Warwickshire Safeguarding

Charlie

Child Safeguarding Practice Review Report

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1. Introduction

1.1 In October 2019 a house fire consumed the upstairs rooms of a family home. Children and neighbours raised the alarm and the fire service rescued a twenty-one-month-old child, Charlie, who was in a critical condition.

1.2 Charlie is White British and lived with parents and four other siblings who were aged between five and eleven years old at the time of the incident. Father was at work and Mother was at a neighbour's address. It is understood that the two eldest children had been playing in a nearby park and they returned to find a fire in the home where Charlie was in the house alone. The fire is believed to have been started by a lit candle in a bedroom towards the rear of the property.

1.3 Neighbours and Charlie's siblings had raised the alarm. Some neighbours bravely but unsuccessfully tried to reach Charlie. The emergency services responded very promptly to the fire and averted a fatality. Charlie needed resuscitation by paramedics and was taken to Birmingham Children's Hospital in a critical condition, unable to breathe unaided and with 28% severe burns. Four adults, including two firefighters, also required some medical treatment after dealing with the fire. Police also responded and with social workers made arrangements for the immediate care of the other children.

1.4 Charlie spent time in hospital and will require ongoing medical treatment for injuries, which are life altering. Charlie's siblings and other children in the area witnessed the fire which must have been very distressing and the incident has understandably had a huge impact upon all the family. Following the incident, Charlie and siblings were made subject to child protection plans due to neglect and the children moved to live with members of their extended family.

1.5 Mother was found guilty of child neglect and received a two-year custodial sentence.

2. Terms of Reference and Methodology

2.1 Warwickshire Safeguarding Partnership decided that a Child Safeguarding Practice Review should be undertaken to consider agencies' involvement with the family between 01 January 2016 and 20 October 2019. An Independent Lead Reviewer was appointed and a Review Panel established. The Independent Lead Reviewer and Review Panel have considered reports from:

- Coventry and Warwickshire Partnership NHS Trust
- George Elliot Hospital
- North Warwickshire Clinical Commissioning Group
- Platform Housing Association
- School A
- School B

- South Warwickshire Foundation NHS Trust
- University Hospitals Coventry and Warwickshire (UHCW)
- GP Practice
- Warwickshire County Council Children and Families Service (including Early Help and Targeted Support and Social Care)
- Warwickshire Fire and Rescue Service
- Warwickshire Police
- West Midlands Ambulance Service

2.2 Two learning events have been held with practitioners and managers involved in providing services to the family.

Key Lines of Enquiry

2.3 The Independent Lead Reviewer and the Review Panel identified the following key lines of enquiry:

- *To explore professionals' understanding of neglect, their interpretations and application of thresholds when risk/neglect was identified as a safeguarding concern, and the effectiveness of interventions;*

- *To consider whether unconscious bias impacted on professionals' ability to identify and respond to safeguarding concerns in local communities where similar family and environmental factors are experienced by families living in those communities;*

- *To consider whether professionals exercise 'professional curiosity', and recognise the need to exercise 'healthy scepticism' when parents appear to engage in interventions, and to escalate concerns when cooperation and/or progress are not forthcoming;*

- *To explore how effective communication and multi-agency working and assessment, particularly between agencies and the Multi-Agency Safeguarding Hub (MASH), with this family were; how well the referral pathway was followed when safeguarding concerns were identified and to what extent professionals and the MASH workers reviewed and discussed previous conversations and referrals and considered the cumulative effect of the concerns of neglect;*

- *To consider how thorough and holistic early help assessments were, how any specialist assessments were incorporated into needs and risk assessment, and if any other specialist assessments could be usefully used in the future.*

3. Family Details and Background

3.1 Mother and Father were both over 30 years old at the time of the fire and living with their five children Charlie, Dani, Connor, Ben, and Alex who were all aged under 11 years old at that time. Names and some details have been changed.

3.2 Mother had been voluntarily looked after by Warwickshire Children's Services as a young teenager for nearly six months. Children's Services had remained involved with Mother and her birth family for about two years but her family did not accept support.

3.3 Mother and Father had moved with their family in 2013 to the address where the fire took place. Mother had experienced domestic abuse from previous partners and she notified the Police in June 2013 when one had contacted her on social media despite a non-molestation order being in place.

3.4 The children in the family received universal services in this review period.

3.5 Health visiting was provided for Connor, Dani and Charlie. Mother gave birth to her fourth child Dani before the review period and Charlie was born in 2018. UHCW Midwifery services made four routine home visits and discharged Charlie to the Health Visiting service in early 2018.

3.6 Alex and Ben moved to School A in late 2014 [possibly following a dispute with another parent at their previous school] and were joined by Connor and Dani who joined the nursery there during the period of this Review. Alex moved to secondary school, School B, in September 2019.

3.7 School A implemented the Early Help process for Alex and Ben.

3.8 There was one referral made to Warwickshire Multi-Agency Safeguarding Hub (MASH) by School A who also consulted the MASH on another occasion during the review period. In writing their information report for this Review, School A has identified an additional concern shared with staff about the children which should have resulted in a referral to the MASH.

4. Family Involvement in the Review

4.1 The Independent Reviewer offered to meet with the children's mother but this proved difficult unfortunately due to the coronavirus pandemic restrictions and the offer to meet was then eventually not taken up.

4.2 Father and paternal grandmother also declined to be involved in this Review.

5. About the Author

Jim Stewart is an independent social work consultant with over thirty years' experience of working in children's services, many in child protection management, and he has considerable experience of conducting serious case reviews. He has not had any previous involvement with any services in Warwickshire.

6. Analysis of agencies' involvement with the family

The effectiveness of interventions

6.1 There is no indication that agencies could have predicted the house fire in which Charlie suffered such serious injuries. However, this Review has provided an opportunity to consider in detail the practice of agencies in working with Charlie's family and the operation of multi-agency procedures.

6.2 The Review has identified some good practice:

- University Hospitals Coventry and Warwickshire's follow up when a child has not been brought to appointments. Dani was offered follow up appointments the following week when he was not brought to outpatient appointments and he attended these subsequent appointments.
- When Dani was discharged from the ophthalmology service a letter was sent to his GP to inform them why he had been discharged and that he could be referred back into the service at any time. A letter was also sent home asking parents to contact the hospital should Dani require another appointment.
- Appointments with the family GP were made available on request.
- Use of Cause for Concern forms generally worked well at School A to highlight issues for individual vulnerable children and School B recorded redness to Alex's face which was judged accidental and not significant.
- School A engaged in Early Help work with the family (the school completed an assessment, held two formal meetings and closed down this work in line with procedures) and are reported to have linked with community-based support from the Children's Centre.
- Substantial written notes for Dani and Charlie were written by the Health Visiting team. There was some challenge and persistent efforts were made to see children.
- School A made appropriate referrals to Warwickshire CAF/Early Help Service and MASH and support was put in place, both with school staff and external agencies, i.e., RELATE and Child and Adolescent Mental Health Services (CAMHS).
- The response to the house fire by emergency services and lifesaving actions and treatment in respect of Charlie. School subsequently coordinated support from the community for the children.

6.3 The Review has identified that some information was known to professionals which raised questions about the level of supervision of the children and about specific potential risks at home in relation to pet dogs and internal bedroom doors which could not be opened. It has also identified some learning about how practitioners could work more effectively together to improve multi-agency assessment of families both at the level of early help and where concerns about children's safety and welfare are referred into Warwickshire Multi-Agency Safeguarding Hub (MASH).

Multi-agency communication, working and assessment, particularly that between agencies and the Multi Agency Safeguarding Hub (MASH) and the response to safeguarding concerns

Universal Services

6.4 The GP had routine contact with most of the children during the review period for various common minor ailments; 4 face-to-face contacts with Alex and one with Ben (in December 2016 regarding concerns about Ben's behaviour:). Connor had sixteen GP appointments and Dani who required treatment for a foot condition had nine. Charlie had four face-to-face contacts between February 2018 and January 2019.

6.5 Connor attended Accident and Emergency Department at University Hospital Coventry & Warwickshire (UHCW) in March 2017 for a cut to a palm caused by a glass which had broken in their hand. Connor underwent surgery and was discharged the same day with planned out-patient follow-up.

6.6 Dani had many hospital appointments from the age of 2 months and underwent surgery to their foot by the orthopaedic team at UHCW in May 2018. Dani attended the Emergency Department later in May 2018 after their cast got wet.

6.7 Paramedics were called to the home in December 2016 after reports that Dani had had a seizure. Dani was taken to UHCW and was diagnosed with a febrile convulsion and a lower respiratory tract infection and discharged from hospital the following day.

6.8 Mother had 27 appointments with the GP, practice nurse, or out of hours GP during the review period, with 5 non-attendances, and had additional antenatal appointments with the midwifery team when pregnant with Charlie. These were for various issues including smoking cessation. There were also medication reviews as she had been prescribed medication for back pain and for low mood.

6.9 Father had 13 appointments with the GP or practice nurse during the review period.

6.10 The Health Visiting Service provided by South Warwickshire Foundation NHS Trust (SWFT) became aware of, and worked with, Mother and her younger children from 2009. In September 2015, the Health Visitor completed Dani's 9-to-12-month assessment and noted delay in many areas of Dani's

development. A Nursery Nurse saw Dani in November 2016 and highlighted concerns about speech and language and concerns about social and emotional development. Although Dani has a foot condition which required surgery and ongoing specialist care, Dani remained in receipt of universal services. The SWFT report indicates that the visiting pattern and frequency with reference to the Warwickshire Health Visiting Standards provides enough evidence to suggest that Charlie and Dani should have been offered a higher service offer. In fact, the level of Health Visitor contact and visiting with this family was essentially that provided to children in receipt of a Universal plus offer (that is, ongoing support from a health visiting team and a range of local services to deal with more complex issues over a period of time). In March 2019, the Health Visitor had recorded that their plan was to check that Charlie had received immunisations, to check home conditions and provide information about finances. There is no record of any further contact with the family before the house fire.

6.11 The School Nursing Service did not work with the school aged children. School A noted a letter from Warwickshire School Health and Wellbeing Service in September 2019 to parents acknowledging a referral and School expected the service to assess and contact the parents. There had been no response or contact from the School Nursing Service before the house fire.

6.12 This review has identified that housing landlords may have significant information about a family which could be important for assessments. Platform Housing Group (PHG) served a Notice of Seeking Possession on occasions during this Review period due to rent arrears and had agreed repayment terms with the parents. The author of the PHG Report's view was that the Platform Housing Group Income Team should have referred Mother to their in-house Welfare Reform and Tenancy Sustainment Team (which was created in 2018) for advice and guidance on her benefit claims whilst she was in debt. The landlord also looked into concerns about home conditions and the family's dogs in January 2019 and reassured themselves that there were no evident concerns.

Early Help Assessments

6.13 Warwickshire County Council describe the purpose of Early Help as to put in the right support at the right time to families so that problems are less likely to escalate to a point where a child becomes vulnerable or in need. Early Help is sustainable so that problems are less likely to re-occur. Early Help is voluntary and a family must consent to any support given and an assessment is completed by a trained professional.

6.14 Early Help was offered to Mother and her family between March 2016 and August 2017.

6.15 School A began a Common Assessment record in January 2016 which listed the family GP as another professional involved with the family. The assessment record was received and read in March 2016 in the Early Help Service who contacted the Lead Professional at School A who agreed to confirm when a Family Support Meeting was planned.

6.16 School A had invited an Early Help Officer from the Early Help Service to attend the first Family Support meeting but at that time the Officer explained that they only attended for cases which the Early Help service rated red indicating priority. The Early Help Officer did provide advice and suggested that the youngest children were considered and that a Children's Centre be invited to a meeting. This advice was not followed.

6.17 School had initiated Early Help in March 2016 to respond to concerns which had arisen about Ben's behaviour at home and at school and concerns about contact from an ex-partner of Mother. Mother was advised to contact the local Children's Centre for support from a Family Support Worker.

6.18 School A had appointed to a Family Learning Mentor (FLM) post in February 2017 to provide additional capacity for pastoral family support. However, there was a significant period where there were no formalised family support meetings due to staff capacity. School did continue to support the family on a day-to-day basis. Meetings re-convened approximately 10 months later with support continuing to be given to the older children and the family by School.

6.19 At the School's invitation, an Early Help Officer attended a family support meeting at the school in March 2017. Their role was to provide advice, support and guidance to the Lead Professional and to receive updates from further Family Support Meetings and ensuring documentation was sent into Warwickshire County Council. School A had noted that Mother had agreed to take part in the Common Assessment Framework process again.

6.20 The Early Help episode was closed by School A at the beginning of August 2017 with a conclusion that the planned intervention had been completed with a positive outcome/significant improvements. It was recorded that the family elected to close the support as they felt they were able to manage their needs independently and:

- It had provided support to help with challenging behaviours displayed by Ben at home and in school. Parenting strategies and support to better manage routine at home were provided.
- It had supported the referral to CAMHS for Ben.
- Connor and Dani were settled in nursery.

6.21 It is recorded that Mother stated that she felt that the support offered to her was very good and the Family Learning Mentor noted that the episode had prevented a referral to Social Care and poor school attendance.

6.22 In October and November 2017 Alex was quite emotional about the death of a relative and would seek out adults to talk to, especially mid-day supervisors. Ben and Alex accessed individual counselling at school. Mother had not engaged with family therapy offered with a counsellor; she said the times were not convenient as she had younger children at home. Mother was also advised to contact Guy's Gift (a bereavement support for children, young people and their families across Coventry and Warwickshire) to access support for Alex in respect of her emotions.

6.23 The School and Health Visitor describe good communication with each other and collaboration generally. However, they did not communicate well about these children or work together on the plan to ensure a holistic approach around Early Help assessment and planning for Alex and Ben. The reasons for this are not clear.

6.24 In the most recent triennial review of serious case reviews covering 2014-2017 entitled Challenge and Complexity (2020), Brandon et al. observe that 'parents who are offered or receive early help services need to have both the motivation and the ability to work on a voluntary basis with service providers. Vulnerable or overwhelmed parents may not have the emotional capacity or material resources to be able to take up the services offered or to attend appointments.' Cooperation may fluctuate and this is an important point which practitioners should bear in mind. It is also relevant in considering disguised compliance and avoidance (which are considered in paragraphs 6.76 - 6.81 in this Child Safeguarding Practice Review report).

Early Help Recording

6.25 There has been discussion during this Review about whether social workers would have had access to Early Help information and assessments when referrals were later received about children and their families. Family Support records were held outside of the local authority database by Barnardo's although the directive was that any engagement with a family should be recorded on the system.

6.26 Early Help Family Support workers are no longer commissioned and they have been managed by the council since 2 September 2019. Since then, all recordings are completed within Children's Services and accessible to all workers (e.g., Early Help Officers, Children and Family Centre Workers and Social Workers). Workers can see workflow and case notes loaded before this time and can therefore see historical information.

The response to safeguarding concerns and the involvement of the MASH

6.27 In October 2018, School A were informed that there were no handles on bedroom doors at Charlie's family home and that the children could only get out using a screwdriver if the door was shut. The referrer wished to remain anonymous, did not want to contact MASH or Childline, and advised school staff to speak to

Connor. The Family Learning Mentor (FLM) mentioned the concern to a teaching assistant (TA) and asked them to note anything Connor said. Later, Connor asked about the lock at the top of the art cupboard door and volunteered that the handles on their bedroom door were broken and sometimes a sibling pushed them and they got locked in. Connor said that Father used an old handle to open the door.

6.28 As part of this review, School followed up this matter with the Family Learning Mentor who no longer works at the school but who had left their personal notes which contained this information. The FLM did not inform any other Designated Safeguarding Leads at the time.

6.29 The Family Learning Mentor said they spoke to the TA, who was able to get some information from Connor and it seemed plausible/reasonable at the time. The FLM felt there was a lot of 'tit for tat' between various parents and this was another example with not enough evidence to back it up, and it could get out of hand. The FLM said that they didn't do any more as they didn't know where to go with it.

6.30 This was significant information which should have been discussed with school management and resulted in, at least a consultation with, and more appropriately, a referral to Children's Social Care. It identified a home safety issue and raised a question about how the parents were managing. It is not clear how long the handles had been broken and we do not know when this problem was rectified. It was not indicated in the enquiries following the house fire.

6.31 Platform Housing Group (the family's landlord) have informed this Review that in January 2019, a Gas Contractor reported that they could not undertake the annual gas service at the family home, because the property was neglected and there were dogs in the home. A Neighbourhood Officer from the Group visited promptly, gained entry to the home and found no sign of the property being in poor condition. No issues of concern or safeguarding were apparent during the visit and photographs were taken by the Neighbourhood Officer to evidence this. This case was logged correctly on Platform Housing Group's in-house data base and subsequently closed with no further action. The gas inspection took place following the visit.

6.32 School A appropriately raised two safeguarding concerns regarding children in the family during the period under review.

Referral following a dog bite to one of the children

6.33 School A were made aware in February 2019 by third parties that Ben was bitten by a dog in the family home over a weekend and they had been present. One referrer said that the dog had cornered Ben indoors and bit Ben on the leg. Mother allegedly told A&E that there was only one dog although the parents have two and also allegedly told another person to 'keep it quiet'. The report to school also described an earlier incident the previous week when the two dogs had been fighting, there was a lot of blood, and Mother could not control them and sent the children outside until the dogs calmed down. Mother called the school on the Monday after the dog bite to inform staff that Ben had a puncture wound and may

complain during PE. Staff had informed the Designated Safeguarding Lead that Ben was limping. When asked to by the MASH, school staff observed Ben's leg (noting a puncture wound, like teeth marks to the top of the thigh as well as some bruising and scratches) and they also spoke to Mother.

6.34 School made a telephone referral to the MASH. The original call was taken and recorded via the Contact and Consultation Pod by a Family Support Worker. It was subsequently reviewed by a Manager who appropriately rated the referral as requiring attention within two hours, as it contained urgent safeguarding concerns about a child or adult requiring immediate action to ensure their safety (rated as 'Red') and passed it on to a social worker to progress.

6.35 Within the referral, the MASH did not record requesting the views of the children from either the school or Mother. However, on 4 February 2020 there was a conversation with school staff who provided fuller details of the injury and confirmed that Ben said that they were scared at the time. Father was not spoken to.

6.36 Mother told a MASH worker that Ben was playing with the dog in the garden and the dog missed a stick that Ben was holding and bit them instead. Mother said that the dogs were staying with Father's mother until they could secure the kitchen door as they knew the stair gate was not sufficient.

6.37 The MASH worker noted that the Police would be in touch with Mother, that the dog is not classed as a dangerous dog and its temperament is such that it is usually loyal and friendly, and that Mother described the incident as out of character.

6.38 MASH recorded that there were no previous concerns about the mother's care of the children. Mother agreed that the children would never be left unsupervised in future with the dogs. The MASH report for this Review states that Police looked into the incident as a potentially dangerous dog matter and did not pursue an investigation. The case was closed with no further action from the MASH before feedback from the Police was received.

6.39 Warwickshire Police Harm Assessment Unit in the MASH had appropriately consulted with the Warwickshire and West Mercia Police Dog Legislation Officer about this referral. The Police raised an investigation with the primary classification of "Owner or person in charge allowing dog to be dangerously out of control injuring any person or assistance dog" in accordance with National Crime Recording Standards. A classification of child protection investigation was also included due to the identified risk of harm to a child. The attending officer assessed the injury to Ben as minimal and reported that the two young dogs were well behaved. The Police Officer considered that the reference to dogs fighting may have been confused with play fighting which they did during the officer's home visit.

6.40 Mother told the Police that she had put one of the dogs up for re-homing through an animal shelter although she was having second thoughts about this. She had also said that she had made the decision to have both dogs neutered. The Police recorded that the dogs were with a family friend until some improvements

were made in the home. Health professionals considered the need for a tetanus injection but it was confirmed that Ben was already up to date.

6.41 Workers in the MASH and the Police Officer involved appear to have limited their investigation to a consideration of whether the breed of dog was listed as a dangerous dog breed rather than making wider enquiries into whether the dogs were suitable for the family and their overcrowded house, what the children's views and experiences were, and how it would be confirmed that the parents actually took the actions discussed to ensure the children's safety. Enquires did not establish that the family also had pet cats in the home.

6.42 The advice on the People's Dispensary for Sick Animals (PDSA) website is that the breed of dog kept by the family is large and can be hard to handle. It notes that given the right socialisation and training, they are gentle dogs but due to their size the PDSA 'wouldn't recommend having one if you have smaller children in case they accidentally hurt them by knocking them over'.

6.43 The West Midlands Ambulance Service has informed the Review that Father had to seek medical treatment in July 2019 after being pulled by a dog whilst out walking and injuring his hand on barbed wire. The records in respect of the house fire in November indicate that the family still had two dogs.

Consultation when Dani brought a gas cylinder into school

6.44 School consulted the MASH about a safeguarding concern in July 2019 when Dani brought an unused small Kayser gas cylinder (used in dentistry and aerating cream but also as laughing gas) into school. The MASH advised school to speak to Mother who informed staff that Dani had picked the cylinder up on the way to school and there were loads in a nearby close. MASH workers were satisfied with Mother's explanation and concluded that no further action was necessary. The school were advised that no Multi-Agency Referral Form (MARF) was required and there was no form uploaded in the MASH recording system. However, Designated Safeguarding Leads in the school felt that it was important to log a MARF and the school report that one was e-mailed to MASH. Mother was very unhappy that Social Services had been contacted and at the end of the day criticised a member of school staff stating that she was 'always sticking her nose in'.

6.45 It could be significant that the capsule had not been used but this was not appreciated by MASH workers at the time.

6.46 The MASH are currently working towards improving the electronic processing of contacts to support integrating contacts directly into their recording system.

Response to the House Fire

6.47 Communication between the Ambulance Service, Fire Service, Police and Children's Services' Emergency Duty Team following the house fire in November 2019 was prompt and effective.

Professionals' understanding of neglect, their interpretations and application of thresholds

6.48 The Warwickshire Multi-agency Safeguarding procedures acknowledge that 'Neglect of children is one of the most difficult areas in child care and child protection to identify, communicate effectively to professionals, assess and intervene in'. It may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger; (it later references inattention to avoidable hazards in the home)
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

6.49 As the procedures state:
'Neglect is persistent and cumulative and occurs over time, despite intervention and its impact may become prevalent over a sustained period of time with evidence to support concerns usually gathered from a number of agencies/professionals'.

'Failure to meet the child's needs does not necessarily mean that the parents/carers are intentionally neglectful, but it points to the need for intervention'.

'Its presentation as a 'chronic condition' requires the collation and analysis of sometimes small and seemingly insignificant events that only when viewed together provide evidence that neglect is an issue of concern'.

6.50 The Health Visitor had identified developmental delay in respect of Dani. This can indicate neglect and a lack of stimulation but as Brandon et al. note in the Challenge and Complexity report (2020), 'Developmental difficulties are common with only 70.3% of children considered to have a good standard of development by the end of reception class, however there are many causes other than neglect for developmental delay'.

6.51 School staff have reflected that this family had not been on their radar in terms of any safeguarding concerns. The South Warwickshire NHS Foundation Trust report notes that the family were not a family of concern to Health Visiting services and there were no previous safeguarding or other alerts for any of the children on their electronic system.

6.52 In Challenge and Complexity, Brandon et al. found that evidence of neglect featured in nearly 75% of the serious case review reports examined; in 68% of the fatal cases and 83% of the non-fatal serious harm cases. It was the primary issue in 19% of all the serious harm cases they reviewed. They identify seven categories of neglect and the third category listed is 'Accidents which occur in a context of neglect and an unsafe environment' where hazards in the home environment and poor supervision may contribute. This accurately describes the circumstances in which

Charlie's injuries occurred. Information shared in this Child Safeguarding Practice Review about Charlie's family reflects the complex and cumulative nature of neglect.

School Attendance and concerns

6.53 The children's annual school attendance was regularly over 90% in the three academic years between 2016-2019. However, Connor and Dani's attendance at nursery had been poor; in 2016/17, it had been 74% for Connor (their attendance in Year in 2017/18 was 86%) and in 2017/18 Dani's attendance was 57% as Dani missed periods of time due to health reasons. In the school year 2018/19, all the four children at school had achieved over 94% attendance. The children were still in the autumn term of the 2019/20 academic year at the time of the fire. Alex had had two days off due to illness and one day off with no reason given between September and November 2019 at School B.

6.54 Mother sought help from the school but was inconsistent in attending meetings to discuss the concerns she raised. School staff also recorded a number of concerns:

- About Ben's presentation in March 2017, May 2018 and December 2018.
- In March 2017 Ben told a teacher that they watched horror 18 rated horror films which Ben named. Mother said that Father had subsequently blocked internet on their iPad and changed access to children's YouTube
- School also recorded dirty lunchboxes for one or more of the children on one day in November 2017, one day in November 2018 and another day in July 2019 and a concern that drinks were not provided on two of those three days.
- In March 2018, Connor was seen taking food from the hall to eat later although staff did wonder if Connor just wanted to go outside to play.
- Later in March 2018 Ben was falling asleep in lessons and said that Dani kept them awake getting into their bed
- Connor told staff in October 2018 that they did not wear a seatbelt in the car coming to school and Mother denied this
- In February 2019, Dani talked about not having had breakfast before school because Mother did not have time. Mother denied this, telling staff that all the children had toast.

Missed appointments

6.55 There were 4 occasions noted when three of the children were not brought to GP appointments in the review period (Alex and Dani once each and Charlie twice). The GP followed up Dani's missed appointment of 4 April 2017 with a telephone call the same day. However, parents could not be contacted on the numbers held by the practice, and Dani was not seen face-to-face until March 2018.

6.56 With regard to family engagement with the Health Visiting service, records for Dani included missed appointments, late completion of developmental assessments, and delayed immunisations.

6.57 Dani was also not taken to a planned Speech and Language Therapy (SALT) appointment. Dani was discharged from this service, due to non-attendance, in line with the Patient Access Policy (South Warwickshire NHS Foundation Trust 2017). Parents had called and booked in for the appointment with SALT but failed to bring Dani.

6.58 In October 2018 Connor was discharged from George Eliot Hospital ophthalmology department for a common and usually minor eye condition and was to be followed up with a local optician. (This is recorded in the GP information report).

6.59 Dani was treated by the Ophthalmology team at George Eliot Hospital but was discharged in May 2019 after not being brought to two appointments. The Hospital notified the GP of the missed appointments and the subsequent discharge. (GEH report).

6.60 UHCW Hospital provided treatment for Dani's foot condition. Dani attended twenty outpatient appointments with both parents predominantly attending together. Dani was not brought to ten appointments and the Trust offered follow-up appointments which he attended; there were no indicators of abuse or neglect documented.

6.61 Father had taken Dani to the Emergency Department (ED) in May 2018 when their cast had become wet. Father did self-discharge Dani but this was following a discussion between ED staff and orthopaedic doctors which states in the notes that as Dani had an outpatient appointment soon then he could leave the cast until then. It is also documented that if Father was worried, he should take Dani to the plaster room the following day. Dani was reviewed in outpatients in June as planned and the cast was changed at this point.

Home conditions

6.62 The Health Visitor had noted that the home was cluttered with debris on the floor in September 2015. During a home visit in February 2018 to complete Charlie's six-to-eight-week check, the Health Visitor noted that the home was untidy with lots of rubbish on the floor. In February 2019 the Health Visitor noted that the outside of the house was untidy with bins overflowing and inside there was debris on the floor and furniture. Also, that the home was overcrowded and parents were behind with the rent.

6.63 The Police Officer had visited in the evening in February 2019 when it was dark and had not been able to see the garden and corroborate what the Health Visitor had noted earlier in the day.

6.64 The Fire Service reported that conditions in the house in November 2019 were clearly cramped for the number of people and pets living there and there was evidence of smoking materials and candles in precarious positions. The garden was covered in dog faeces and the Fire Service estimated that it had not been cleaned for a long time, possibly months.

Supervision of the children

6.65 There were no reports to agencies of the children being left unsupervised during the review period.

6.66 When a Police Officer visited Mother about Ben being bitten and the dogs in February 2019, Ben had answered the door and Mother returned from a neighbour's home nearby within a couple of minutes. The Officer had not pursued this with Mother or considered this information significant enough to record or to report to other agencies at the time. With the benefit of hindsight, it would have been appropriate to have shared this information with the MASH and, in turn, for it to have been discussed with School and the Health Visitor and clear advice given to Mother.

6.67 The Health Visitor had noted that the front door was ajar on her arrival for a planned home visit in February 2019. There was initially no reply and Mother arrived from next door with Charlie. There is no suggestion that any other children were in the house.

6.68 During their investigation, the Police established that Mother had left the two youngest children for at least forty minutes on the day of the fire and Mother shared that she had left them previously on a number of occasions.

Any impact of unconscious bias

6.69 Warwickshire has low levels of child poverty overall but small localised pockets where relatively high levels exist. The distribution of child poverty is complex.

6.70 The family lived in a community which professionals describe as close knit but also quite deprived. The two adults and five children in this family lived in a two bedroomed property. It was quite a new property but too small for the family. However, the family liked the location of their home. Professionals were aware that rented properties in this area were sparsely furnished which presented challenges for some families and overcrowding was not uncommon.

6.71 The rate of emergency admissions for injury in the 0-14 year age group in the Joint Strategic Needs Assessment area where the family lived (115.8 per 10,000 population) was the third highest JSNA rate and well above the Warwickshire average (96.5 per 10,000 population). The proportion of pupils registered as eligible for and claiming a Free School Meal in 2018 in this JSNA area was 12.2% - similar to the borough average (12.4%).

6.72 The Challenge and Complexity report refers to earlier research findings 'that childcare professionals working with families living in areas of high deprivation [can] come to accept lower standards.' It notes that 'practitioners can become desensitised to the impact of poverty and accept lower standards for children and families.'

6.73 This review has found no indication that any of the professionals involved used the presence of child poverty to explain or condone abuse or neglect or to prevent appropriate action. However, school did record a pattern of low-level neglect of the children's needs over the period under review. The Health Visitor had also identified developmental delay for Dani and had to work really hard to engage Mother and to see the children.

6.74 South Warwickshire NHS Foundation Trust found no clear evidence that unconscious bias impacted on health professionals' ability to respond to any safeguarding concerns about this family. The Health Visitor caseload for the area where the family lived is incredibly mixed and has affluent areas, areas of deprivation and everything between those two extremes. Health professionals reported that this promoted a balance perspective. Nonetheless, the author of the South Warwickshire NHS Foundation Trust report concluded that it would have been pertinent to discuss and escalate the concerns around the home environment, poor engagement with services, and Dani's developmental delay in supervision and/or a consultation with the MASH who can signpost practitioners to Early Help resources.

6.75 It appears that professionals and assessments did not fully consider the impact of overcrowding upon this family or the financial pressures they faced which could have been identified if there had been consideration of wider family and environment using the Assessment Framework.

Professional curiosity, healthy scepticism and awareness of disguised compliance

6.76 The Health Visitor and school staff viewed Mother as a likeable mother of a number of young children who was very busy as a consequence and sometimes missed appointments. Mother was seen by the Health Visitor to struggle to keep her house clean. Father worked long hours and was not often seen.

6.77 The Health Visiting Service and School A recorded that Mother often cancelled appointments without arranging another, some rescheduled appointments were still not kept, she could be difficult to contact or find at home, and she sometimes said that it was not convenient to visit or meet at the specified appointment times.

6.78 There is evidence that Mother could be difficult to engage and could be evasive and was potentially demonstrating disguised compliance in her relationship with professionals.

- In September 2015 the Health Visitor completed Dani's twelve-month assessment at the fourth attempt. A home visit by the Health Visitor on 27 February 2019 was the fifth attempt to assess Charlie's development.

- Mother told the Health Visitor that she would make an effort to clean and tidy the home and it is not clear that this happened.

- Mother declined a number of offers of assistance from the Health Visitor and school staff.

- Mother declined a number of services offered through Early Help (individual counselling and a group to foster parent-child attachment) which may have been beneficial to her. She said that she had previously completed parenting courses but it is not evidenced that she had. These services may have helped her to develop her parenting of, and her relationships with, her children.

- Mother allegedly asked another person to keep quiet at hospital about the incident in February 2019 when Ben was bitten, told Hospital staff that there was only one dog, informed the Police and the MASH social worker that the family were getting rid of one of the two dogs (although she was having second thoughts) and that she would not leave the children unsupervised with the dogs. She gave differing accounts about who was looking after the dogs immediately following the incident. There were still two dogs in the home when the house fire took place.

6.79 As highlighted in the Challenge and Complexity report, 'professionals have to be both robust and compassionate in addressing the strategies parents use to defend themselves and their family from scrutiny'. That report also notes that 'parents' own childhood adversity or behaviour during adolescence may lead to social isolation, stress and difficulties in engagement'.

6.80 There is little evidence of MASH workers questioning accounts of events, or challenging and exploring inconsistencies in response to the school's referral and consultation about concerns.

6.81 The GP information report has highlighted that there was no documented evidence of professional curiosity in relation to how the parents were managing with the care of all five children, particularly as it was known that Mother was prescribed medication for low mood and a physical health condition and Father had reported feeling stressed in August 2019 when he was signed off work for two weeks.

Needs and risk assessment

6.82 The Early Help assessment focussed on the needs of the two oldest school age children. There was limited communication with the Health Visitor and Health records did not record that an Early Help intervention had been in place for this family. This limited the scope and quality of the assessment.

6.83 A Health Visitor attended the GP practice fortnightly in person to discuss concerns about any of the practice's patients, and these are recorded directly into the patient notes by the GP. The practice also has a vulnerable patient alert which is added to the system so that all staff, particularly on reception, are aware of this when patients contact the practice.

6.84 This Review has noted the unique position a GP can hold in having an overview of a family's situation and the important contribution they can make to any Think Family approach. The GP was the only professional who was aware of both parents' health needs in summer 2019. There is no evidence in the GP records that parents were signposted by the GP to the Health Visitor, or that the GP and Health Visitor discussed any concerns about the family.

6.85 There is no documented evidence in the GP records of professional curiosity in relation to how the parents were managing with the care of all five children, particularly as it was known that Mother and Father had their own health needs. There is no reference to the dog bite to Ben in the GP report to this review but the hand injury to Father whilst he was walking one or both of the dogs is recorded and he received post-operative wound care at the GP practice on two occasions**.**

6.86 It is not clear from agency reports that the GP was consulted either directly or indirectly through the Health Visitor as part of the Early Help process or the response to the referral to, and consultation with, the MASH.

6.87 It would have been helpful if the school had completed a chronology as part of their Early Help assessment and/or to accompany their referral to the MASH. This could have been multi-agency if joint working had been established with the Health Visitor and could have provided a valuable overview of events and any trends or patterns of behaviour.

6.88 Neither the Common Assessment undertaken as part of the Early Help pathway nor the referral taken in respect of the dog bite to Ben or the consultation in respect of the capsule brought into school by Dani highlighted that Mother had been a looked after child herself. This significant piece of information was only brought to light when information was requested for this Child Safeguarding Practice Review.

6.89 The Voice of the Child was not clearly evident in agency responses to concerns for the children or in agency recordings. School A knew Charlie's siblings and attempted to offer Mother and her family help. However social workers in the MASH did not specifically ask staff to speak to the children about their wishes and feelings. For example, there is no information in agency reports to state how the children felt about the pet dogs and Ben's account of the incident and being bitten. The Police Officer had noted that the children were not 'fazed' by the dogs during his visit.

6.90 The South Warwickshire NHS Foundation Trust report found that the Health Visitor did not consistently interpret and record the children's wishes and feelings after visits.

6.91 There is no evidence that wider family and their potential support for Mother and Father and the children were considered in assessments.

6.92 The Health Visitor had noted that Mother had rent arrears. There is no reference to any other agency discussing finances with the family. Father worked but many working families have financial difficulties. Platform Housing Group have confirmed to this review that Mother and Father had issues with rent arrears for the time period set out in this report between 2016 and 2019.

Specialist assessments

CAMHS Involvement

6.93 The GP made a referral to Child and Adolescent Mental Health Services (CAMHS) in December 2016 for an older child. An initial appointment took place in March 2017 and the CAMHS practitioner recommended that Mother attend a Fostering Attachments Group but she declined this.

6.94 In February 2018 an e-mail referral was made to the Warwickshire Neuro Development Team because parents wanted an Attention Deficit Hyperactivity Disorder (ADHD) assessment. The service contacted Mother in July 2018 to reassure her that that her child was on the waiting list

6.95 In August 2018, an ADHD screening assessment went ahead. It was reported that an older child had had sleep difficulties since the age of 2 years old but other agencies appear not to have been aware of this. Further assessments were recommended and these took place in December 2018. Information was sought from School by the Neuro Development Team. However, there was a delay because the school only received forms from the Neuro Development Team to complete in October 2019 as they had not been forwarded by Mother in May 2019 as requested.

6.96 The references to waiting lists and delays in service responses reflect the demand upon CAMHS services locally and nationally and the corresponding pressure on resources.

Dog or Pet Assessments

6.97 Children's Services had noted that Warwickshire Police would investigate the concerns about Ben's dog bite and an Officer was tasked to attend. The focus of the investigation was very narrow. Warwickshire does not have any guidance about a dog or pet assessment in the current safeguarding procedures which were in place during the review period.

Accident Prevention

6.98 The judge in the criminal proceedings noted that Mother had left Charlie asleep without adult supervision in a room where there had been a lit candle in a jar on a high shelf.

6.99 There are campaigns in Warwickshire about home safety and accident prevention and the Fire Service has a range of events and activities each year to highlight fire prevention.

6.100 There is information on the Warwickshire Council website about safety inside and outside the home including links to the Child Accident Prevention Trust website and the Royal Society for the Prevention of Accidents website which both contain information about fire safety.

6.101 Platform Housing have informed this Review that the group routinely undertake safety checks before letting a property and install fire alarms routinely in its properties.

7. Service developments in Warwickshire since October 2019

7.1 Warwickshire County Council has brought Children's Centres and Family Support Services back in-house. They had been commissioned services during the period under review.

7.2 The Early Help offer to families has been revised. New Early Help Pathway guidance were introduced in February 2020. The Early Help Officers have been renamed Targeted Support Officers and have a clearer quality assurance role to monitor and promote good practice. They provide training to Designated Safeguarding Leads and provide increased support to Head teachers; they will also be responsible for the delivery of the Targeted Help clinics in schools.

7.3 Warwickshire's Think Family Protocol was updated in May 2020. The intention is to ensure that practitioners, managers and services working with either adults or children work together to safeguard children, young people, adults, carers and families; and to place a shared responsibility at the heart of practice across all partner agencies within Warwickshire Safeguarding.

7.4 Following a joint strategic review of the MASH, led by an independent an improvement consultant, there were significant changes made to the MASH in June 2021. The MASH, alongside the Emergency Duty Team, Initial Response Team and Family Information Service now forms a newly formed "Front Door". The aim is to strengthen the 'front door' and to provide a consistent approach across the key social care teams and to dovetail in the link with Early Help and the wider offer from the Family Information Service. Initial Response Team Leaders now play a joint role in Strategy Meetings held by the MASH to ensure prompt information sharing at the point of more collaborative decision-making.

7.5 Within the updated Multi-Agency Contact form which replaced the Multi-Agency Referral Form in October 2020, it now explicitly asks the person completing the form, 'What does the child say/how does the child see themselves? This is intended to promote the voice of the child early in the process.

7.6 Increased health (nursing) capacity and the creation of a new MASH Education Lead Officer have strengthened multi-agency working and decision-making in the MASH (now known as the Front Door).

8. Actions planned in response to this incident and Review

8.1 Individual agencies have identified actions to strengthen their arrangements and responses to any future concerns or referrals where necessary. Agencies have confirmed that several actions have already been implemented and Warwickshire's Safeguarding Partnership will monitor the implementation of any outstanding actions and the impact on practice of these changes and the service developments outlined above.

8.2 Warwickshire's Safeguarding Partnership will produce a Lessons Learned briefing in respect of Charlie's case and also develop seven-minute briefings in respect of Early Help and safeguarding children where there are concerns about pet dogs.

8.3 Warwickshire's Safeguarding Partnership will review the placement of, or signposting to, the Warwickshire Threshold document on the Warwickshire Safeguarding Partnership website. The Policy and Procedure Group have been reviewing the document.

8.4 Training in respect of the new Early Help arrangements is available for all stakeholders in Warwickshire.

8.5 Discussions during this review have identified the important role which community workers play in the areas they cover in Warwickshire and potential to involve them in safeguarding and safety campaigns. Community workers could hand out leaflets to raise awareness of safeguarding issues or arrange speakers for meetings and events if requested by a community group. They work with a wide range of organisations and attend a number of boards and committees. They also hold workers' network meetings and have a mailing list covering over one hundred and thirty local organisations.

9. Conclusions and Learning Points

9.1 The actions by Charlie's mother and the accident which led to Charlie's injuries could not have predicted by agencies. However, there is learning for professionals around the offer and delivery of universal services and early help to families. There is

also learning about the response to concerns referred to Children's Services and the importance of thorough information gathering, professional curiosity and multi-agency assessment and intervention in families where there are stresses and indicators of low-level neglect. If there is not a thorough, holistic assessment which considers the voice of the child, any adverse childhood experiences of their parents and any potential support and stresses in the wider family and environment, professionals will not fully understand the complexity of children's lives or a family's circumstances. Some of the issues identified have been highlighted in other recent serious case reviews in the county.

Learning Points

- Professionals should exercise professional curiosity and healthy scepticism when investigating and/or assessing concerns for children and their families and their histories - to establish all the facts and accounts around potential safeguarding incidents and to explore any discrepancies or missing information.
- When agencies make referrals to the MASH, they ensure that the information included accurately and fully reflects the concerns of the referrer and the MASH should clarify any information that is not clear.
- The importance of completing chronologies in Early Help and Safeguarding/ Child Protection work to provide an overview, a valuable oversight of children's lives, and to help identify any emerging patterns of behaviour and recurring issues.

  (***These learning points echo those identified in the Warwickshire Serious Case Review in respect of the Wilson Family published in August 2020 and the Serious Case Review in respect of two children Alice and Beth published in September 2020***).

- The challenges in objectively assessing low-level neglect and the importance of multi-agency holistic assessment
- The importance of recording safeguarding concerns and sharing them with line management in all settings
- The importance of establishing the views of children
- The importance of checking for information about parents as children to better understand their life experiences
- Where members of the public report safeguarding concerns about children to any agency, professionals should carefully record and consider them and communicate them to managers and to other appropriate agencies. There should be no presumption that such a referral is malicious and judgement should be reserved until all relevant information has been collected and assessed.
- The importance of regular consultation between GPs and Health Visitors about children where there have been safeguarding issues or concerns.

9.2 Agencies have provided information about changes and improvements to services which are intended to strengthen practice in Early Help and within the Multi-Agency Safeguarding Hub in Warwickshire.

10. Recommendations

1. Warwickshire Safeguarding Partnership to ensure that the shared and new learning points noted above continue to be highlighted in briefings and training, are addressed in future quality assurance auditing, and that progress in embedding good practice is monitored. Also, the Partnership to ensure that any outstanding individual agency actions are completed and their impact evaluated.

2. Warwickshire Safeguarding Partnership to review the recommendations of the joint Strategic Review of the Multi-Agency Safeguarding Hub (Completed in June 2021) when available and any further learning about the work required to strengthen the MASH arrangements.

3. Warwickshire Safeguarding Partnership to produce new guidance around safeguarding children where concerns are raised in respect of pets including dangerous dogs and add to the Warwickshire section or the main body of the West Midlands Safeguarding Procedures.

4. Warwickshire Safeguarding Partnership's Policy and Procedures Group to develop a multi-agency version of the Neglect Toolkit.

5. Warwickshire Safeguarding Partnership to liaise with Warwickshire County Council's Localities and Communities Team to discuss the potential for community workers to promote information within the communities in which they work regarding the safeguarding of children in relation to injury and accident prevention. In relation to this review, the information should promote fire safety /prevention and highlight the risks of accidents taking place if children are on their own or unsupervised. Furthermore, information regarding the referral route if members of the public have concerns about children who may be at risk of abuse or neglect.

6. The Safeguarding Partnership to review arrangements with the relevant Health Trusts to strengthen consultation between GPs and Health Visitors in local arrangements where necessary.

References

Complexity and challenge: a triennial analysis of SCRs 2014-2017 Final report (March 2020) - M Brandon, P Sidebotham, P Belderson, H Cleaver, J Dickens, J Garstang, J Harris, P Sorensen and R Wate

Warwickshire Joint Strategic Needs Assessment (Thematic needs assessments and annual updates)

West Midlands Child Protection Procedures including Warwickshire Specific Safeguarding Information and Procedures