



## **Family 'A' Serious Case Review**

### **Response by Somerset Safeguarding Children Board (SSCB)**

This Serious Case Review (SCR) concerns three children from the same family who experienced neglect between 2012-17. Somerset Safeguarding Children Board deeply regrets the years of neglect experienced by these children and the lack of a concerted, effective and timely response by too many agencies.

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs. It can have a serious impact on a child's life.

The purpose of the review was to look at individual and collective agency involvement with the family to understand what happened and why, in order to take action which results in lasting improvements to the effectiveness of multi-agency practice for those children who experience chronic neglect and sexual abuse.

SSCB is grateful to the middle child of the family who helped us with this review by contributing their thoughts and reflections, helping us to understand fully what happened in order that we might be better informed in preventing other children from experiencing persistent neglect in the future. The report has been significantly strengthened as a result.

The report highlights a number of areas in which professional practice in Somerset fell short of the standards expected. These include:

- Poor identification and assessment of the neglect the children were

experiencing with a lack of effective interventions.

- Professionals not addressing the parents' resistance to agency offers of support and attempts at statutory intervention.
- A focus on maintaining a working relationship with the family – leading to a 'start again' syndrome<sup>1</sup> and a limited understanding of the lived experience of the children over a period of time.<sup>2</sup>
- Concerns about the children were not being recorded and communicated systematically, as required by statutory guidance.
- Agencies not escalating concerns when they did not agree with what was happening.
- The ineffective use of statutory arrangements as part of the planned multi-agency intervention with a family.
- Ineffectual responses to suspicions and allegations of sexual abuse, including confusion about the requirement for consent within the child protection process.

SSCB and all the agencies involved accept the report and its conclusion that the significant neglect experienced by these children should have been identified and responded to earlier. All agencies involved with the family over the years share some responsibility for the failure to address the safeguarding needs of these children.

In considering its response, the Board recognises that the events described in the review took place over a number of years. Since that time, there have been significant changes locally to understanding, training and practice standards across the professional system. A number of the recommendations made in the report have also been addressed or are in progress, including:

- Developing a Neglect Strategy, Neglect Toolkit and associated training materials. The toolkit helps professionals to recognise and assess the impact

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<sup>1</sup> [Analysing Child deaths and serious injury through abuse and neglect: what can we learn 2008](#) p5. The 'start again syndrome' prevents practitioners thinking and acting systematically in cases of long-standing neglect.

<sup>2</sup> [How children become invisible in Child Protection Work: Findings from research into Day-to-Day Social Work Practice](#). This paper examines how social workers become overcome by the complexity of the task and are also affected by organisational cultures and insufficient resources.

of neglect on a child at an early stage and provides the basis for effective support and assistance. Since its publication on 29 June 2018 the Neglect Toolkit has been downloaded from the SSCB website on 2216 occasions. The training materials, associated with the toolkit, have been requested on 65 occasions since it was published in October 2018.

- Revising and publicising the 'Resolving Professionals Differences' protocol, to facilitate professional challenge where concerns exist around effective planning for children, which may not ensure a child's safety.
- Ensuring that schools are fully compliant with the statutory guidance 'Keeping Children Safe in Education'. In addition, professional safeguarding support to schools has been enhanced through the local authority.
- Holding agencies to account for practice standards through use of audits and case reviews, and by regular reporting to the Board.
- Participation in a multi-agency peer challenge with another local authority, focusing on recognition and response to neglect across the partnership.
- Stabilising the children's workforce within social care and education.
- Training for Child Protection Chairs and development of systems to facilitate case escalation to senior managers.
- Increased senior manager oversight of cases in pre-proceedings and in family court proceedings.
- Addressing the points raised in the Serious Case Review about the response to individual victims of sexual abuse to ensure every step is taken to bring to justice those who abuse children by improving the recording of crime and tackling national concerns about the apparent lack of recognition of boys through education and training

- Promoting greater understanding amongst health professionals of their roles and responsibilities to safeguard and protect children at child protection case conferences, especially when the proposal is to end a Child Protection Plan.

A multi-agency action plan has been developed by the SSCB in response to the review findings. The plan includes the following actions, some of which are already in progress:

- Developing and delivering training on working with families who are difficult to engage, whilst maintaining unwavering focus on the lived experience of the children.
- Renewing the SSCB's focus on child sexual abuse, to include practice standards, training and effective interventions, in addition to holding individual agencies to account for their professional practice in this area.
- Reviewing the impact of the neglect strategy and toolkit through a multi-agency audit in 2019.
- Strengthening multi-agency training on statutory child protection processes, to include a greater emphasis on understanding the limits of parental consent. This will include regular auditing of child protection plans.
- Seeking assurance from individual agencies that their practitioners are sufficiently trained in detailed, contemporaneous record keeping and are able to substantiate their professional judgements. Case records must also be monitored through supervision.
- Developing training for early help practitioners focused on the recognition, impact and effective response to neglect.
- Incorporating content across all multi-agency training which reflects the particular vulnerabilities of children with additional needs to abuse and neglect.

SSCB will closely monitor the multi-agency action plan and will continue to hold individual agencies to account in addressing the shortcomings in practice identified in the course of the review.