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**Childhood Neglect and the Multi Agency Response**

**Forms of Neglect**

* **Supervisory:** Children- not protected from danger and harm. Younger children-Greater risk of accidents. Older - failure to protect from risky behaviours such as substance misuse.
* **Medical Neglect**: May include failing to seek treatment for emergency or acute illness. Failure to provide care and treatment for chronic illnesses or disabilities.
* **Educational Neglect**: When parents and caregivers do not adequately meet children and young people’s need for stimulation, or support them in education.
* **Physical Neglect:** Failure to provide for basic needs, including not providing adequate nutrition, clothing or shelter.
* **Emotional Neglect:** Failure to meet and respond to children’s emotional needs and develop appropriate attachment relationships. Can include failure to promote a positive sense of self in the child or young person.
* **Socialisation Neglect**: A failure to take account of the need of the child or young person to engage positively with peers and significant others
* Children may experience neglect in all aspects of their care (global neglect), or only some aspects. Neglect often co-exists with other types of abuse.

**A Framework for Considering Neglect**

* The form the neglect takes and the aspects of the child or young person’s life that are affected.
* Its persistence and pervasiveness.
* The impact from the point of view of the child.
* What has caused the caregiver to neglect the child
* Whether neglect is intentional or unintentional, and if the caregiver has commitment and capacity to change.

**Mark and Sarah**

Mark is seven. He lives with his parents and sister in a flat with no carpets and curtains. His bedroom is full of bin bags of rubbish, and his clothes are left mixed in with more rubbish on the floor. He sleeps on a stained mattress with an old blanket. The family’s flat is cold and in a poor state of repair. Mark’s parents keep their dogs inside and there is both dried and fresh excrement on the living room floor, walls and sofa. Mark’s sister is Sarah. She is three years old. Sarah and her brother haven’t received any childhood immunisations and they both regularly experience colds and gastroenteritis due to their living conditions. Sarah’s father has limited involvement in his daughter’s day-to-day care. Her mother doesn’t like the nursery, so she doesn’t take her there. Instead, Sarah spends long periods in a baby walker that has had its wheels removed. Mark attends school irregularly and his parents do little to encourage him to participate more. Mark and Sarah’s parents are struggling with addictions to drugs and alcohol, and find their children’s demands for attention and cuddles difficult to cope with. Sometimes they get angry with the children because they are not able to look after themselves.

**Aisha**

Nine-year-old Aisha has spina bifida. Spina bifida is a fault in the development of the spine. For Aisha, this means that she is partially paralysed, leading to weakness in her leg muscles. She has crutches and ankle supports to help her mobility.​

Aisha’s grandmother, who looks after her, does not believe Aisha needs special treatment. She thinks too much of a fuss is made about it all. She doesn’t take Aisha for her regular hospital appointments or physiotherapy sessions, and does not implement the plan of physical exercise recommended​

She also does not believe it is necessary to use the special equipment provided, and has put it all in the shed. ​

**NEGLECT CASE VIGNETTES**

Please consider the case study below which is based on real cases taken from Brandon 2013. On flip chart paper:

* **Using the different areas of neglect identify which are present in this case.**
* **Discuss the lessons learnt in your group.**
* **Bullet point the implications this learning has for your practice**.

**Composite Vignette – ‘Ben’ aged 6 – medical neglect**

**Key features of the case:**

**•** Ben had an epileptic seizure when unsupervised and drowned.

**•** Ben was born prematurely to a young mother who had limited extended family support.

**•** After Ben was diagnosed with epilepsy, numerous health care professionals became involved with the family.

**•** A pattern of missed medical appointments, and concerns that medication was not always being administered properly.

**•** A caring mother who, when prompted, improved care, attendance at appointments – as a result of which health services never referred to children’s social care.

**•** After the birth of Ben’s sibling, his mother’s administration of Ben’s medication was increasingly erratic.

**•** The health visitor was concerned about Ben’s slow weight gain, developmental delays and seizures after his sibling’s birth but there was no contact with Children’s Social Care (CSC).

**Event prompting the serious case review:**

This serious case review was conducted following the drowning of six-year old Ben, after an epileptic seizure.

**Background to the family and case:**

Ben was born prematurely to a mother in her early 20s. Not much was known about Ben’s father although he was intermittently involved with the family and sometimes lived with Ben and his mother.

Ben’s epilepsy required regular hospital visits and medication. Although judged to be aware of her child’s complex medical needs, his mother had difficulty attending all of Ben’s medical appointments and was not always consistent with administering his medication. The health visitor observed that she was struggling to cope but also had a loving bond with her son. Medical professionals who cared for Ben noted that he had a sunny disposition and that his mother tried her best. When medical appointments were missed, professionals responded by making new appointments but did not puzzle over the reason for the missed appointments or consider making a referral to children’s social care.

When Ben was five years old, his mother gave birth to a second child. It is not clear whether this child had the same father as Ben, as the mother had recently told her GP that she and Ben’s father had separated. After the sibling’s birth, Ben’s mother took him to fewer medical appointments. Hospital staff were increasingly concerned about Ben’s failure to grow and suggested that his mother was not appropriately administering his medication, which she denied. Despite suspicions, hospital staff failed to follow-up on these concerns and did not contact children’s social care. When the health visitor suggested a referral to a social worker, the mother refused the health visitor access to her home but still no referral was made.

**Types of neglect experienced:**

Ben’s mother failed to act on medical advice regarding her child’s complex health needs and had a longstanding difficulty in keeping up with medical appointments, including specialist visits, and a history of not always administering Ben’s medication when he ‘seemed better’. When prompted by professionals, these patterns improved for a while but inevitably deteriorated again. The mother’s failure to act on medical advice put her child at risk of developmental difficulties and seizures such as the one which preceded the drowning. Whether Ben’s mother’s failure to administer his medication was accidental or deliberate is hard to say. Lapses in essential supervision while she cared for her new baby suggest that Ben had possibly become less of a priority or more of a burden to his mother, or that she could not cope with Ben’s

complex needs as well as the demands of a young baby.

**What it was like to be a child in this family:**

Ben was secure in his mother’s love and interest and he enjoyed and benefitted from playing with her and singing songs. His life was not always predictable however and things at home were different when his father was around, when his mother did not play with him so much and there were sometimes arguments. When Ben’s baby brother was born things changed and Ben’s mother had less time for him and forgot to give him his medication more often. He knew he had to look after himself now and was on his own more often and didn’t go to the hospital or see the doctor so often. Without regular medication Ben had more seizures, and in the days that followed, less energy and more impaired function. Life was harder, more confusing, and at times frightening.

**Agency involvement:**

**• GP and specialists:** Many medical professionals including specialists remained involved with Ben throughout his life because of his diagnosis and saw him frequently in spite of numerous missed appointments. Although hospital staff were concerned that Ben’s mother was not managing Ben’s health related needs, they did not refer the case to children’s social care as they felt the otherwise loving mother was complying with their concerns and attempting to improve.

**• Health visiting:** Two health visitors were involved in Ben’s life. The first health visitor observed that the relationship between him and his mother was warm, and that Ben seemed happy and confident. The

home, although small, was clean and comfortable with adequate food. Although the relationship between the mother and the health visitor was initially good, it deteriorated when the health visitor became concerned about Ben after his sibling’s birth. She discussed involving social care, and as a result Ben’s mother stopped seeing the health visitor. The second health visitor did not follow up on her colleague’s suggested referral.

**Learning:**

Themes emerging from the serious case reviews included:

**• Undue professional optimism:** While Ben received adequate medical treatment and was prescribed medication, medical staff did not follow up his failure to grow and thrive. Even when staff suspected the mother might not be administering medication appropriately, the case was not referred to CSC as they wanted to give her more time to improve. The SCR suggests that medical professionals may be overly optimistic that families will be able to care for a child with a long-term illness even when there is evidence to the contrary.

**• Non-compliant parent(s):** Ben’s mother refused to continue working with the first health visitor when she expressed concerns over Ben’s deterioration after the birth of his sibling. Rather than follow up on the

health visitor’s intentions of involving social care, however, she was replaced by a second health visitor who again allowed the mother time to improve. The SCR suggests professionals did not appropriately

challenge the mother’s behaviours in order to safeguard Ben.

**• Changing family circumstances:** Professionals (health care and second health visitor) did not seem to have considered the impact of another child’s arrival in a family unit, where the mother was already

struggling to care for a child with a long-term serious medical condition and a newly ended relationship. While allowing the mother more time to cope might have been an adequate response for a limited period

of time, the changing family circumstances should have prompted a change in approach.

**• Failure to involve father/partner:** There was no sign that professionals included the father of the child in any assessment or asked about his involvement with Ben. For a long time, the identity of the father seemed

unknown to professionals. This led the SCR to highlight the importance fathers/partners have on children’s wellbeing.

**Please consider the second case study below which is based on real cases taken from Brandon 2013. On flip chart paper:**

* **Using the different areas of neglect identify which are present in this case.**
* **Discuss the lessons learnt in your group.**
* **Bullet point the implications this learning has for your practice.**

**Composite Vignette – ‘Chloe’ aged 2 – house fire**

**Key features of case:**

**•** Chloe, who was 2 years old died in a house fire; her siblings managed to escape.

**•** Both Chloe and her three siblings were the subjects of child protection plans under the dual categories of neglect and emotional abuse, at the time of the incident.

**•** Long history of severe neglect and inadequate response by agencies.

**•** Maternal alcohol abuse.

**Event prompting the serious case review:**

A young child died in a house fire at their home. The fire service were able to rescue the mother and her other three children. The fire was attributed to the use of candles in the house as the pre-payment meter had been disconnected and there was no electricity. The mother was found to be in a highly intoxicated state. The smoke detector at the property was not working, and investigation by the fire service showed that this was not the first incident of a fire at the address. Following an earlier incident the risk to the children from a house fire had already been discussed with the children’s mother by a fire officer.

**Background to the family and case:**

The mother, who was in her mid-twenties, was living on her own with her four children at the time of the incident. Chloe was the third child in the family – she had two older siblings of primary school age, and a baby brother.

As the family size grew, the mother was increasingly unable to cope and home conditions and the children’s physical care steadily worsened. There were also an increasing number of reports from neighbours of instances of violence and alcohol abuse.

The mother’s own experiences of being parented were poor and she had endured many negative experiences throughout her life and had been in care as a teenager due to both sexual and physical abuse at home. She had experienced depression for many years and attempted to manage her personal distress through the harmful use of alcohol. Chloe’s mother had a number of partners, from the birth of her first child onwards, some of whom had lived at the family home. Little information was available about

Chloe’s father, although the mother had said that domestic violence had been a feature of this relationship.

**Types of neglect experienced:**

The children experienced physical neglect; there was mention of decayed teeth, matted hair, and the children smelt of urine. Their health needs were neglected, with a number of missed medical appointments, including antenatal and postnatal attendance.

There was a lack of safe parental supervision; the children were left unsupervised, or left with unsuitable carers. The home environment was disorganised and unsafe. There was a lack of hygiene in the house, a state of disrepair and the accommodation posed a fire risk. Old food and faeces were on the floor. There were also concerns about the number of pets at the property and minor bites and scratches caused by the animals to the children. There were overflowing ashtrays and matches around the house.

**What it was like to be a child in this family:**

The mother’s capacity to care for the children had decreased with each new birth, and she became increasingly emotionally detached from her children. Basic needs were poorly met, and the children often went hungry, had no bed linen, and hardly any toys. The lack of supervision, the squalor, frequent

house moves and, above all, the mother’s alcohol intake must have made all the children’s lives very bewildering and distressing.

**Agency involvement:**

Over time a large number of social workers and family support workers had been involved with the family, and concerns over the care of the children had been voiced by health visitors, police, a nursery assistant, a school nurse/school staff and neighbours. Following a domestic violence incident, police were concerned about the conditions in which the children were living, and subsequently a child protection enquiry was initiated and a core assessment undertaken. All the children ultimately became the subject of a plan for

emotional abuse and neglect. Initially the mother was noted to be making an effort to cooperate and to attend appointments with social workers, however her engagement became increasingly sporadic and unsatisfactory. Health appointments for the children were not kept, including for spectacles,

dental care, and speech and language therapy. These specialist services responded by closing the case instead of treating non-attendance as a warning sign, triggering greater vigilance. The oldest two children were at primary school, where repeated absences, dirty clothing and hunger were noted but the information was not always passed through to children’s social care in a timely manner. Chloe attended nursery, where health visitor concerns about an injury to the child were discussed and passed on to the mother, but not to children’s services. Chloe was noted to play happily at nursery, as were her siblings at school, and the clean and stimulating play environment provided predictability and a respite from the chaos and lack of play facilities at home.

**Learning:**

Themes emerging from the serious case review included:

**• Drift:** At one point, there was no social worker allocated at all and concerns reported by other agencies were not responded to. Assessments were often not completed and there were recording gaps in the CSC files. There was no sense of urgency regarding this family even when heightened concerns resulted in a child protection plan for all the children. Key staff rarely attended core group meetings and tasks were undertaken by a social work assistant rather than a qualified and experienced social worker. There was confusion and delay in responding to the threat of homelessness, and the critical housing issues that the family faced. Even after this tragic accident, this sense of lack of urgency continued, and a year passed without any formal multi-agency review of progress in safeguarding the surviving children. This practice was set within a broader context of overwhelming workload, high staff turnover and vacancy rates alongside high numbers of unallocated cases.

**• Tolerance by professionals of dangerous conditions and poor**

**care:** The older siblings had been described as ‘happy and playful’ despite smelling of urine, glasses frequently missing or broken, minor illnesses, and school absences. This sense that the children were happy

seems to have allowed agencies to avoid action. This was combined with a professional tolerance of extremely poor, cramped and unsafe living conditions. The children’s welfare was thought to be ‘good enough’ and the mother considered to be ‘just about’ coping without any clear sense of what this meant in relation to the children’s development or immediate safety.

**Serious Case review Undertaken into the death of Child I**

**Lambeth Safeguarding Children Board**

**Group Activity**

1. **Read the case study individually**
2. **Considering the categories above evidence the extent of neglect.**
3. **Applying the framework what are your conclusions?**
4. **Consider why professionals may have failed to respond to the neglect the children were experiencing?**

**On the morning of 23 July 2013, mother left the house to take their eldest child to school. On her return, she found Child I in the bath face down. Attempts made to resuscitate Child I, were not successful. He was pronounced dead on arrival at hospital. Although the exact circumstances of Child I’s death were not clear, and were subject to on-going police investigations, the pathologist concluded that Child I’s death was consistent with drowning. Mother reported that she placed Child I in the bath that morning, advising father that she had done so, before leaving the house to take the eldest child to school. The three remaining siblings were removed using police protection powers, and were placed in foster care.**

**Family Composition**

|  |  |
| --- | --- |
| **Family Composition Family member**  | **Age in July 2013**  |
| Father  | 24  |
| Mother  | 26  |
| Sibling 1  | 6  |
| Sibling 2  | 3  |
| Child I  | Aged 1 year 8 months at time of death.  |
| Sibling 3  | 9 months  |
| **Ethnic Identity**  | White British  |

Child I was born in November 2011 to white British parents living in Lambeth. Child I had two older sisters, a younger brother and a large maternal family, all of whom lived in Lambeth. His childhood was spent living at home with his mother and father and his siblings; he was described as a “happy bonnie” child. Both parents had been known to professionals, from various services, since their childhood. In his teenage years, father had been assessed as having a learning disability. Mother was also thought to have learning difficulties; she had been the subject of a statement of special educational needs (SEN), as a child.

Prior to the birth of the second child in the family (Sibling 2), in April 2010, an assessment using the Common Assessment Framework (CAF) was completed. This led to the allocation of an early intervention social worker. The family were assessed as being vulnerable and isolated and there were concerns about parenting capacity, and domestic violence/anger management. There was regular input from the Early Intervention Multi-Agency Team (MAT) and a number of services were provided to the family during this time.

In August 2011, Sibling 1 was found to have an injury to her eye and was referred to Children’s Social Care. A child protection investigation commenced. In November 2011, Child I was born. The child protection investigation, into the injury to Sibling 1, resulted in an initial child protection conference, on 18 November 2011 all three children were made the subject of child protection plans, under the category of neglect. They remained the subject of child protection plans, until July 2013, when I died. A wide variety of services were provided. These services supported the parents in their care of their children.

The birth of the fourth child, the youngest child in the family, in September 2012, was a challenging time for the family.

A conservative estimate, of the professionals, staff members and their managers involved, numbered over 40 individuals. Although child protection conferences and core group meetings were generally held within required timeframes, there were no separate pre-birth assessments, or conferences, held on the new infants. Instead, discussions about risk to Child I and Sibling 3 took place alongside the discussions on risk to the other children in the family. This had a detrimental impact on the planning for all the children – the specific needs of the new infants were not considered, nor the critical nature of the increased risks posed by the growth of the family – this was contrary to procedures. Key professionals, who could have provided first-hand accounts of their work with the family, either did not attend, sent a substitute or were not invited. However, the onus of professional intervention was disproportionately slanted towards the provision of more and more support services. Critical aspects of plans, made at the child protection conferences aimed at protecting the children from harm, were not implemented in a number of areas.

Overall, professional interventions were characterised by a superficial response to the presenting issues. The needs of the parents and the children were viewed in isolation, and services were provided to address each of the presenting needs. These presenting issues/needs were symptomatic of neglect, yet whilst many of the interventions dealt with the symptoms; the whole picture was not brought together by any of the agencies, either individually or collectively. None of the services effectively dealt with what was driving the neglect, or put another way, the causes of neglect. Judgments about progress were predicated on mother’s ability to access the services offered, and the children’s response to the services. These judgments were made on the basis of the ‘here and now’ evidence, not on the overall picture. This resulted in a pattern of interventions and service provision which lacked an overall coherence. This had a direct impact on the way in which the parents understood what they needed to do, to bring about meaningful change in the parenting of the children. This led to risk assessment, and decisions made in response to evidence of risk, being incident driven and left largely in the hands of the social worker and case conference chair. An existing multi-agency Lambeth Safeguarding Children Board protocol that outlines the need to work jointly with adult services to safeguard children, where parents have learning difficulties, was not followed.

A protocol in place in the CYPS, which ensures senior management review of children who are the subject of child protection plans for eighteen months, was initiated but was not concluded. Hence, an opportunity for senior management overview, at this critical juncture, was missed. This was particularly noted in relation to the absence of any coherent multi-agency plan/action to prevent accidents within the home

***Balancing the needs of the parents with risks to the children***

Throughout the period under review, both parents were frequently observed to be hostile and aggressive, and, in a number of areas, resistant to change. Parental behaviour frequently disrupted the functioning of meetings and the implementation of plans. When challenged, father would often become verbally abusive and threatening, particularly to a number of social workers. This meant that social workers often felt unable to challenge his behaviour for fear of reprisal, and worked hard to engage with father and to avert his rage. These emotional needs of the parents eclipsed the needs of the children- this was not sufficiently recognised or acted upon.

***Hearing the voice of the child***

During the course of this review it was difficult to gain a picture of Child I and his siblings. Their personalities, their likes and dislikes and their relationships, were largely unrepresented in the data gathered. There were good attempts by social workers to work directly with Sibling 1, in order to elicit her voice. However, during this work, Sibling 1 was found to be withdrawn. There was information available to suggest that Sibling 1 was silenced by the actions and words of her parents, but this was given insufficient attention. Due to the age, and communication needs, of the other children in the family, direct work to elicit their voices through the spoken word was not possible. There was a range of information available that should have enabled professionals to interpret the children’s voices. Observations, detailed in social work reports, revealed the children would seem ‘oblivious’ to the anger and hostility of the parents, and maternal family members, and to exist ‘as if they were in their own bubble’. These were good examples of the children being observed at home that provided opportunities to gain important insights into their worlds. Other professionals noted their observations during parent-child interaction, or through what they saw displayed in the children’s behaviour, but few saw the world through the child’s eyes. This left the voices of the children unrepresented in the evaluation of risk, and in the provision of services

***Compliance with procedures***

The four children in the family were suffering from harm associated with neglectful parenting. However, professional practice showed a seemingly contradictory pattern in which professionals placed significant emphasis on investigating and ‘proving’ some physical injuries, at the expense of considering numerous other indicators of neglect. There were a number of bruises observed on the children, and a number of concerns were identified that provided medical evidence of neglect. There were two occasions when concerns were investigated (under s47 of the Children Act 1989), triggered by concerns about physical injury to the children. However, there were also occasions when concerns were not the subject of multi-agency investigation under the required procedural framework10. These concerns included the significant weight loss experienced by Sibling 3, a significant finger injury to Sibling 3, a burn on Sibling 1, and bruises seen on Sibling 2 and Child I. The lack of investigation of these concerns meant that information about the injuries either was not shared, or, when it *was* shared, it was not given sufficient weight in the consideration of risk.

***Balancing risks and strengths***

In this case perceived strengths were given undue weight in comparison to risks.

***Parental learning difficulties***

The learning difficulties of the parents were “obvious” to the multi-agency group. These difficulties were not sufficiently understood in order to inform risk assessment and service provision. Father had been assessed by the Children’s Looked after Mental Health Service (CLAMHS) as a teenager, when it was concluded he was functioning at half his chronological age. In terms of his future, the assessment concluded: *“we would not expect him to ever manage his daily tasks fully independently”*. Mother’s presentation suggested to professionals that she had a learning difficulty, and it was understood that she had been the subject of a statement of special educational needs (SEN), when at school.

On many occasions, father was observed to be in the sole care of the children at home. Practitioners believed, and on occasions observed that, whilst they were in his care, he did not provide adequate supervision to the children. He was often pre-occupied with loud and violent video games, and seemed ‘oblivious’ to the children’s emotional needs. Father rarely engaged with the services provided to the children, he did not adequately feature in assessments, aimed at understanding parental roles, or in plans and services put in place to improve parental capacity.

When assessing the care the children were being provided with, and when targeting interventions, the assumed learning difficulties of the parents were responded to sympathetically. However, the way in which these difficulties impacted on the parenting of the children was not given sufficient attention. There was no consideration given to obtaining learning disability support services for the parents in their own right.

The existing Lambeth Safeguarding Children Board protocol (September 2010), is very clear about the joint work that is required between adults and children’s services. Namely, that individuals who have a learning difficulty and are parents are entitled to a services from Adult Social Care learning disability services, and should be referred by children’s services. This protocol was not followed, and the need to make a referral to, and work with, adults’ services was not identified by any members of the multi-agency group, or their managers. Failure to follow the required protocol had the effect of silencing the voices of both the parents and the children. Written agreements, minutes and assessments, neither took proper account of parental learning difficulties, nor provided this documentation in a form that would have permitted parental understanding. The experiences of the parents, in being involved in the complexities of the child protection processes, were not understood, and as a result the support provided to the parents in these processes, whilst well-meaning, was ill-informed. The needs and experiences of the children, living with parents who had learning difficulties, were unknown.

 ***Written agreements***

*Written agreements* were used in response to safeguarding concerns, to supplement the protection planning. These written agreements were put in place in order to provide the Local Authority with parental assurances that the maternal grandfather would be supervised in his contact with the children, and that the maternal grandmother would stay with the family to support the early care of Child I. These agreements were not shared with a significant number of multi-agency group members. Both agreements were immediately, and consistently, breached by the parents. There was no action taken in response to these breaches, and the written agreements remained unchanged. At best these agreements provided no added protection to the children. At worst, they served to undermine the protection of the children by providing a false sense of security.

**Professional response to Sibling 3’s ‘failure to thrive’: December 2012 - May 2013**

Minutes from the child protection conferences, recordings on file, and reports from the Case Group, suggested there were a number of assumptions made by the multi-agency group. These assumptions were not adequately articulated or assessed. A number of these were held onto, regardless of information available to suggest the assumptions were based on a false premise. This included an assumption that the children’s basic care needs were being met.

There were times when the parents were not able to meet the children’s basic care needs. When Sibling 3 was seen by the family GP for his 8 week developmental check, he was found to have lost weight and was below his birth weight. The GP, and members of the child protection conference, assumed that his weight was being measured, and plotted, by health professionals in the community. This was a reasonable, but incorrect, assumption. Proper management of Sibling 3’s weight did not happen, and fell short of expected standards. Medical investigation concluded there was no medical reason for this loss of weight. Implicit in this conclusion, and in the actions taken by the GP, was that Sibling 3 was not being fed an adequate amount of milk. The loss of weight was reported to Children’s Social Care (CSC), but there was no multi-agency child protection response to this incident.

At a Review Child Protection Case Conference (RCPCC), in May 2013, a recommendation was made to seek legal advice, with the view to place the case within legal proceedings. This recommendation was not made in response to Sibling 3’s failure to thrive, it was made in order to achieve funding for a specialist assessment. The recommendation was not acted upon with sufficient speed, and the case continued along the same path.

**Family Perspectives**

The perspectives of Child I’s parents were gained during a meeting involving the Lead Reviewers, both mother and father were present. The purpose of the meeting was to gain an understanding of parental experiences. This was not an investigatory interview, in that it was not an opportunity to establish fact or to challenge parental perspectives. The meeting was held in an attempt to understand how mother and father experienced the services that were provided, and to see this period of time through their eyes. The following is a summary of this meeting:

At the start of the meeting, both Mother and Father reported that they did not understand what they needed to do to change the way in which they provided care to their children. Mother: *“I just did not know what I was supposed to be doing”.* This remained a theme throughout the meeting. When Mother was asked how professionals viewed father’s role in the family, she replied: *“Social Services wanted me to leave father with the kids more often…….. That was their solution to make him do more”.* Mother went on to describe the parenting routines within the household that included the different responsibilities for bathing the children: “(*Name of father) would bath the boys and I would bath the girls….. (Name of father) would help the girls to put on their pyjamas after their bath”.* The range of information, provided by the parents, suggested that the role of father, in the parenting of the children, had been critical in a family where there were 4 small children.

The parents spoke about not getting the help they needed and of feeling let down by the agencies, and a number of professionals, providing support to them. When asked what support they felt they had needed, mother talked about needing help with the children’s routines and with parenting skills. She spoke about waiting for support from an organization (which she named), but said that this had not been provided. She spoke about the kind of support she would have received at home, had the funding for this help been agreed.

Whilst the parents were positive about a number of professionals, they felt angered and frustrated by others. When mother was asked about the things she would have wanted to change, about the services she received, she answered: *“Don’t talk down to me, talk to me as an adult instead of talking to me as if I am a child (I hated them for that)”.*When speaking about the meetings she attended (core groups and child protection conferences), she talked about how difficult she had found these meetings. *“I felt ambushed …I never saw any of the reports before the conference……people said things at the meeting that they had not told me about before…….I could not read the reports or the minutes.* It was observed by the Lead Reviewers that during these discussions mother appeared to be demonstrating her frustrations in being within a process that she experienced as on one hand patronising, and on the other as showing a disregard for her needs.

The Lead Reviewers noted mother seemed to have a slight speech impediment. Mother was asked if she had any difficulties with her hearing. She stated that she had, and described receiving treatment as a young child for “a hole in my ear drum”. The Lead Reviewers subsequently confirmed that mother had a glue ear and repair of a ruptured ear drum in childhood, and wondered whether this had affected her speech development. Mother described problems with her hearing, particularly in hearing someone who is placed some distance from her. She demonstrated the distance at which she found it difficult to hear, and showed how near somebody would need to be in order to hear them. The Review Team were left wondering whether this would have had an impact on her engagement in meetings, particularly case conferences, where members sit some distance away from each other in a formal setting. It was concluded that the problems mother identified with her hearing, combined with her learning difficulties, would have placed additional strain on mother, in attending these meetings.

**The Findings Finding 1: There is an insufficient understanding of the concept of neglect and how to understand and articulate the cumulative impact this has on the health and development of individual children. This results in children continuing to experience neglect, despite input from professionals from across all agencies.**

Placing this finding as the first finding of this serious case review reflects the important systemic implications of this issue in how children are safeguarded, both locally and nationally.

The term ‘concept’, used in this finding, has been intentionally chosen by the Review Team to reflect the complex considerations required in safeguarding children from neglect. To a greater and lesser extent, this finding is echoed in a number of significant features detailed in other findings presented in this report, demonstrating the complexity of this safeguarding issue.

**How did this feature in this case?**

Throughout this case, it seemed that professionals struggled to articulate a professional opinion in a way that contributed to the assessment of risk. Professionals appeared to struggle to synthesize and make sense of knowledge, from across services and over time, to form a holistic picture of the neglect the children were experiencing. Each of the incidents/concerns were responded to separately, and considered in isolation, by different parts of the professional network, but their longer term cumulative impact was not assessed.

Child I, and Siblings 1 and 2 were all observed to have developmental delay, both in terms of their motor development and their speech and language. This was believed to be as a result of the poor stimulation the children received at home. The package of intensive services, provided to each child, allowed these developmental needs to be progressed from what services unanimously agreed was a ‘low base’. There was little evidence to suggest these needs were met at home. The fact that progress was predicated on individual service provision, not on the parenting received by the children, was not given sufficient weight in the assessment of risk.

Concern about the ability of parents to be aware of, and to meet, the emotional and behavioural needs of all the children**,** was identified by a wide range of professionals. Recordings of these observations were characterised by descriptive, episodic accounts.

There were various observations, noted in the case records across agencies that questioned parental ability to provide adequate supervision in the home, to ensure the children were protected from household hazards. A number of bruises were seen on the three youngest children and a burn was observed on Sibling 1, all of which were regarded as being caused by a lack of supervision at home. The home environment, and the injuries noted on the children, suggested that the parents did not understand the risks posed within a home where there are young children. This was illustrated in a home visit made by a SW, when a large mattress fell onto Sibling 2, parents did not attempt to remove the mattress and showed no concern about the dangers to the children. When professionals visited the family home, and observed potential hazards, these were largely brought to the attention of the parents. However, there was no effective overview of the ongoing risks or of the parents’ ability to anticipate them.

On a number of occasions mother and father were noted to handle the children ‘roughly’. There were a number of incidents that were suggestive of poor hygiene, and there was a pattern of inconsistent administration of prescribed medical treatments. These incidents were either simply recorded, or dealt with as they arose, by separate parts of the multi-agency team. The meaning of these, in the context of neglect, was overlooked.

When Sibling 2 was seen by the GP for a review of her eczema, the GP noted a number of bruises. She was concerned about these bruises and made a referral to the SW. The SW arranged a child protection medical. This medical concluded the bruising was likely to be accidental. However, the Paediatrician noted her concern about neglect of Sibling 2’s nappy rash and eczema, and expressed concerns about the supervision of Sibling 2. Information shared, by the GP and Paediatrician, also included concerns about mother’s ‘rough handling’ of Sibling 2 and questioned mother’s ability to adequately respond to Sibling 2’s emotional needs. The strategy discussion that followed, concluded the ‘concerns were not substantiated’, the basis of this decision was that the bruising was thought to be accidental. No further action was taken.

These examples illustrate the way in which the whole picture was not brought together by the multi-agency network. Whilst there were core group meetings and case conferences these were marked by, what appeared to be, a lack of a framework about how to conceptualize what was being witnessed in the family. The use of concept is necessary to cognitive processes such as categorization, memory, decision making, learning and influence - all of which are necessary if neglect is to be understood. There was a lack of clarity and understanding about how neglect can be successfully assessed and measured,

Case group members gave other case examples of children who are subject to a child protection plan under the category of neglect, where they are unclear how to work with the family in order to achieve required changes. They spoke of the high numbers of children who are the subject of a child protection plan as a result of neglect, and of the length of time these children often spend subject to a child protection plan.

Members of the Review Team and Case Group shared their experiences of working with neglect. Case group members spoke of how difficult it can be to articulate the evidence of neglect. They spoke of their frustrations in seeing the neglect of children, but of feeling ill equipped to know how to make the desired changes. There was a lack of clarity about when a case had met a threshold, requiring escalation to a higher level of intervention (such as a referral to Children’s Social Care), or in order for legal intervention to be achieved. Staff representing the CYPS spoke about the legal threshold for neglect being high and of this possibly influencing the thinking/mindset of front- line staff, when working with neglect. Members of the Review Team, with experience of providing supervision/management guidance in cases of neglect, spoke about these cases often not being prioritised for discussion by front-line staff during supervision. Overall, the response of the case group was characterised by both confusion and despondency.

**How prevalent/widespread is the pattern?**

Being able to respond effectively to cases of neglect is particularly important given the high frequency

This pattern is also borne out nationally. National figures for England (DfE 2012- 2013) show that the number of children subject to child protection plans under the category of neglect, far outnumber the numbers of children categorized as suffering from other forms of abuse. At the end of March 2013, of the 52,680 children subject to a plan, 21,600(41%) were the subject of a plan as a result of neglect.

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| **Finding 1: There is an insufficient understanding of the concept of neglect and how to understand and articulate the cumulative impact this has on the health and development of individual children. This results in children continuing to experience neglect, despite input from professionals from across all agencies** Neglect is a complex safeguarding issue that requires a complex response. Unlike other forms of abuse neglect may not be easily observable in a single incident. Rather, numerous pieces of evidence must be pieced together over time, and across agencies, in order to gain a holistic picture. This case has suggested that practitioners in Lambeth do not currently have access to the tools and support that would facilitate this way of working.**.**  |

Kyra Ishaq Chronology

Khyra Ishaq died at her home in the Handsworth area of Birmingham in May 2008, following months of neglect and physical abuse. She died as a result of severe malnutrition. Her mother Angela Gordon, 35, and ex-partner Junaid Abuhamza, 31, were jailed in 2010 for her manslaughter.

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| March 2006 | Three attempts were made by members of the public to share their concerns, one by a telephone call, the second by a referral in person at a children's social care office. The information resulted in no further action. These were not progressed due to failures of paperwork to reach the correct departments, failure to follow safeguarding procedures and to conduct thorough checks prior to case closure. This was clearly a challenging time within the household. Adult relationships presented as extremely fragile, domestic abuse was alleged and reported to the police and also to the family GP, who despite evidence provided by the mother, that the father presented a safeguarding risk to the children, did not follow prescribed procedures by informing Children’s Social Care, instead encouraging the mother to do this herself. |
| March 2007 | The issue of food first appears on professional records following a handwritten letter from the mother to one school and a face-to-face meeting at another to discuss the children's eating habits. This includes a suggestion from the mother that Kyra was stealing food from other children whilst in school, a situation of which the school at that time were unaware. |
| September 2007 | Junaid Abuhamza, the mother's partner, was living in the family household at the time of the child's death. Available evidence suggests he moved into the household around September 2007. From information provided by the mother and evidence supplied within the criminal trial, changes in attitudes and routines became noticeable from September 2007, placing the adult male in a position to exercise considerable influence on the family, including, diet, feeding routines and discipline of the children. Prior to the adult male's links with the mother, she had been seen by professionals who knew her as an engaged and protective mother of the children.Junaid Abuhamza’s childhood is regarded traumatic. When three, a sibling aged six months, died as a result of cot death. Two years later another three year old sibling, died following significant trauma, after being hit by their father in the stomach as a form of “discipline” whilst being toilet trained. His father was convicted of manslaughter and imprisoned for seven years. He was seen as a strict disciplinarian with rigidity and high, unrealistic expectations. The impact upon this man’s development, from these early traumas and his views on discipline and parenting, were unknown prior to criminal proceedings. He was briefly in receipt of adult mental health services during 2001. Whilst he did not provide a full diagnosable history, he did give the Psychiatrist sufficient evidence to strongly suspect a low grade psychotic illness. He was not compliant with attempts to provide medication and this was communicated to his GP.  |
| October and December 2007 | Between October and December 2007 several school appointments were missed by both parents. Although they were living separately at this time, their previous commitment to engaging with schools to discuss their children’s progress had existed. Failure to attend presented a change of behaviour. |
|  | It is not until some nine months later, during December 2007, that professionals again began to record issues around food. Clear evidence of the child stealing food from other children existed and other siblings within the family were indicating obsessive traits towards food and feeding. What we now know, is that the mother was struggling to address her own weight at that time, which was causing her health problems. Evidence from legal proceedings indicate that a regime to enable her to lose weight, was also applied inappropriately to the children’s food intake. |
| December 2007 | Following changes to the mother's behaviour, deteriorating relationships with schools, increased aggression to and reduced co-operation with all professionals, the child and some siblings were removed from state education and a clear statement issued by the mother of her intention to educate them at home.Note : The responsibility for a child’s education rests with parents. In England, education is compulsory, but school is not. The legislation that enabled the mother’s action is contained within S7 of the Education Act 1996, supported by additional guidance within the Elective Home Education Guidelines for Local Authorities 2007. On this occasion, the legislative framework contributed to the unintended outcome of isolating some children within a home environment and restricted access to those children by professional agencies, effectively removing any oversight of their welfare or development |
| December 2007 | The safe-and-well check conducted by the police in response to a professional request from the school, appears to have hardened the mother's resistance to further professional intervention.Khyra had been removed from school in December 2007 and subjected to a punishment regime which included standing outside in the cold for long periods, having cold water poured over her and being beaten with a bamboo cane.School staff attempted to communicate professional concerns on several occasions to Children’s Social Care, but were not properly heard. Concerns were inaccurately recorded initially and the focus placed upon attendance issues, as opposed to mother’s changed behaviour, increased aggression to professionals and the children’s obsession with food. Recommendations by Children’s Social Care for school to conduct an assessment using the agreed Common Assessment Framework and to request a police safe & well check were inappropriate given the information provided. |
|  | The review calls for changes to the law to ensure that social services speak to children to assess whether home education is in their interests, as well as their parents. The review found Gordon had become increasingly aggressive towards her children's teachers when she removed Khyra and some of her siblings from school in December 2007. Gordon wrote to authorities to tell them that she wanted to educate her children at home. Birmingham city council's education welfare service – known as the Education Otherwise team – visited Gordon with a social worker to assess whether she was fit to home-educate her children. The serious case review found the welfare worker used a "tick-box" approach for this assessment. The welfare worker did not ask to see examples of the kinds of lessons Khyra would be taught or inquire into how many hours of education Gordon's children would receive each week. At no point did the welfare worker request to see Khyra or her siblings. Nonetheless, the welfare worker concluded that Gordon was fit to home-educate her children**6 December 2007** Khyra's mother, Angela Gordon, withdraws her from primary school, where she had a perfect attendance record.**19 December** The deputy headteacher contacts the [children's services department at Birmingham city council](http://www.guardian.co.uk/uk/2008/may/23/ukcrime.childprotection) to raise concerns about Khyra's welfare. The teacher and a colleague later visit Khyra's home but are not allowed in. |
|  | **28 January 2008** Khyra's school again contacts social services to raise concerns about whether Gordon is able to meet her daughter's educational needs by home teaching. Social worker Ranjit Mann visits the house but leaves after 10-15 minutes as nobody answers the door |
|  | **29-30 January** Gordon contacts Mann by phone, leaving a message, but later refuses to arrange for the social worker to visit |
|  | **8 February** Educational social worker Richard Lewis and council mentor Irving Horne visit the home to offer advice on home schooling. Neither official sees any children. |
|  | **21 February** Social workers Sanya Scott and Anne Gondo pay a joint, pre-arranged visit to the family home but are refused entry. The women decide that they have no concerns for Khyra after she is brought to meet them at the front door |
|  | **8 March** Amandeep Kaur, who lived nearby, sees Khyra dressed in underwear in the back garden of her home. She was later to tell police that it was a cold morning and the "abnormally thin" child was whimpering. |
| Feb 2008 | Education Otherwise provides advice, support and assessment to parents who have elected to educate their children at home. The lack of a robust and rigorous process by Education Otherwise, during February 2008, to assess the capability of adults within this household to provide effective home education, coupled with the absence of any risk-assessment process to address safeguarding concerns previously communicated by education welfare, must be viewed as a significant failure. School staff attempted to communicate professional concerns on several occasions to children's social care, but were not properly heard. Concerns were inaccurately recorded initially and the focus placed upon attendance issues, as opposed to mother's changed behaviour, increased aggression to professionals and the children's obsession with food |
|  | Other authorities held "great store" by the welfare worker's assessment, the review found, and this led to a catalogue of missed opportunities to spot neglect and abuse in the home. |
| Feb 2008 | The initial assessment by Children’s Social Care in February 2008 was not completed. As a result, Children’s Social Care failed to accurately assess the risks posed to children within the family. Adult resistance to professional intervention, doorstep conversations, the mother’s sound knowledge of home education legislation and a hostile and aggressive approach, influenced and affected professional actions, preventing a full understanding of conditions within the home and seemed to render professionals impotent, thereby directing the focus away from the welfare of the children. Adults within the household fully controlled, monitored and limited access to the children and through their behaviours and attitudes frustrated a thorough analysis and assessment of the issues. These actions reinforced a power imbalance that undermined the rights, welfare and protection of the children who were at that time educated at home. A complaint of harassment by Gordon against a social worker who visited their home in February 2008 generated a reluctance to complete an assessment "for fear of wider repercussions within the complaints process". Gordon, 35, proved extraordinarily adept at swatting aside attempts by professionals to intervene in her chaotic family life. At times she would threaten physical violence, at other times threaten legal action, or accuse them of racism or harassment. She ruthlessly exploited safeguarders' ignorance of the law on home schooling and kept them constantly on the back foot. |
|  | On one occasion, in February 2008, a social worker visited the family home to attempt an assessment. The social worker was not allowed into the home but after refusing to leave was eventually given brief doorstep contact with some of the children. "By the time the senior practitioner returned to the office," noted the review, "a complaint had already been made by [Gordon] against the social worker of harassment." An agreed follow-up visit the next day did not go ahead as a result of the complaint. |
|  | Between 1998 and 2008 the children missed a minimum of 129 professional appointments. Undoubtedly, with a family of six children, some of whom had statements of special educational need, there are particular pressures and stresses for parents and a degree of failed appointments would be expected, particularly, when the mother was operating as a single parent for periods of time. However, the pattern of failed appointments escalated dramatically during 2007 as relationships with professionals deteriorated. The response to these failures within the agencies was not always actively addressed, or the significance fully understood and therefore not communicated with partner agencies. Whilst a number of agencies and individuals sought to deliver effective services to the child and her family, there were others who lost sight of the child and focussed instead upon the rights of the adults, the adult’s behaviours and the potential impact for themselves as professionals.  |
| May 2008 | A postmortem on Khyra found 60 marks, 34 of which could have happened a week before her death. Eight were consistent with being struck by a cane.There were echoes of the death of Victoria Climbié, who was abused by an aunt, before she died in Haringey, north London, 10 years ago. |
| 17 May 2008 | Kyra's mother made a 999 telephone call requesting an ambulance because of serious concerns over this child's health. An ambulance crew found the child lying on a mattress in an upstairs bedroom. Death was pronounced at 06.25am.The cause of death is recorded as bronchial pneumonia and septicaemia with focal bacterial meningitis. The child's weight at death had fallen below the 0.4th centile, with a body mass index of 10.7, which was so low that it could not be plotted on a body mass index chart. The child was described as extremely malnourished with severe wasting.Evidence clearly indicates that severe malnutrition was entirely due to an inadequate intake of food and that there was significant starvation over a period of several months. All of the surviving siblings were malnourished to a greater or lesser extent and all had specific nutrient deficiencies. |

The review suggested that Gordon's intimidatory behaviour did not excuse professionals' missed opportunities to intervene, but it noted: "Dealing with safeguarding inquiries and assessments can be a stressful process for workers, particularly when attempting to undertake work with aggressive and highly resistant adults." Although Gordon's life was far from straightforward, the review noted that before her relationship with her partner, Junaid Abuhamza, she had been known to professionals as "an engaged and protective mother of the children". Teachers considered her a "powerful personality" but had never previously found her threatening or violent. But the review suggested that under Abuhamza's controlling and irrational influence her behaviour changed. She became aggressive, obstructive towards teachers and distrusting of other professionals.

