regard to the length of time this support had been ongoing and its episodic nature. Despite the lack of sustained progress made by the family and the cumulative harm created by a history of 'barely adequate parenting' there was a lack of focus on the importance of their parenting history and impact on the children.

4.5. Assessment therefore tended to dismiss concerns as historical and a focus on the immediate presentation and the reassurances given by parents which were not tested out. Children's Social care felt that this analysis was lacking in the two Single Assessments completed in 2019, where although chronologies were included there was a focus on the "here and now". The review has found that most agencies felt more weight should have been given to their professional views at the MASH review and in their individual considerations of the lived experience of the children. This is a learning point for the review which links to findings around resolving professional disputes and use of the escalation protocol.

4.6. This review has identified gaps in practice in general and systems issues around multi-agency assessments, including Early Help Assessment, that affect how well multiagency practitioners recognise and respond to the impact of cumulative harm linked to neglect.

## Voice of the Child and Lived Experience

4.7. While there were many examples of practitioners identifying how the children were likely to experience the care given to them, these did not necessarily translate into assessment and plans to support the children. There were also examples where too much emphasis was placed on the needs of the parents and self-reporting or assurance from Maisie or Paul that the children's needs would be met.

4.8. Had there been a wider assessment of 'a day in the life of' the children according to their age and stage of development the assessments may have identified that there was a likelihood of significant harm. There was particularly not enough emphasis on understanding Sibling 1's lived experience as a disabled child and the impact on his long-term health and development of not receiving the care his medical team had identified necessary to his future wellbeing. Given that there was unmet need it would have been beneficial to consider what services could have been provided under section 17(1), Children Act 1989.

### Learning point one – Responding to the Voice of the child and their lived experience

The voice of the children was not always heard or responded to and was not always designed into assessment or delivery plans that were child focussed and considered all unmet need, and in particular Sibling 1's needs as a child with a disability.

**Recommendation 1**

- The RSCP to seek assurance regarding how the lived experience and voices of children of all ages and ability are heard, reflected in assessments and plans and to address any gaps in practice particularly regarding children who have a disability or developmental delay.

## Understanding and responding to cumulative harm through neglect

4.9. It was noted within the practice appraisal that no practitioner used the tools available to them to identify and assess neglect. The RSCP had in place a Neglect Strategy, which is currently being reviewed, and had promoted and provided training on use of the Graded Care Profile 2 to benchmark the care the children were receiving, this was not used. Many practitioners held a presumption, the care the children received was due to Maisie having a learning difficulty and they contextualised this as to whether she was unwilling or unable to provide appropriate care.

4.10. However, regardless of the root cause of the neglectful parenting, practitioners needed to assess the impact on the children of the care they are receiving. Neglect, whether wilful or due to other parental factors, is significantly harmful, particularly in pregnancy and infant and early years development. It has been known for many years to potentially have an adverse impact on brain development. This is therefore seen as a systemic issue in general practice, and this needs further exploration around how practitioners are supported to work with children who have experienced or likely to experience neglect given that there is existing guidance and tools to support the multi-agency safeguarding system.

4.11. While practitioners were aware of the repeating pattern of neglect and inadequate care of the children the practitioners did not recognise this in terms of the cumulative harm. Sibling 1 's poor presentation was also seen in the context of his known disability and when he presented with minor scrapes scratches and bruises these were seen as fitting a dialogue of him having mobility problems. Statutory guidance highlights a barrier to recognising abuse and neglect as 'assumptions that indicators of possible abuse such as behaviour, mood and injury relate to the child's disability without further exploration'[2] and is reflective of practice in this case.

4.12. Throughout the period under review Maisie presented as ambivalent, defensive and at times aggressive towards staff in hospital settings and those visiting her at home. Paul was viewed as more approachable and easier to engage and motivated to do so and sought understanding of the concerns held. However, this may have given an overly optimistic view of his ability and motivation to change and to prioritise the needs of the children given that it has now been established that Paul had an unassessed learning difficulty. Given Sibling 2's history and experience of childhood trauma it is commendable that practitioners were able to establish a relationship-based intervention with her. Sibling 2's reluctance to engage and apparent literacy issues were also seen as evidence of a possible learning difficulty and this meant staff were often more accepting of the care she provided as they were unsure whether she was unwilling or unable to comply.

4.13. However, fuller consideration should have been given to understanding Maisie and Paul 's ability to parent effectively and the factors affecting their parenting capability. Maisie often presented as hostile and unwilling to engage with practitioners in assessments and the plans in place in a meaningful and consistent way. There was a lack of professional curiosity within many key practice episodes with little exploration of her motivation to change, especially given that she didn't hold the same concerns as professionals nor recognise that her parenting behaviours which had been evidenced over a significant period were problematic.

4.14. It was assessed that Paul was complying with but there was little evidence of engagement in interventions over time that were aimed at achieving change in his cannabis use or that recognised the need to assess the possible impact of his learning difficulty and improve the level

[2] Keeping Children Safe in Education (2018) – updated September 2019

of care to Baby April and her siblings over time. As a result of this many of the aspects of care the children received, that form a pattern of low-level but chronic neglect, were over time seen as parental lifestyle choices that parents are free to make. In addition practitioners did not want to appear judgemental of Maisie and Paul and wanted to provide support which they hoped would bring about lasting and sustained changes to improve the children's care and lived experience. There was also consideration of 'confirmation bias' in that the practitioners may have too readily accepted explanations and assurances from parents as signs of improvements and changes that would be made and that revisiting previous Early Help work could bring about sustained change.

4.15. There was good engagement with Paul by practitioners especially whilst he was in the family home. The school and Physiotherapy Service particularly sought to involve him in their work with Sibling 1. This is an area of practice that is often noted to be problematic in reviews where the strengths and protective factors provided by a father are not recognised. However, agencies involvement with Paul was noteworthy and recognised this in the rapid review as good practice.

4.16. Unfortunately not all agencies were aware of Paul's learning needs, nor that he had a hearing impairment. The agencies that were aware of his learning difficulty did not know how to work with him to be as effective as possible and did not share this information across other agencies. The agencies working with Paul in relation to his mental health needs and substance misuse and his GP practice were not aware of the extent of his role in the family and the fact that he was in most respects the primary carer of the children.

4.17. The review found that despite the long-held concern that the neglectful care received was due to a parental learning disability and a professional recognition as to the possible impact of this on parenting capability, there was no assessment of either parent or liaison with adult learning disability services in order to understand any implications for the care the children received.

4.18. Practitioners were noted to have persevered in their attempts to engage with Maisie, despite her avoidance and at times hostility. This tenacity in seeking to bring her on board and engage in the plans in place was good practice. However, most agencies also held concerns regarding Maisie having a learning difficulty and this was not referred for assessment during the period under review. This is an area of practice that practitioners felt was important to expand their knowledge, confidence and competence.

4.19. This review therefore also found that there was evidence of professional over optimism that appears to be a feature of general practice when working with cumulative harm linked to chronic neglect. This finding is reflective of Brandon et al. (2014) who described that parenting approaches accepted by practitioners reflect fears about being considered judgemental when working with families who are vulnerable, poor, socially excluded or who have made certain life-style choices. This can cause 'undue professional optimism and an acceptance of less than adequate parenting practice that results in a failure to grasp the child's lived experience and a downgrading of chronic neglect.' This was described within the practitioner contribution as resulting in 'starting over' each time with Early Help each time rather than looking at the 'bigger picture' and ensuring consistency in meeting the children's needs and maintaining their basic care needs.

4.20. It was identified that training delivery for the Graded Care Profile 2 (GCP2) was paused during 2019 while a Task and Finish Group considered the use of the tool against the Signs of Safety Scaling. This was because within GCP2, Grade 1 indicates the child's needs are met, a child first

focus and best care is given, whereas low scaling in Signs of Safety[3] is used when it is considered unsafe for the children to remain at home. However, following the review of the tool, the RSCP Executive has agreed that use of the GCP2 to assess and benchmark neglect is to continue. Neglect Training is being updated to clarify how the scoring works and to promote its use as an assessment tools that supports the Signs of Safety approach.

4.21. As part of the assurance provided, evidence was provided of work being undertaken with South Yorkshire Police and other Local Authorities in the region regarding the response to chronic neglect and cumulative harm. This work is intended to provide a joint response and remove over reliance on local authority action in cases of neglect that may meet the threshold for police investigation. The partnership may therefore also wish to receive assurance around the impact of this work in their local area.

### Learning point two - Recognition and response to neglect

This review has highlighted, where there is evidence of neglectful parenting or care, that practitioners need to routinely use the full range of tools available to them to effectively identify, benchmark, assess and respond to the presenting concerns in a timely way.

**Recommendation 2**

- The RSCP should refresh and relaunch its Neglect Strategy and promote the use of the tools to benchmark and assess neglectful parenting. Practitioners should also be equipped to recognise feigned compliance, over optimism and confirmation bias in in a competent and confident manner. The RSCP should seek assurance as to the impact of this on practice and in improving outcomes for children.

### Application of Thresholds

4.22. The review found several key practice episodes where the thresholds were not consistently applied in accordance with the Multi-Agency Threshold Document, and which were not in line with Early Help Strategy nor the Neglect Strategy. This meant that the family stayed with Early Help too long and the same work was attempted episodically rather than recognising that the planned work had already been attempted several times. The assessments undertaken did not recognise Sibling 1 as a child with a disability and therefore that the threshold for receiving support a Child in Need was met and provision of further services as described in the disabled child offer could have been considered.

4.23. Practice appraisal has shown that while assessments were undertaken by practitioners within their individual settings, these often did not accord with the presenting features of the case, nor routinely considered the wider family functioning, the longevity of concerns and lack of sustained change. The assessments made, therefore gave a focus to the presenting issues rather than taking a longitudinal view of the lived experiences of the children and the risks from cumulative harm due to chronic neglect.

4.24. A pre-birth assessment was not undertaken when Maisie was pregnant with Baby April. However, it was known that there were concerns regarding her attitude to being pregnant in both this and previous pregnancies. Therefore, had a robust pre-birth assessment been completed prior to Baby April's birth that included consideration and assessment of Sibling 2's history, possible learning needs and Paul 's long-term substance misuse this would have supported and informed

[3] Evolving and locating rigorous risk assessment process at the heart of the Signs of Safety practice framework (Turnell and Murphy, 2017)

decision making regarding the possible level of risk and support required once Baby April was born.

4.25. Practitioners knew that Maisie was pregnant in February 2019, and the Single Assessment undertaken in March 2019 would have been the ideal opportunity to consider the implications for her care when born and to undertake a pre-birth assessment. As highlighted by Calder et al (2000), 'if a referral is made at this point, the pre-birth assessment should begin as quickly as possible.' Instead, a management decision was made that the family would be stepped down to Early Help with no indication of the need for a pre-birth assessment to be undertaken. Therefore, a pre-birth assessment did not take place, and this was not subject to effective management oversight nor was the need for one escalated by any of the involved practitioners.

4.26. Pregnancy and childbirth can offer a unique window of opportunity for change and there is a wealth of evidence to show that parental difficulties may have a significant impact in pregnancy and on the longer-term health of the child (Lushey et al., 2018). The lack of a pre-birth assessment was less than expected practice as, where the threshold is met for an ongoing role for Children's Services, a Pre-birth Assessment should be undertaken. This was not challenged by the practitioners involved with Maisie and Paul and this might have provided the opportunity to recognise a likelihood of harm and to develop a collaborative and cohesive plan for Baby April.

4.27. Early Help Assessments were not undertaken at appropriate points. Although practitioners shared information, either through referrals or practitioners meetings Early Help Assessments (EHA) were not undertaken in this case by practitioners outside of Children's Social Care as expected by the Rotherham Early Help Strategy. This is reflective of assurance information provided by the partnership, that shows while the number of Early Help Assessments undertaken by other agencies is increasing, there are still too few initiated outside of the Children and Young People Service, Early Help provision. Practitioners need to be encouraged to undertake Early Help Assessments as part of their own routine assessments and to include them in referrals as evidence of unmet need requiring an Early Help or Children's Social Care intervention.

4.28. The application of the thresholds was also flawed in that there was no assessment or liaison with adult services for learning disability or referral for assessment of parental learning difficulties during the period under review. This was explored within the review and practitioners and agencies felt that the framework for assessing levels of need and intervention within the Multi-agency Threshold Document was appropriate. However, that the thresholds were not consistently applied, and practitioners felt that in this particular case it was difficult to have their professional voice heard that the case met the threshold for social care intervention.

4.29. It was highlighted in the rapid review, that a factor in this was that the Single Assessments undertaken had not had the concerns updated and the analysis did not include all the current presenting factors. While a feature in this case, this is not seen as a feature of the safeguarding system and CSC audit evidence and moderation has shown that the thresholds are generally appropriately applied. However, Single Assessments are not shared with the practitioners working with the family. Therefore, Children's Social Care are considering how their Single Assessments can be shared with the multi-agency practitioners who contributed to them.

4.30. There were many good examples of multi-agency work within regular communication, information sharing, professional meetings, joint work as well as regular and appropriate supervision of the involved practitioners. Practitioners were in regular contact with each other and checked their understanding of the concerns, seeking re-referrals and a dialogue with the Early Help and Social worker regarding the levels of concern and action to be taken.

4.31. The RSCP also provided evidence of the strong co-working relationship between Early Help and Children's Social Care and the results of their audit and analysis of CIN and Early Help Work Programme. This showed that the thresholds are well understood and that there is now good use of the Step-Down protocol and meetings. There has also been development of joint supervision and practice learning days which are held monthly where different localities present cases that may be stuck or need moving on. Therefore, given the strength of the 'Step-Down' meetings it should be considered how this model can be utilised for 'Step-Up' as a collaborative approach.

### Learning point three – The importance of consistent application of thresholds

This review has highlighted the importance of consistent application of thresholds and in ensuring early understanding of possible risks, as well as the level of support required by parents to ensure the future safety and well-being of children, including unborn siblings. There is a need to value the professional opinions of others in their application and to ensure children are safeguarded at the earliest opportunity.

**Recommendation 3**

- The RSCP should seek assurance that the application of thresholds and the Step-Up and Step-Down within the Early Help Strategy is being applied consistently with appropriate and timely completion of Early Help Assessments by partner agencies. The RSCP should ensure that practitioners are alert to and routinely use the RSCP procedures and practice guidance for children in particular circumstances.

### Resolving professional disputes and escalation

4.32. There were many examples within the review that are outlined in the narrative chronology where practitioners such as the Community Midwife, Health Visitor, Early Help workers and school sought to raise their concerns the case had been held in Early Help for far too long. These concerns while frequent remained at Stage 1 within the Practice Resolution Protocol: Resolving Professional Differences of Opinion in Multi-Agency working with Children and their Families. It should be noted that practitioners explained that they had only recently become aware of this staged approach to resolving professional differences. This was also identified within the rapid review and agencies have promoted the use of the protocol internally during the early part of this year.

4.33. There also appeared to be a lack of recognition in the period under review that, as per Working Together 2018, 'a strategy discussion can take place following a referral or at any other time, including during the assessment process and when new information is received on an already open case'. It was identified that this was partly because, where cases are already open and a referral is received, it is dealt with by the locality team rather than the MASH. There were also several occasions where a strategy discussion or section 47 enquiries could have taken place but did not.

4.34. This could have provided an opportunity to convene a child protection conference to consider whether the cumulative neglect experienced by the children was significantly harmful and to take authoritative safeguarding action. It was the case that over time, the family were stepped down to Early Help too soon and also stayed within Early Help services too long, although agreed outcomes were not always achieved, or improvements sustained.

4.35. Therefore, more needs to be done to promote the role of escalation in partnership working together with respect and mutual understanding of others' roles and responsibilities and understanding of the limitations in practice and the need to formally escalate through the stages

within the protocol.

### Learning point four – Escalation and resolving professional disputes

Resolving professional disputes should focus on restorative practice principles that foster and enhances partnership working and a culture where respectful professional challenge is productive and welcomed.

**Recommendation 4**

- The RSCP should seek assurance that the systemic findings in learning point four are being addressed within their threshold document and the Step Up/Step Down process and includes restorative practice principles and problem-solving approaches to address them.

## Trauma informed approaches

4.36. This practice appraisal provides a context of the difficulties experienced by Maisie's in her own childhood including domestic abuse, behavioural issues and physical harm. A wealth of research has highlighted strong associations between adverse childhood experiences and the likely impact on parental mental health, wellbeing and parenting capacity[4]. However, this did not form part of later assessments and plans and was not known to all agencies.

4.37. The practitioners recognised that this was an area where there had not been a wider assessment on Maisie's parenting capacity as the importance of history was not considered. In seeking to understand the reasons for this, practitioners advised that Maisie's full history was not known nor was Paul's experiences of disability and having a learning need well understood. This is an area of practice which practitioners felt was important to expand their knowledge, confidence and competence. Although the review found that there was not sufficient information available across the partnership around adverse childhood experiences or trauma informed approaches there are plans already in place to address this. The Trauma and Resilience service are rolling out 'Talking Trauma' training and are looking at developing a trauma informed Rotherham pathway. The RSCP needs to assure itself regarding the impact of these plans on practice.

### Learning point 5 – Trauma informed approaches

The parent's own experiences in childhood were not always known or understood and therefore did not feature within assessments made around levels of need, risk and vulnerability. The likely impact of these experiences on the care received by the children was not known or understood.

**Recommendation 5**

The RSCP to ensure that practitioners can increase their knowledge, confidence and competence in trauma informed approaches and that its impact on practice is understood.

[4] Routine enquiry about childhood adversity (REACh) across mental health, sexual health and substance misuse

services (HM Government, 2015)

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[i] https://www.england.nhs.uk/mental-health/adults/iapt/