Local Child Safeguarding Practice Review

‘Rachel, Andy & Dean’

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Overview

In April 2020 police used their emergency powers to remove Rachel (7), Dean (3) and Andy (10) from their mother's care, due to concerns that all three children were at risk of sexual abuse. When the children were removed from their home, professionals identified that their basic care needs had been neglected, they were living in poor home conditions

The family had a history of children's social care involvement. Rachel, Dean and Andy were known to universal and early help services; however, there had not been any recent professional contact with the children leading up to the time when the children were removed and placed in foster care.

The Wandsworth Safeguarding Children Partnership (WSCP) reviewed the information known to the multi-agency partnership and agreed to undertake a Local Child Safeguarding Practice Review (LCSPR).

The key findings

1. Despite professional concerns, there was limited understanding of the children's day-to-day lived experiences, and an apparent lack of curiosity from professionals to understand what the children's presentation and behaviour may be communicating
2. Professionals in universal services commonly do not know how they should engage with either the parent/carers or the children when concerns arise
3. The emotional harm of mixed heritage children is often unaddressed because of an unconscious bias of professionals that limits recognition of racist treatment of mixed-heritage children by family members.
4. There is no consistent training to enable professionals to recognise and address the impact of unresolved multi generational trauma on parents and children.

Conclusion

The review highlighted the central importance to multiagency professional practice of understanding the child's lived experience and internal world, and how this applies to how we think about, and communicate with children and families. This core principal creates opportunities for collective professional curiosity and shared thinking, and also and importantly, challenges around unconscious bias, racism and intersectionality.

Training opportunities have been created to include this in reflective learning and multidisciplinary safeguarding supervision and support.

The need for enhanced practice has been acknowledged by the relevant agencies and actions taken under the oversight of the WSCP to support the learning.

1. Outline of the family

1.1 Summary

In April 2020 three children; Rachel, Andy, and Dean, were taken into emergency police protection and subsequently placed in foster care following concerns that the children were at risk of sexual abuse.

At the time of their removal the children had suffered significant neglect, found to be living in poor conditions. The children required urgent support to address their physical and emotional health needs and the risk of sexual abuse.

The family had a history of children social care involvement, which included their four older brothers and sisters being removed from their mother's care. The maternal grandmother shared the family home with Rachel, Andy and Dean and their mother.

This is significant given the children's mother's own experience of neglect and her exposure as a child to men with sexual offending history.

1.2 Family composition & anonymisation

Name	Relationship	Ethnicity/Heritage	Age at event
Andy	Brother	Mixed White / Black African heritage	10 years
Rachel	Sister	Mixed White / Black African heritage	7 years
Dean	Brother	White British	3 years
Ms X	Mother	White British	
Ms Y	Maternal Grandmother	White British	

1.3 Pen portrait

Andy is the sixth child to his mother and the eldest of his younger brother and sister. Andy is of mixed heritage with his father being of Black African ethnicity, no information was known about Andy's father. During the scope of this review very little was known about Andy except he was under the care of the paediatric incontinence service.

Rachel is mixed heritage and has a different father to her two brothers , no information was known about Rachel's father.

Dean is the youngest of the children and is white British no information is known about his father. Dean was identified as having speech delay.

Ms X and her children shared their home with maternal grandmother who played a key part in the children's daily care. It is not known if these children had any contact/ relationship with any paternal family members.

At the time of removal, the children were known to universal and early years services and had not been seen by other professionals during this time, which was the start of Covid-19 national lockdown. No professionals had, had recent contact with these children and as a result no-one knew what life was like for them.

Since coming into care the children are now settled and having their needs addressed.

2. Aim, Methodology, and Independent Review

2.1 Aim

The aim of the Local Child Safeguarding Practice Review (LCSPR) was to identify:

- **Family findings:** considering what went well and where practice was poor
- **Systems findings:** considering what enabled or what hindered good practice and the implications for influencing beyond this family.
- **Questions for the Wandsworth Safeguarding Children Partnership (WSCP)**

2.2 Methodology

The methodology incorporated the Social Care Institute of Excellence (SCIE) Learning Together and the Review in Rapid Time approach. A hybrid model was applied as the review authors received training in the SCIE Rapid Review in Time methodology in July 2021, which was almost four months after the review panel meetings started and the practitioner event was held.

The authors offered to meet with the children's mother to understand her experience of accessing services and support. Unfortunately, she did not accept requests to meet during

the writing of the report and prior to publication, so her views are not available to inform the learning from this review.

3. Review Findings and Questions for the Wandsworth Safeguarding Children's Partnership [WSCP]

This section sets out the learning from this LSCPR into the lived experience of Rachel, Andy, and Dean and identifies questions for consideration by the WSCP, in response to the four key findings identified in the review, to help decision making about what actions will be most effective in addressing the issues raised.

- **Key Finding 1**

Is the messaging loud and clear enough from leadership across the whole network, about the importance of seeing presenting concerns about the neglect of children, in the context of family history, especially where older children have been removed because of child protection concerns, and there is multi – generational child abuse and neglect?

Themes: Professional Norms and Culture and Importance of family history

- **Key Finding 2**

Across the network professionals in universal services commonly do not know what they can do personally when they are concerned about the quality of care and parenting of children, so end up gathering evidence to get children's social care involvement rather engaging with either the parent/carers or the children and naming their concerns?

Themes: Management system issue and Knowledge gaps

- **Key Finding 3**

There remains an unconscious bias whereby racist treatment of mixed-heritage children by family members is not treated with the same seriousness as racism in other contexts. This leaves emotional harm of mixed heritage children unaddressed.

Themes: Cognitive and emotional biases

- **Key Finding 4**

There is currently a vacuum in terms of helping parents and children, within and across generations, address unresolved trauma with no consistent training or approach to enable all professionals to recognise the impact and play an effective role to help or provide specialised evidence-based treatment.

Themes: Management system issues and resource gaps

4. Key Finding 1

Is the messaging loud and clear enough from leadership across the whole network, about the importance of seeing presenting concerns about the neglect of children, in the context of family history, especially where older children have been removed because of child protection concerns, and there is multi – generational child abuse and neglect?

4.1 How did the issue manifest itself in this family?

A feature of this family was that despite significant concerns about the three children by the professionals involved which included school, early help, housing, police, GP and HV, nobody stepped forward to get alongside the children and proactively try to find out more about what their day-to-day experiences were like. It is imperative for child-friendly and rights-respecting network to have reliable ways to hear the voice of children and be attentive to what their presentation and behaviour is telling us. This also means that children who are being neglected or abused have the best chance of being able to have their pain and distress noticed.

The Practitioner event identified that individually professionals were concerned about the presentation of these children with reference being made to them being observed as sullen and withdrawn despite some practitioners being aware of the family history. There was no evidence that further exploration or consideration was given to understanding multi-generational child abuse and neglect as a risk factor for these children especially with older brothers and sisters being removed from Ms X's care. Records showed that the elder brother was also a risk factor by physically and emotionally abusing Andy.

Another factor is when electronic family systems change, practitioners must have

continued access and prompts to the historical records and where possible systems should have a “flagging system” and available chronologies, so that key information, such as children having been removed, is considered when parenting assessments are being undertaken, and care is handed over to other professionals to prevent a ‘start again’ approach ensuring the needs of children are paramount.

During the period of the review, two of the main services had experienced changes to their electronic record keeping systems, processes and the family had moved into a new provider for community health services. There was no flagging system noted to local authority records or health records to alert practitioners to the previous history. However, the local authority systems may have held chronologies which would have been on the system as an attachment document, which would require practitioners to open files and access the history which can often be impacted on due to time constraints particularly when practitioners are very busy or overstretched.

4.2 How do we know that this is not a one off but an underlying issue?

Exploring why this was, surfaced that this is seen as a social worker’s role, and therefore not a role that other universal services discuss to identify who is best placed to take on. Where there is no social work involvement we can, therefore, end up with no-one talking directly to the child(ren) despite their distress and unhappiness being in plain sight.

A key factor in this family was despite significant concerns about the three children, professionals lacked curiosity to really get alongside them to proactively consider their lived experience or their mother’s capacity to care for and protect them. The same key factors here have been identified in a few of the local CSPR’s and SCR’s Grace and Georgina (2020), Child A (2019) and the Jamie Learning Audit (2020), therefore one could assume that very little change has happened across practice in relation to professional curiosity and respectful challenge where concerns have been identified and where the history is known.

4.3 How common and widespread is this problem?

Research into the learning from national serious case reviews (SCR) identified that neglect was a feature in three quarters of the 278 SCR examined, manifesting as:

children not taken to appointments, poor school attendance and developmental delay due to a lack of stimulation (Department of Education, 2020). In this family, professionals did not challenge each other or children's mother or the maternal grandmother when Rachel, Andy and Dean were not taken to appointments or presented as unkempt and unhappy. Arguably, professional optimism may have been a barrier to the children being heard and protected.

The concept of invisible children is not new, indeed the review into the death of Maria Coldwell in 1974 established that the most commonly cited reason as to why children known to be vulnerable and at risk are not protected is due to poor information sharing between professionals and agencies (Ferguson, 2017).

Other neglect families in Wandsworth and nationally have identified that workers have not considered previous family history to help with analysis and inform decision making.

4.4 What are the implications for the reliability of the system?

There is a need to ensure consideration is given to the change in electronic family systems so that practitioners have continued access and prompts to the historical records and systems talk to each other. There is also need for management oversight and supervision to ensure that practitioners are tasked/ encouraged to undertake background checks and review historical information to inform assessments and care provided where neglect or parenting concerns have been identified. Additionally, there needs to be leadership recognition of the factors that impact on practitioners such as workforce pressures, high case load numbers and timescales for completing work, practitioners understanding and compliance with national, regional, and local safeguarding processes and procedures and ease of access to historical information.

Questions for the Partnership to consider:

1. How does the partnership assure itself that practice across the children's workforce including managers and supervisors identifies multi-intergenerational child abuse and neglect and that practice draws upon innovation and developments regionally and nationally ?

2. What is the role of first line management across the multi-agency providing supervision, supporting, and encouraging curiosity by asking the right questions which seeks to identify historical concerns, “Think Family” when concerns are identified across the network?
3. How do we get the message out there that services and support is available when concerns are identified even if practitioners are not aware of the solution or services that can support?

5. Key Finding 2

Across the network professionals in universal services commonly do not know what they can personally do when they are concerned about the quality of care and parenting of children, so end up gathering evidence to get children’s social care involvement rather engaging with either the parent/carers or the children and naming their concerns.

5.1 How did the issue manifest itself in this family?

Abuse and neglect of children can trigger tragic inter-generational cycles that see child-victims with significant trauma and attachments needs, becoming parents without the emotional and psychological resources to love and care for their own children.

In this family, we saw how an abused and neglected child, exposed to known sex offenders with whom her mother had relationships, grow up and go on to have her own four children removed due to persistent neglect of them. She then relied on her abusive, neglecting mother to care for her fifth, sixth and seventh children one of whom was being bullied by one of her older children who had already been removed.

Signs that Rachel, Andy, and Dean were experiencing neglect and emotional abuse were ‘normalised’ by professionals, despite how the children were presenting, what they told professionals or that their behaviours indicated they were experiencing abuse and neglect. Professionals did not get alongside them to listen to what they had to say, consider their lived experience, or assess their mother’s capacity to care for and protect them. Historical information about the family was known by some professionals, but the impact of this was not considered in terms of the risk to Rachel, Andy, and Dean.

The practitioner event identified that individually professionals were concerned about the quality of care and parenting for the children. However, professionals did not address their concerns about Rachel, Andy, and Dean directly with the children's mother and/or the maternal grandmother at the time, partly because their mother was not seen as the main care giver due to her being at work, and professionals described feeling intimidated by the maternal grandmother.

The children's mother's role as a nursery worker was considered a protective factor; the risk she posed to her children and those for whom she provided paid care was not considered until after the children were removed in April 2020.

5.2 How do we know that this is not a one off but an underlying issue?

The review provided a window on the system regarding how professionals identify and manage families of chronic neglect and sexual abuse. Sadly, ignoring or not recognising the impact of chronic neglect or the risk of abuse (including sexual abuse) has been a recurring factor in several recent reviews undertaken by the WSCP.

There was no standardised approach across the system for professionals to consider and address the impact of chronic neglect on children. Although, child centred approach is fundamental to safeguarding and promoting the welfare of every child (Working Together Safeguard Children, 2018).

5.3 How common and widespread is this problem?

The LCSPR Grace and Georgina (2020) and the Learning Audit Jamie (2021) highlighted the lack of professional curiosity regarding parental disguised compliance and avoidance of contact with professionals was a key factor regarding professionals looking 'beyond the obvious' or questioning what they were told.

5.4 What are the implications for the reliability of the system?

Working with neglect families it is important that the right balance is achieved across services in defining and determine thresholds in determining next steps. Where agencies perceive reliance of involvement is left to one agency then the likelihood is that the needs of the family becomes lost and risks will increase where neglect/abuse is suspected.

There is a need to ensure all practitioners across the system have access to a robust model of safeguarding supervision to support reflective practice. To support practitioners with making sense of some nuances' and encourage confident curiosity when working with vulnerable families where intersectionality is a feature.

The introduction of the Graded Care Profile 2 Neglect Tool (GCP2) September 2021 and the Family Support Approach (FSA) in January 2022 and Systemic practice will support professionals to identify and measure the quality of care being given to children, where there are concerns about neglect. These tools support a consistent and agreed approach to neglect, with the focus on evidencing the child's experience and whether their needs are being met.

Both tools will enable families and professionals build relationships which will lead to better assessments and outcomes for children.

Questions for the WSCP to consider:

1. What would be the best mechanism to engage with professionals in universal services knowing what they can do as part of the multiagency network to address quality of care and parenting issues?

2. How can the WSCP ensure professionals are confident in having respectful, robust conversations with families, colleagues, and partners when they are concerned about neglect and abuse and what prevents them from talking directly to a child or parents?

6. Key Finding 3

There remains a conscious/unconscious bias whereby racist treatment of mixed-heritage children by family members is not treated with the same seriousness as racism in other contexts. This leaves emotional harm of mixed heritage children unaddressed.

6.1 How did the issue manifest itself in this family?

The children were of mixed white and Black African heritage, apart from the youngest

child Dean who was White British along with his Mother and Grandmother.

No-one spoke to Rachel or Andy to understand what life was like living in a mixed heritage household. No one spoke to Andy to find out what and how he felt to be racially abused by his own grandmother. However, what is known is the children presented as sad and expressed their emotions through their behaviours. Concerns about Andy's behaviour was expressed by the professionals in contact with him, however, there was no curiosity from professionals of what life was like for a black male in this family, neither child had contact with their fathers who were of Black African descent.

No professional explored what life was like for Andy and Rachel two children of mixed heritage living in a household where the adults were white ethnicity heritage.

The chronology and the practitioner event, references were made to incidents where the children in particular Andy were treated differently from their younger brother. Reference had been made to grandmother making racially derogatory comments towards Andy in the presence of a professional, which was documented but not explored or challenged. Rachel also commented that Mrs Y Grandmother had been nasty to her, and she did not feel comfortable in her care.

6.2 How do we know that this is not a 'one-off,' but an underlying issue?

Racism and racial abuse or bullying can be really distressing for children and young people. When a child is bullied or treated differently because of their race, it can lead to feelings of isolation, depression, anger or even shame about their race or how they look and have a significant impact on their mental health (NSPCC, 2021).

However, in this family the marked difference was how professional perceived/ understood racism within families, Andy was treated differently being a black male within a family where his parent and carer were white British.

We know nationally and locally there has been a shift in terms of professionals being reconnected and aware of racism in light of the George Floyd (2020) and Black Lives Matters movement. However, the questions remain as how to we identify racism within families and how is this managed across the network.

6.3 How common and widespread is this problem?

Evidence from a wealth of analysis of SCRs indicate that race receives limited attention or is virtually absent in reviews. It is argued that race is often an important factor influencing Black children's experiences of abuse and neglect, as well as their encounters in the child protection system (Bernard, 2018).

From the WSCP reviews undertaken within the last 18 months the issue of abuse and neglect in mixed heritage children has been a theme identified.

There is limited body of research into racism within families, as a result conscious/ unconscious bias remains an area requiring further work and exploration to understand racism and the impact of emotional harm on children, alongside understanding and addressing racism and discrimination towards children of mixed heritage within the concept of the family. This type of action is recognised as a hate crime defined as 'Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's race or perceived race.'

From the practitioner event it was noted that practitioners working with the family did not challenge the discriminatory behaviour towards Andy. The reason remains unknown; however, one could suggest practitioners did not feel confident to address this issue or may not have recognised the impact nor this to be a criminal offence.

6.4 What are the implications for the reliability of the system?

Leadership and support are required within all organisations to ensure the impact of racism on children of mixed heritage within the family is fully understood in the context of emotional abuse and can be appropriately called out for what it is, and children can be safeguarded. In addition, there is a need for all leaders/professional to identify and address racism within the workplace.

Questions for the Partnership to consider:

1. How does the WSCP assure itself that safeguarding practice proactively identifies, assesses, challenges, and responds to racism that children may experience within their family in the context of harm and abuse. Is the WSCP assured that professionals are aware of the emotional impact racism and discrimination has on children when experienced within the family context and it is not addressed?

2. What is the evidence that the WSCP is robustly challenging racism and setting priorities around anti-discriminatory practice?

3. Are there wider training and assessment examples that can be built into the educational /all establishments in relation to conscious/ unconscious bias and racism within practice across the Southwest London Integrated Care System (ICS)?

7. Key Finding 4

There is currently a vacuum in terms of helping parents and children, within and across generations, address unresolved trauma with no consistent training or approach to enable all professionals to recognise the impact and play an effective role to help or access specialised evidence-based treatment.

7.1 How did the issue manifest itself in this family?

Family and social norms experienced in childhood that are deemed as being 'less than nurturing', can lead to feelings of shame and affect how children form relationships and attachments with their primary care giver (NSPCC, 2021). In this family the mother and the maternal grandmother were involved in caring for the children.

The removal of Rachel, Andy, and Dean to a place of safety in April 2020 exposed professionals to the lived experience of the children and the multiple traumas they had suffered in their young lives. It galvanised that the children were powerless to stop the fear, abuse, and shame they were experiencing and how they relied on professionals

advocating and acting to protect them from harm and abuse.

Professionals working with the family seemed oblivious to the inconsistency between how Rachel and Andy presented at school and what they were saying, compared to what their mother reported. The impact of the mother's adverse childhood experiences and abuse were not considered, in terms of her ability to safely parent her children.

7.2 How do we know that this is not a one off but an underlying issue?

Unresolved trauma and adverse childhood experience and parenting capacity has been identified in recent reviews undertaken by the WSCP. The reviews have highlighted the lack of robust parenting and risk assessments by professionals to safeguard and protect vulnerable children.

7.3 How common and widespread is this problem?

There is a growing body of research into acknowledging the impact of unresolved trauma and how to address it. Locally professionals across the system do not have the understanding or the resources to recognise, assess and plan care in relation to intergenerational and unresolved traumas, such as sexual abuse, neglect, or exposure to domestic abuse.

7.4 What are the implications for the reliability of the system?

Implementing a trauma-informed methodology across the health and social care system in Wandsworth must be a priority to ensure all professionals working with children to understand and respond to the cause and effect of trauma on a child's health, educational and social potential and ultimately their life chances.

Question for the Partnership to consider:

1. What is the best mechanism to embed a trauma informed approach across the system in Wandsworth that acknowledges the lived experiences of children and their parents and how Southwest London Integrated Care System (ICS) assist this by addressing wider determinants of trauma?

The review posed assurance questions of the WSCP; the action plan provides assurance in response to those questions, and redefines the learning.

Appendix 1

System Challenge Questions for the WSCP to consider

1. How does the WSCP assure itself that practice across the children's workforce including managers and supervisors identifies multi-generational child abuse and neglect and that practice draws upon innovation and developments regionally and nationally?

2. What is the role of the first line management across the multi-agency providing supervision ,supporting and encouraging curiosity by asking the right questions which seeks to identify historical concerns, "Think Family" when concerns are identified across the network?

3. How do we get the message out there that services and support is available when concerns are identified, even if the practitioners are not aware of the solution or services that can support?

4. What would be the best mechanism to engage with professionals in universal services knowing what they can do as part of the multi-agency network to address quality of care and parenting issues?

5. How can the WSCP ensure professionals are confident in having respectful, robust conversation with families, colleagues, and partners when they are concerned about neglect and abuse and what prevents them from talking directly to a child or parents?

6. How does the WSCP assure itself that safeguarding practice proactively identifies, assesses, challenges, and responds to racism that may experience within their family in the context of harm and abuse. Is the WSCP assured that professionals are aware of the emotional impact racism and discrimination has on children when experienced within the family context and is not addressed?

7. What is the evidence that the WSCP is robustly challenging racism and setting priorities around anti-discriminatory practice?

8. Are there wider training and assessment examples that can be built into the educational /all establishments in relation to conscious/unconscious bias and racism within practice across the Southwest London Integrated Care System (ICS)?

9. What is the best mechanism to embed a trauma informed approach across the system in Wandsworth that acknowledges the lived experiences of children and their parents and how the Southwest London Integrated Care System (ICS) assist this by addressing wider determinants of trauma?