



**Suffolk Safeguarding
Children Board**

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SERIOUS CASE REVIEW THE ANDERSON FAMILY

Overview Report

Independent Safeguarding Leads;

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1. INTRODUCTION

- 1.1** This report will summarise the findings of the Serious Case Review which was conducted in respect of the multi-agency involvement with the Anderson family, for the period of almost 4 years before the tragic deaths of all three children in April 2013 and the subsequent death of their mother on the same day. At the time of her death the mother was 7 months pregnant. The parents of the children were not married and the father of all three children lived separately from the family for much of the period of time of this review.
- 1.2** The Anderson family were known to a variety of child care agencies from the time of the mother's first pregnancy in mid-2009 up until the deaths of all three children. At the time of writing there has been no coroner's inquest, although current evidence would suggest that the mother took the lives of the children prior to taking her own life.
- 1.3** There were two periods of time when Child Protection Plans were in place for one or more of the children; for almost a year up until June 2010 and then from October 2011. These Plans identified concerns in respect of possible physical and emotional neglect, and were in place at the time of the children's deaths. There were also legal initiatives to obtain care proceedings in respect of the first child and although these were withdrawn, later legal strategy meetings were held to continue to consider if the children met the criteria to seek care or supervision orders. Overall there was very limited success in engaging the mother and the father in professional interventions especially by Children and Young People's Service (CYPS) although other professionals such as health workers and children's centre workers did achieve a limited level of involvement.

2. THE SERIOUS CASE REVIEW PROCESS

- 2.1** Suffolk Safeguarding Children Board made the decision to conduct a Serious Case Review (SCR) which reflected the government guidance contained in Working Together March 2013. The purpose of the SCR is to "Identify improvements which are needed and to consolidate good practice"¹. Additionally, SCRS should be conducted in a way which:
- Recognises the complex circumstances in which professionals work together to safeguard children;
 - Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
 - Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
 - Is transparent about the way data is collected and analysed, and
 - Makes use of relevant research and case evidence to inform the findings.²

¹ Paragraph 7, Chapter 4, Working Together to Safeguard Children – A guide to inter agency working to safeguard and promote the welfare of children – HM Government - March 2013

² Paragraph 10, Chapter 4, Working Together to Safeguard Children – A guide to inter agency working to safeguard and promote the welfare of children – HM Government - March 2013

2.2 Suffolk Safeguarding Children Board chose to use a SCR learning model to undertake the review consistent with the principles in the government guidance. This model is referred to as a Partnership Learning Review, and formed the basis of the work of the SCR and is attached as an appendix to this report.

2.2 An independent Chair, Bob Cook, was appointed to lead the SCR and another independent person, Ron Lock, was appointed to be the author of the SCR Overview Report. Both independent persons have considerable experience in safeguarding children and young people, including involvement in SCRs in other parts of the country. Neither had previously worked in Suffolk in a professional capacity.

2.3 Senior managers from Suffolk were appointed to be part of the SCR team, whose role was to assist with the scrutiny and analysis of professional practice in the case. These were: -

- Detective Supt., Joint Protective Services, Suffolk Constabulary
- Manager, Suffolk Safeguarding Children Board
- Designated Nurse Safeguarding Children and Looked After Children, Suffolk Clinical Commissioning Groups
- Director of Patient Safety and Quality, Health East
- Interim Head of Safeguarding, Children and Young People’s Services, Suffolk
- Lead Lawyer, Suffolk Legal

2.4 The SCR team met on three occasions with the independent chair and independent author in order to progress the SCR and to provide comment in respect of draft Overview Reports. Members of the SCR team were also very active in their contribution to the two one-day “Learning Events” which were conducted with frontline practitioners and their line managers. These meetings were held in order for as many of the practitioners and line managers who had worked with the family as possible, to contribute to the SCR team’s understanding of the detail of the work that had been undertaken with the family and to contribute to the analysis of professional practice. In total 41 professionals attended the first Learning Event and there were 31 attendees at the second. The local agencies represented by these professionals at the Learning Events were:

- East Coast Community Health Care (e.g. health visitors, named nurse for safeguarding)
- Norfolk and Suffolk NHS Foundation Trust (named nurse for safeguarding)
- Ipswich & East CCG/West CCG (named nurse for safeguarding)
- James Paget University Hospital (midwives)
- Suffolk Constabulary
- Education (e.g. head teachers, nursery school staff)
- Children and Young People’s Services (e.g. social workers and line managers, children centre workers, family support practitioner, child protection conference chair)
- Legal Services
- Waveney District Council (Housing Options advisors)
- Cafcass
- Access Community Trust

- 2.5** The outcome from these Learning Events, which were chaired by the Independent Chair of the SCR Team, was clarification of the factual details of the work undertaken with the family and contributions to the analysis of practice which in turn informed the key lessons learned from the work undertaken with this family. The findings from these Learning Events have been included within the body of the report in terms of both the factual and analysis components. Additionally to ensure greater understanding of particular parts of the work with the family, the Independent Overview Report Author spoke individually with some of the practitioners and managers
- 2.6** At the outset of the SCR process, detailed chronologies were requested from all of the involved agencies as identified above, of their involvement with the family from the time of the mother's pregnancy with her first child in early/mid 2009 until the children's deaths in April 2013. Each person completing the chronologies (the Individual Agency Representative) had no direct line management involvement in the case and was also asked to complete a summary of commentary and analysis of the professional practice within their agency. They also completed a separate document to identify any organisational or contextual factors which may have impacted on the work with the family. All of this material was collated and reviewed by the SCR Team, and the factual contents of the chronology were fully shared with all attendees at the Learning Events.
- 2.7** Each of the Learning Events were evaluated by the completion of a questionnaire by attendees, and this will prove useful for the Suffolk Safeguarding Children Board in determining what lessons to take from these evaluations and how these might inform the structure of future SCRs locally. The SCR Team have learnt lessons from the sessions, and those participants who felt a different approach would have been more productive, have made their views known. Overall the evaluations considered the different components of the Learning Events and an amalgamation of all the responses rated the Learning Events as:
- Excellent (22%), Good (67%), Adequate (10%), and Poor (1%)
- 2.8** The father of the children was interviewed by the independent Overview Report author in order to gain an understanding of his experiences of the professional interventions with himself, the children and their mother. His contributions are included in the body of the report. Additionally, the maternal grandparents met with the Chair of Suffolk Safeguarding Children Board and LSCB Manager to discuss the Report and lessons identified. Their views were shared with the overview author.
- 2.9** At the time of the presentation of the final Overview Report to the Suffolk LSCB in December 2013, the "Lessons Learned" in section 14 of this report were utilised to develop appropriate actions by local agencies and the LSCB for future learning and for the development of safeguarding practice in Suffolk.

3. SUMMARY OF THE FACTS AND FINDINGS OF THE SCR

Facts

- 3.1** In terms of professional interventions with the family, this can be divided into three distinct phases. The first began just prior to the birth of the couple's first child, Levina, when there were high levels of professional concern about possible neglect of this child and the parental refusal to accept any professional advice or contact. As a result, the unborn child was made subject to Child Protection (CP) Plans and Care Proceedings³ were instigated although an application by the Local Authority was not granted by the court in June 2009.
- 3.2** By the time Levina was approximately 6 months old, the local authority withdraw the Care Proceedings in recognition that the assessment which had been completed did not provide the necessary evidence to substantiate the concerns. Levina nevertheless remained subject to CP Plans for a further 6 months before they were discontinued when it was considered that the family were appropriately accessing universal services and living with the family network which was viewed as a protective factor.
- 3.3** The next phase of professional involvement was from June 2010 to July 2011 when there were no formal "child protection" or "child in need" inter agency procedures in place to work with the family although some concerns were on occasions raised about possible neglect. By this time, the second child of the family had been born. Health and local children's centre involvement continued throughout much of this time, although this was limited in nature because of the parent's continued reluctance to accept professional interventions.
- 3.4** The final phase of professional interventions occurred from August 2011 until the death of the children when they were all subject to CP Plans under the category of neglect. The third child of the family was born in May 2012 and included in the CP Plans. Although legal interventions were again considered in order to protect the children, the plans for these drifted and ultimately no Care Proceedings were initiated. Although there continued to be considerable concerns about the care of the children, the refusal of the mother particularly to accept any intervention, meant that there was minimal contact with her and the children, and therefore the CP Plans achieved very little. Parental attendance at Child Protection Conferences (CPCs)⁴ and Core groups was almost non-existent. Whilst the mother's behaviours and attitudes to her children and to professionals raised concerns during this time, the process of the CP Plans was unable to secure any psychological or mental health assessment of the mother.

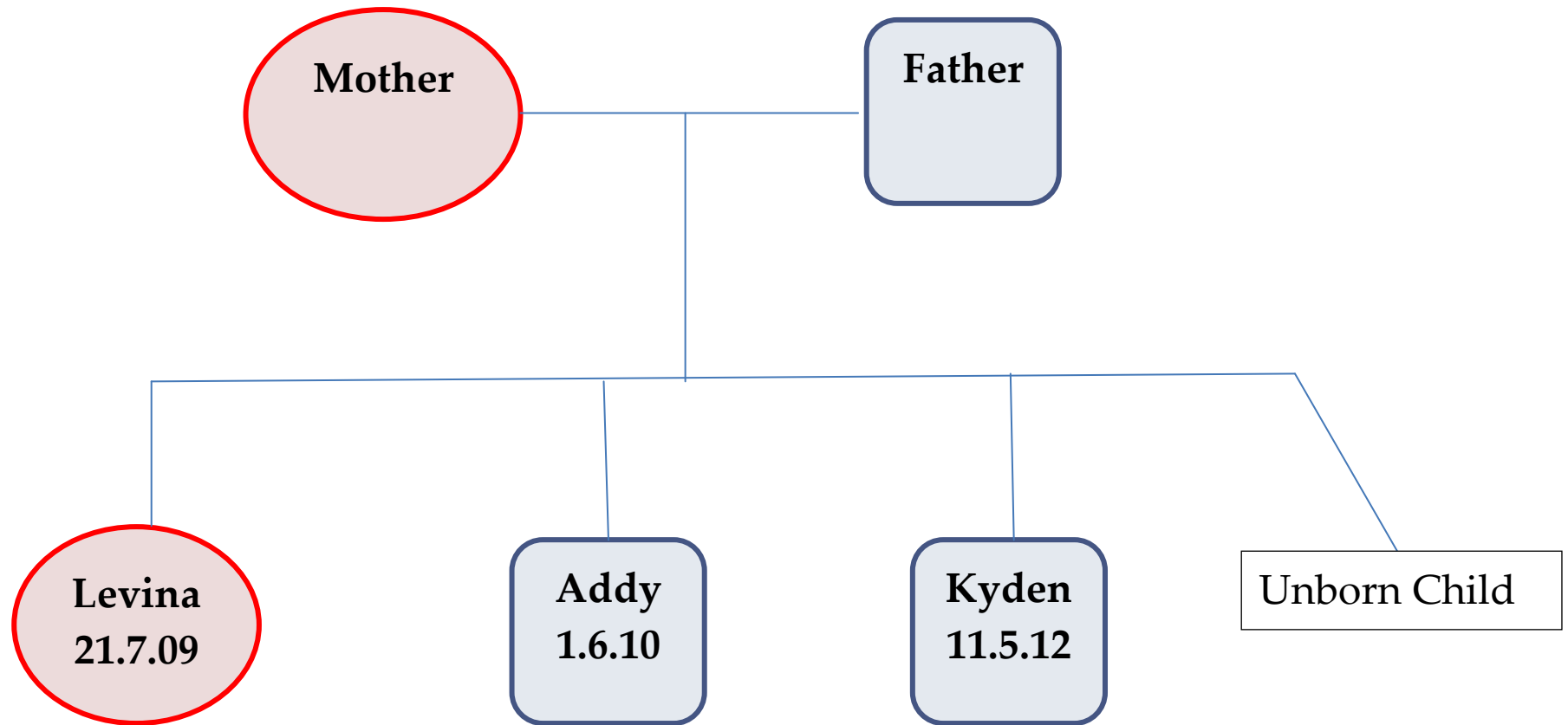
³ Care Proceedings are when a court is asked to consider the care needs of a child or children based on evidence of the care of child concerned provided by the local authority and other agencies involved with the family. A number of court hearings are usually held before a final hearing can hear all the evidence and assessment of the family and a final decision is made.

⁴ A formal meeting of professionals from key agencies such as Health, Police, Children and Young People's Services and those professionals who have worked with and know the family. The purpose is to decide the level of concerns for any child or unborn child in the family and whether they are at risk of significant harm or will likely be in the future. The parents are invited to attend the full conference.

Findings

- 3.5** Despite some committed interventions by a number of practitioners, no success was ever achieved in effectively engaging the family in interventions by professionals, and this meant that overall the implementation of the CP Plans was significantly compromised. The early application for Care Proceedings in respect of Levina set a tone of an adversarial relationship for the parents, particularly with Children and Young People's Services (CYPS), and this strained relationship changed little for the final period of CP Plans and up until the deaths of the children.
- 3.6** Overall, the child protection process was implemented in line with procedures, but were not ultimately successful in engaging this most challenging of families who were avoidant of professional interventions. It was inappropriate for the CP Plans to continue largely unchanged for a period of eighteen months from August 2011 without some form of review and formal revision of the way forward with the family. Whilst there was a system of senior management overview in place, it did not impact on this case.
- 3.7** Although there was much consideration of the need for a legal intervention to secure the safety of the children during the latter phase of involvement with the family, this was never taken forward and unfortunately the process was allowed to drift for a period of over a year. Ultimately this was the key remaining strategy to use as a form of sanction with the family and to demonstrate the seriousness of the professional concerns, but its effectiveness was never tested.
- 3.8** Whilst the main professional concern was in respect of neglect from both a physical and emotional perspective, it was the physical neglect which was given most attention when there was also evidence of emotional neglect. Overall the professional interventions and the concerns about neglect were never sufficiently supported by evidence that needed to be collected and collated on a multi-agency basis. Emotional neglect proved especially difficult for professionals to evidence, although a more concerted collation of these areas of concern could potentially have realised greater evidence.
- 3.9** There had been no known history of either the mother or the father intentionally causing physical harm to the children, or of any self-harming episodes by the parents themselves. In this respect, the deaths of the children and their mother was completely unexpected and not predictable or thought in any way likely, from what the professionals knew of the family.
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Genogram/Family Tree



All three children died in April 2013 – Their mother died at shortly after – she was aged 23 years old at the time. The father was aged 22 years.

4. FACTUAL SUMMARY OF THE CASE – KEY EVENTS

The year from June 2009 – May 2010

4.1 The midwifery services made a referral to Children and Young People’s Service (CYPS) in **June 2009** due to the mother’s poor ante natal attendance, her vulnerability, difficult family background and low mood. A “cause for concern” sheet was also shared with the health visitor. Numerous attempts to contact the mother by the midwife and encourage her to attend medical appointments had been unsuccessful from **March 2009**. In response to those concerns the social worker who was allocated the case (a student social worker) made direct contact with the family on the **29th June 2009**, which was the third occasion of trying.

The Child Protection/Legal processes

4.2 Very soon after the referral was received by CYPS, who considered the concerns to be serious, plans were made for an Initial Child Protection Conference to be setup, followed immediately by a legal initiative to secure Care Proceedings in respect of the new born child. These processes then ran simultaneously for the period **from July 2009 until May 2010** in respect of Child Protection (CP) Plans, and until **November 2009** in respect of the Care Proceedings.

4.3 Therefore the first key decision made at this time by CYPS was to call an Initial Child Protection Conference (ICPC) in respect of the unborn baby, not only because of the poor engagement of the parents but also because “some prior knowledge about both parents suggests that parenting capacity will be limited”. As a result of the ICPC on the **13th July 2009** a Child Protection Plan⁵ was established for the unborn baby. Although invited, the parents did not attend the ICPC and the mother refused to speak with either the police officer or social worker later that day when a visit was made to the home. The father was however engaged in conversation.

4.4 The next significant event was that a Legal Strategy Meeting⁶ was called the day after the ICPC with the legal advice given that the threshold criteria for care proceedings were met in these circumstances. CYPS’s interim care plan was for an Interim Care Order⁷ and removal of the

⁵ If a child or unborn baby is considered by the ICPC and by later CPCs to be at risk of or suffering significant harm, then a set of Child Protection Plans are set up to address the concerns and identify what needs to happen to reduce the risks and improve the care of the child. These plans identify who will action and monitor each specific plan.

⁶ A legal Strategy Meeting is usually held between Children’s Social Care staff and the legal officers of the local authority, when legal advice is sought about the strength or otherwise of evidence of concerns about a child within a family, and based on that advice Children’s Social Care will decide whether to initiate care proceedings.

⁷ This is where an application is made for a Care Order but that the application is adjourned by the court, potentially whilst awaiting further assessment. The court will only grant an Interim Care Order if it is satisfied that there is reason to believe that the threshold criteria pertaining to a full Care Order are present. This is a short term measure which will likely include the child being removed from parental care, and will last for a specified period of time until a full Care Order is applied for or the application is removed. There are restrictions to the time period for which Interim Care Orders can continue to exist.

baby to foster care in order to complete a core assessment to identify either alternative carers for the baby or whether it would be appropriate for the baby to be returned to the parents.

- 4.5** Levina was born on the **21st July 2009**. CYPS formally requested the parents to agree to a voluntary arrangement for Levina to be placed into care (under Sec. 20 of the CYP Act 1989) – they refused.
- 4.6** In terms of the Care Proceedings, an Interim Care Order was not granted in court on the **24th July 2009** and the child’s guardian opposed the application and did not consider that there was sufficient evidence of concerns to warrant separation of Levina from her mother. The case was progressed by way of a written agreement that the parents would cooperate and work with professionals. Assessments were to be undertaken to ascertain parenting capacity.
- 4.7** The child’s guardian initial Analysis and Recommendations Report in **mid-August 2009** identified that there were no concerns about Levina’s health, that the mother had cooperated sufficiently with professionals and that the local authority should provide assistance and support to the mother. The guardian stated that she was unclear about CYPS’s current concerns and whether these met the Care Proceedings threshold.
- 4.8** At the 5th and final court hearing in **November 2009**, the local authority applied to withdraw from the Care Proceedings. The core assessment had been completed but the evidence it contained did not support the Court making an order. Whilst there was satisfaction that Levina’s basic needs were being met, there remained concerns about the stability of the family and of their housing situation. It was recognised that the CP Plans were continuing and it was anticipated that these would monitor the situation and address any concerns if they arose. The child’s guardian’s position had been that the family were in the need of support and that if the care proceedings were dismissed (or withdrawn) that Levina should remain subject to the CP Plans.
- 4.9** The CP Plans therefore continued beyond the cessation of the Care Proceedings, and there were Core Groups⁸ held in **August, October and December 2009**, the first of these not attended by the parents. They also did not attend the Review Child Protection Conference (RCPC)⁹ **in October 2009** although the decision was made to retain Levina as subject to CP Plans. It was only the father who attended the next Core Group in **April 2010** and at the following RCPC on the 4th May 2010, the CP Plans were ceased because it was considered that there were appropriate preparations (relevant equipment acquired) for the next child, soon to be born, and that the parents were accessing universal services.

⁸ Core Groups are held regularly between Child Protection Conferences and include the key professionals working with the family along with the parents, to monitor and ensure that the Child Protection Plans are being progressed.

⁹ Review Child Protection Conferences follow three months after the Initial Care Protection Conference if the child/children have been made subject to Child Protection Plans, and then continue on a six monthly basis until the child/children are deemed to no longer need a Child Protection Plan.

Concerns about parenting and engagement with professionals

- 4.10** The professional's concerns about the care of Levina related to the parental lack of preparation for her birth, and then for concerns about neglect in terms of sufficient feeding, lack of stimulation and that overall the parents were refusing to engage with professionals.
- 4.11** At a very early stage of intervention, there was a mental health assessment with the mother and father at home on the **15th July 2009** by a mental health link worker, which identified no presentation of depression or anxiety in the mother, and she denied ever experiencing these. Overall there was no presentation of concerns about mental illness and therefore it was concluded there was no role for mental health services. The couple stated that they were unhappy with CYPS's "interference" and the style of intervention at this time, e.g. regular visiting, once with the police, and checking food cupboards. The issue of the need to assess the mother's mental health arose again from a Core Group meeting a month after the earlier assessment, and whilst an appointment was set up for the mother to meet with the mental health link worker on the **25th August 2009**, the mother did not turn up and later said that she did not need it as she considered she was not suffering from post natal depression.
- 4.12** There were concerns about Levina's physical development and her poor weight gain and in this regard, breast feeding nurses were involved to support and monitor this with the mother. In fact Levina was admitted to hospital in **early September 2009** following serious concerns about her low weight although she had gained sufficient weight to enable discharge 3 days later. The mother had remained in the hospital throughout the stay.
- 4.13** Different views emerged regarding worries about Levina's poor weight gain, sometimes with conflicting information about the actual level of concern. There were other concerns about how easily the mother could be distracted and that she did not always recognise when the baby was hungry. There were periods of progress in the feeding by the mother and despite some of the difficulties of getting access to the mother and child, there was some consistency of involvement by health professionals, with regular checks on the status of Levina's dirty nappies to help identify whether she was being appropriately fed.
- 4.14** In terms of the concerns about parental non engagement with professionals, there was considerable evidence of the parents avoiding contact with CYPS staff who were endeavouring to undertake the parenting assessment, with only six out of the 12 assessment sessions attended by the parents **by 11th September 2009**. On other occasions of planned visits to the home, reasons were given for not being present or cancelling, and when they did attend appointments, they were often very late. There was greater success for the health interventions. Some of the inconsistency of the parental attendance at Core Groups and CPCs has already been referred to.
- 4.15** The family moved to stay with friends when they were evicted in **October 2009**. The family had made formal requests for CYPS to provide financial assistance to avoid the eviction, but they failed to provide the necessary financial details to enable this to be considered. The family eventually moved to live with the paternal grandparents.

Summary

4.16 During the first year **up until May 2010**, the level of professional concerns about the parenting capacity of these parents, especially the mother, began at very significant levels, leading to the establishment of CP Plans and an application for Care Proceedings being made with the plan to place the new baby in foster care. The first social worker to be appointed to the case was a student social worker. Whilst the threshold for making an application of Care Proceedings had been met, the social work assessment provided insufficient evidence to justify the making of a Care Order, and was therefore withdrawn. Levina needed a brief hospitalisation because of weight concerns but overall the initial serious concerns about parenting ability and Levina's physical care were not supported by the evidence, although concerns in this respect nevertheless remained for much of the year. The avoidance and lack of parental engagement in the professional interventions continued to be a concern and it remained the view of professionals that the family would continue to need support to manage Levina and to plan for the new baby, which was due. Nonetheless, at the end of this period, there was greater professional confidence in the parenting and care of Levina, leading to the CP Plans ceasing. A parental mental health assessment had not identified any concerns about depression or anxiety. Because of the understanding that the parents were engaged with universal services, then CYPS closed the case **on the 21st May 2010**.

The year from June 2010 to July 2011

4.17 The first key event for this period of a year was the birth of the couple's second child, Addy on the 11th June 2010.

Housing Issues

4.18 It was also during this period that the family had further housing difficulties and were evicted for rent arrears. The couple and the children went to live with a relative who then wrote a letter to evict them by the **5th July 2010**. However no eviction followed as the couple did not want to move into B&B accommodation. The father made a homeless application to the District Housing Department but **by the end of July 2011**.

4.19 **By August 2010** it was apparent that the family were "sofa surfing" and were living with another family previously assessed by professionals as "unsuitable" – there were concerns that they were living in unkempt conditions and in an environment that was unsafe. The mother and children then moved into temporary council accommodation without the father who moved into hostel accommodation. CYPS had been briefly involved because of the housing difficulties but then closed the case at this time in their understanding that the housing problem had been solved. This was not the position of the housing authority who considered that the housing issues still had not reached a satisfactory conclusion.

4.20 In **December 2010**, the mother and children moved to an address in Lowestoft and then moved to another home in Lowestoft by **February 2011**. There were no further house moves.

Concerns about parenting

- 4.21** There was a domestic abuse incident reported which occurred in **November 2010** when the mother complained that the children's father was outside the home refusing to leave and being aggressive. As a result, a Strategy Discussion between the Police and CYPS was held, and it was decided that there was no need for any further action.
- 4.22** **At the end of May 2011**, concerns were expressed from an anonymous referral about neglect, claiming that the children had been sleeping in a double pushchair for 13 nights and had only been fed biscuits. This resulted in CYPS initiating an Initial Assessment two days later on the **30th May 2011**. The result of this was that as the mother had agreed to engage with the local children's centre, then CYPS subsequently closed the case.
- 4.23** **On the 27th June 2011** there was a domestic abuse incident when the mother called the Police and claimed that the father had pushed her whilst holding Levina. The Police reported that whilst the flat was in reasonable condition, the children looked malnourished, very tired with full nappies. There were bits of bread lying on the floor with only a large carton of milk in the fridge and a dry loaf of bread. There was a home visit by the social worker on the **28th June 2011** and a visit from the family support worker from the children's centre followed the **next day** when the children were witnessed to be in play pens for long periods with little stimulation and both silent – Levina looked very thin. The support of the nursery was offered but refused by the mother – this was because the mother said that she thought that the children would be exposed to sexual abuse.
- 4.24** **By early July 2011** the health visitor also witnessed the children in their play pens when she visited, but they were removed and fed by the mother. The health visitor recorded that Levina had lost weight for the second consecutive month and Addy also had a slight weight loss – she was also concerned about the children's social and emotional development. A referral was sent to Speech and Language therapy. A professionals' meeting took place on the **11th July 2011**. By the **13th July 2011** the health visitor made a referral for a paediatric assessment of the children and **two days later**, a Strategy Discussion was held because of the health concerns and because of the recent domestic incident. By this time the mother had said that she wanted to renew her relationship with the father and have another baby. A decision was made to call a new Initial Child Protection Conference (ICPC).

Summary

- 4.25** This period of a year **from June 2010** began with greater professional confidence about the parenting of Levina and of the preparations and eventual care of the second child, Addy. Therefore, throughout the period there were no child protection or child in need processes in place, although involvement of the health visitor continued, and the children's centre became involved. Housing services were also involved and eventually the family's housing situation was satisfactorily resolved. It was the emergence of two domestic abuse incidents and renewed concerns about neglect at the end of this period which led to an ICPC again being undertaken at the end of this period.

The four months from August 2011 to December 2011

The Child Protection/Legal processes

- 4.26** The key decision during the latter part of 2011 was to once again make the two children subject to CP Plans under the category of neglect. Neither parent attended the ICPC on the **3rd August 2011**, but it was reported that the children were attending the children's centre where they were noted to be well presented, clean and playing. A joint visit by the health visitor and social worker to discuss the CP Plan was made on the **5th August 2011** where the children were seen to be interacting well with their father. The mother talked incessantly.
- 4.27** At the same time a Legal Strategy Meeting was held, when concerns about the lack of stimulation of the children were discussed as well as their language difficulties and that they appeared malnourished. The legal advice to CYPS was that if the mother failed to engage in any of the children's medical appointments, the local authority should immediately issue Care Proceedings and seek an Interim Care Order.
- 4.28** Following parental failures to attend the Core Group and because CYPS had only been able to engage the family in a very limited way, on the **20th September 2011** a letter was sent by CYPS to the parents expressing concern about their non-engagement, explaining that should this continue, legal advice would be sought.
- 4.29** Because it became known that the mother was again pregnant, the Review CPC on **the 31st October 2011** for the two children was linked with an Initial CPC for the unborn child. The decision was made that the two children would remain subject to CP Plans and the unborn child would now also be included. The parents did not attend the next two Core Groups up until the end of the year.
- 4.30** The mother said that she was very offended by the suggestions that she was not a good mother and said that she felt victimised by the child protection process. At a Legal Strategy Meeting **on the 16th December 2011**, it was decided that the case would move to the pre-proceedings stage.¹⁰

Concerns about parenting

- 4.31** The main concerns during these four months related to lack of stimulation of the children and for example, that the home went from no toys to lots of toys but that the children did not know how to play with them. There were concerns about the poor weight of the children and their physical and emotional development, and this led to a paediatric assessment on the **9th August 2011** by a community paediatrician, when both children were considered to be cheerful and happy during the assessment. The outcome of the assessment was that Levina was small and needed to increase her calorie intake. The paediatrician reported that there was no need for a follow up although the health visitor challenged the outcome and was able

¹⁰ This is part of the Public Law Outline process in that these "pre-proceedings" meetings need to be held with the family to explain the process, agree and arrange assessments and to consider possible different options with the family, potentially including the extended family. A successful "pre-proceedings" meeting could negate or avoid the need to progress to Care Proceedings.

to discuss the children later with a community paediatrician who advised the children's weights to be checked every four-six weeks.

- 4.32** **Two days prior** to the paediatric assessment, the mother presented at the A&E Dept. of the local hospital as very distressed and talking non-stop, wanting Levina to be examined because of her poor weight gain. Whilst the doctor examined Levina and reported there were no signs of physical abuse, the doctor was concerned about the mother's high anxiety and accordingly informed the Emergency Duty Services for CYPS. The matter was followed up by a home visit by the day time services
- 4.33** During this **latter four months of 2011**, the non-engagement by the parents was of significant concern to professionals, particularly CYPS. Although there was better engagement by the parents with health workers and the children's centre, this still tended to be inconsistent. The speech and language therapist also experienced difficulties in sustaining contact with the family at this time. A Core Group **in November 2011** considered that the mother would benefit from a psychological assessment due to her own childhood experiences and the affect it was having on her own adult/parenting life.

Summary

- 4.34** This four month period saw the reinstatement of CP Plans and formal consideration of legal interventions although the latter was not progressed by CYPS. The concerns about neglect were similar to those identified in 2009/10 and the parental lack of engagement appeared to become more intransigent. Whilst there were concerns by CYPS and the health visiting service about the parenting abilities, these were not necessarily supported by the paediatrician and the speech and language therapist. During this time, the children's centre began to have some limited involvement and was able to provide some observations of the care of the children.

2012

The Child Protection/Legal processes

- 4.35** **Throughout 2012**, Levina and Addy remained subject to CP Plans under the category of neglect, with the third child of the family, Kyden, added to these plans following his birth on the 11th May 2012. Kyden had already been the subject of CP Plans as an unborn child.
- 4.36** Review CPCs were held in **late January 2012 and again in June and November 2012**, but only the father attended the first of these. There were no substantive changes to the CP Plans at this time. During the year, of the nine Core Groups held, seven of them were not attended by the parents.
- 4.37** CP Plans were unable to be progressed because of lack of engagement of the parents. In **January 2012**, the need for the mother to have a psychological assessment was again discussed among professionals, although it was considered again **in June 2012** and more particularly in the CP Plans of the Review CPC in **November 2012**. On this occasion it was felt that such an assessment would be appropriate for both parents. This proposed assessment was linked to the need to understand the parental lack of engagement and the impact of their

background on their parenting. No such assessment was ever able to be progressed. Also at this Review CPC, as the mother was again pregnant, it was noted that an ICPC now needed to be set up in respect of the unborn child and that this would need to coincide with the next Review CPC for the older children. It was also noted that a pre-birth risk assessment would need to be completed.

4.38 In respect of the legal processes, whilst a pre proceedings meeting was held at the beginning of the year on the **13th January 2012** to confirm the instigation of the Public Law Outline¹¹, the parents failed to attend. The meeting identified concerns about the children's weight, lack of food in the home and a general lack of stimulation of the children. Since a home visit a month earlier there had been ten attempted visits by CYPS but no access had been gained. The meeting considered that the threshold had been met for Care Proceedings. The meeting stated the need for an updated paediatric assessment.

4.39 The parents failed to attend a further pre-proceedings meeting in **February 2012** and although it was planned to hold another, this did not take place. Prior to the birth of Kyden in **May 2012**, there was a plan to undertake a pre-birth risk assessment but this was abandoned as it had not been completed in time, but that a core assessment nevertheless needed to be undertaken. **By August 2012**, it was decided that once the core assessment and chronology had been completed, that a Legal Strategy Meeting would be called. The assessment was not completed during 2012 and it was acknowledged by CYPS in **October 2012** that the Public Law Outline had not been progressed. As a result the social worker was asked to make a home visit and to send a summary of concerns to the Legal Department. There was no record that any summary was sent to Legal.

Concerns about parenting

4.40 For 2012, the concerns about the care of the children was little different from previously, but was against the backdrop of increased lack of engagement by the parents, particularly with CYPS. With other professionals, the mother would talk incessantly about her anger with CYPS and her distrust of social workers. Joint visits between professionals often took place to try to facilitate contact with the children, on one occasion on **24th January 2012** the Police attended with the social worker and health visitor, but this led to the mother becoming distressed and only prepared to speak through the door.

4.41 The need for a paediatric assessment of the children was immediately identified by the health visitor and CYPS because of the lack of contact with the children and the lack of clarity about the level of concerns about possible neglect. The parents failed to attend the first paediatric appointment offered, but the two children were eventually seen on the **21st February 2012** by a community paediatrician, (a different paediatrician than the one who conducted and assessment a year earlier), when it was identified that the children were meeting their developmental milestones apart from Levina's social and interactive skills and that Addy was slightly quiet, with concerns about his vocal development. The paediatrician recommended

¹¹ Public Law Outline (PLO) is a process which requires a local authority to complete all relevant assessments before applications are made to the court. If any pre-proceedings action or assessment has not been taken, the local authority must explain why in the application.

that Levina, now 2 years 7 months old, would benefit from a nursery placement. An additional comment by the paediatrician was that the mother was focussed more on her own needs than the children's.

- 4.42** Overall there was a continuation of missed health appointments and inconsistent involvement with the children's centre, but the parents did attend some sessions with the children, although there was very poor take up of the nursery for Levina. (In fact there was only approximately 15% attendance). These initiatives had been promoted when discussed at Core Groups, but it proved very difficult for professionals to encourage the mother to attend and make use of the support facilities being offered. Against medical advice, Kyden was weaned at 12 weeks but due to non-engagement with the family it was not known what he was being weaned onto. He had been observed to be a very passive baby.
- 4.43** **On the 12th November 2012**, Levina arrived at nursery with a bruised cheek and marks on her face and the nursery contacted CYPS who suggested that they (the nursery) gain an account from Levina. The explanation from both the mother and Levina was that she had fallen in the car park and the mother said that Levina had been taken to the GP. The health visitor was asked to obtain confirmation of this, which she did and the GP said that there were no concerns about non accidental injury.
- 4.44** Although it was not apparent that the father lived with the family, he was in evidence for a lot of the time, and on some occasions when seen at home with the children, he was noted to have a good relationship with them and played with them very well.

Summary

- 4.45** **Throughout 2012**, whilst the child protection and legal processes continued, they had little impact on being able to engage the parents in taking forward the elements of the CP Plan. Evidence of concerns had not been provided to legal services to progress any Care Proceedings. Whilst there were some family support services available for the family, in effect these were sparsely used by the parents. As had happened since the birth of Levina, whilst there were continual professional concerns about neglect, often via poor care witnessed occasionally in the home, overall there was no objective evidence to support these concerns, as demonstrated by the paediatric assessment which did not identify anything significant. Also the health visitor felt that the baby's (Kyden) weight was a concern whereas the paediatrician considered that it was acceptable. In this way, alongside the lack of engagement by the parents, the professional impasse with the family continued unabated during 2012. **By the end of 2012**, professionals had become aware that the mother was pregnant with her fourth child.

2013

The Child Protection/Legal processes

- 4.46** Little changed during 2013 in respect of these processes in that it remained difficult to progress the CP plans although there was some improvement in the parent's engagement in terms of attendance at the first two Core Groups and the mother's agreement to an adult

attachment interview¹², although ultimately this did not go ahead. The alternative for this was the intention for the mother to have a psychiatric assessment. Whilst **during January and February 2013**, there were plans to have a Legal Strategy Meeting “as a matter of urgency”, this did not materialise. One reason given for this was the agreement to await the outcome of the adult attachment interview.

- 4.47** A decision had previously been made to include the unborn child as part of the Review CPC, although this meeting was brought forward to 17th April 2013 as no pre-birth risk assessment had been completed. Therefore no further Review CPC was held prior to the children’s deaths.

Concerns about parenting

- 4.48** The mother placed Levina in a new nursery school and she started there on the **23rd January 2013**. In this school, Levina told one of the staff that she was not to touch her because she was a bad lady like the ladies in her other school. She said “they did bad things to my body. My mummy says ladies must not do bad things to me.” This was after Levina had been removed from the previous nursery by the mother because she complained that Levina had sustained cuts and bruises there, although the nursery challenged this.

- 4.49** By **mid February 2013**, Addy’s weight had increased to the 50th centile¹³ and Levina was now on the 25th centile although there were concerns about Kyden’s lack of expression (he was 10 months old at this time). The midwife made a referral to CYPS in respect of the unborn baby – the mother was 25 weeks pregnant. At this time the other three children were aged approximately 3 ½, 2 ½, and 9 months old.

- 4.50** The relationship between the parents became more strained during 2013 with the mother referring to the father’s lack of help with the children, and **by March 2013** the father reported that the couple were not talking and that she was jealous that he was spending time with another local resident. The mother reported that the couple had separated. The father later confirmed in his contribution to the SCR that he had separated from the mother at this time but that he continued to visit the flat daily to make lunch for the children.

- 4.51** The family support worker who had been allocated the case earlier in the year undertook a home visit on the **4th April 2013** when no concerns were identified although the mother said that the children had been out a lot with their father and that she had been up a lot at night because the children kept waking. The mother said that she wanted to attend the next CPC.

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- 4.52** During the afternoon of the **14th April 2013**, the father reported (via his statement to the Police), that he had been at the home and had fed the children lunch on that day and had left

¹² An Adult Attachment Interview asks a series of questions that ask the person being interviewed to consider their childhood and how this might affect their thought and behaviour in the present, especially as a parent.

¹³ If a child’s weight is on the 25th centile, this means that for every 100 children of that age, 75 would be expected to be heavier and 24 lighter. A child’s weight can be similarly placed on a centile chart. Therefore the lower the centile, the lighter or shorter the child to the average (which would be the 50th centile)

in the evening telling the mother that she needed to accept that their relationship was over. He was now in a relationship with another woman.

- 4.53** At 8.05 p.m. the father called an ambulance claiming he had been stabbed from behind by an unknown male. As the initial statement by the father had said he had been in the vicinity of the mother and children's flat, in the early hours of **the next morning**, a police officer spoke to the mother at her address through the intercom. The Police also thought the incident might have been linked to a domestic dispute. She said that she had not seen the father for a month and would not come to the door.
- 4.54** Just before 9 a.m. on the **15th April 2013** the mother was found deceased in a public location – it was believed that she had jumped from a nearby multi story car park. Just after 11 a.m. **that morning**, the three children were found deceased at their home.
- 4.55** **Later that day**, the father informed the Police that it was in fact the mother who had stabbed him following an argument about their separation in which she said that if he remained with his new girlfriend, he would not be able to see the children again. He also explained that soon after the stabbing incident, when in hospital he had told the mother via text that he had not told the Police what had happened and that she should hide the knife. He was then discharged from hospital, although prior to this the mother had telephoned his accommodation and had been both upset and angry about the situation with the father, when speaking to a staff member at the hostel. She said that no one was helping her and that people were trying to take the children away. The mother was offered the number of the Samaritans but declined to take this.
- 4.56** The mother arrived at the father's accommodation the next morning at 6.21 hours and handed her flat keys in for collection by the father. It was just over two hours later that she was found deceased.
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5. THE CHILDREN'S LIVED EXPERIENCE

The purpose of this section of the report is to try to convey an understanding of the day to day lives of the children and to view the circumstances of family life from their perspective, to better understand the impact and affect upon them of the parenting they received and of other experiences such as school and the involvement of professionals in their lives. The information is taken from case records which described the behaviour and reactions of the children, but also from the observations and recollections of the numerous professionals involved with the family who contributed directly to the SCR process via the Learning Events. Based on what was known about the parenting and adult behaviours and actions, then it is acknowledged the understanding of the children's experiences has been based on the likely impact of such care. This nevertheless facilitates the analysis from the child's perspective.

Levina

- 5.1 Levina was 3 $\frac{3}{4}$ years old when she died, and during her life she experienced a number of house moves and attendance at two nursery schools, although her attendance was so inconsistent that it was said to be like her first time each time she attended. Her father in his contribution to this SCR commented that Levina was always keen and excited to go to nursery school, and that it was very unfortunate that her mother only allowed her to go infrequently.
- 5.2 Those practitioners who worked with the family had some different experiences of their contact and observations of Levina, but what was clear was that her social development was delayed and she had limited opportunities to establish relationships with her peer group.
- 5.3 Whilst some practitioners considered that there was a special relationship between Levina and her mother, who it was said idolised her, and always dressed her very well, others considered that there was limited interaction from mother to child, especially as a baby, and that Levina craved attention, often seeking it from visitors to the home as she got older.
- 5.4 As she developed, Levina went from being quiet, to being boisterous, and was able to display some strong thoughts at nursery and at times appeared fearful of adults when outside home, calling nursery workers "bad ladies". This view seemed to have been influenced by her mother who presented as highly suspicious of nursery school and of the motivations of professionals generally. In this way this appeared to have influenced Levina's attitude to people outside her home environment. Levina did struggle with her toilet training. There was evidence that sanitary towels were used as knickers for Levina. Her lack of social development made it difficult for her to follow routine or to play with other children.
- 5.5 As with her siblings, the children's father was observed to have had a more natural relationship with Levina and it was said that she was always happy to see him. However his presence in the home was not constant so it was not very clear for what periods he was involved in her life on a day to day basis. He has maintained in his contribution to this SCR that he generally visited the flat daily and prepared lunch for the children on a regular basis.

Addy

- 5.6** Addy thrived more as a baby and the mother seemed more natural in her handling of him. Overall though he was described as a passive child, sometimes left in his pushchair for long periods for which he appeared to give no resistance. He could however be mischievous at times. In terms of his play there was evidence of a level of control by mother in this regard in that on occasions he was only allowed to play with one toy at a time and also on one occasion when he played with girl's toys, his mother put him in a dress and called him Abby. In contrast to this, the activity of the children dressing up appeared to have been a positive feature of the mother's care of them. Because of the difficulties in engaging the family, there was limited contact with Addy by professionals, and so it remained unclear what the overall impact of this lifestyle had upon him. At a paediatric assessment it was stated that the mother was more focussed on her own needs than the children's.
- 5.7** Addy was considered to be a bright child and like his older sister, had little opportunity to interact with other children and families. He was less than a year younger than Levina and died at the age of 2 years 10 months.

Kyden

- 5.8** Less was known of Kyden who died at the age of 13 months. However the practitioners who came in contact with him considered that there was not a strong emotional bond and that the mother was mechanical in her handling of him. Kyden showed little emotion, though as with the older siblings, was always immaculately dressed.
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- 5.9** It is striking that observations of each of the child's experiences were not particularly consistent among those practitioners who came in contact with them, especially of their relationship with their mother and of their personalities and demeanour. Their mother's energies were often used in avoiding contact and help from professionals, though whilst having three small children to care for would have been very demanding, she did not use the local facilities to any extent that would provide much needed respite.
- 5.10** As the levels of concern among professionals about the level of neglect in the family fluctuated over time, it may well have been that the children's day to day experiences also changed and they experienced a wide range of parenting, food and emotional stimulation. There were certainly different occasions when observations of the mother – child interaction were quite concerning in that she was very much focussed on her own needs. On other occasions however, she could relate to the children very positively. These different observations account for the range of experiences at home for the children. The lack of consistency would however have been unsettling for them.
- 5.11** Their weight fluctuated and on occasions the children may have been hungry. Their father seemed to be much more consistent in his approach to the care of the children and this was reflected in the positive nature which was observed of his relationship with them. However he was not present all of the time, and so did not provide a regular balance of parenting styles but nevertheless generated some additional positive experiences for the children. Lack of

social interaction was a factor for all children as well as a lack of regular stimulation – being in play pens or push chairs was often reported as well as the children hardly ever playing outside.

- 5.12** It was generally difficult to understand with any certainty what the day to day experiences were like for the children as they were seen infrequently by professionals and when they were, it was often their mother who monopolised the contact by talking incessantly, making it impossible to have any meaningful dialogue with her. She appeared to have little insight into the impact of this sort of behaviour on others and upon her children. The lack of regular professional contact meant that it proved difficult for any professional to develop a continuous relationship with any of the children.

THEMES FOR ANALYSIS

6 The appropriateness and effectiveness of the legal strategy with the family from the outset, and of the simultaneous work with the children subject to CP Plans for the period June 2009 - May 2010

- 6.1** It was very evident from the content of the Initial CPC minutes, that before the first child was born to the couple, there were significant concerns about the lack of preparation for the baby, that the mother would leave their accommodation when in labour and deliver the baby unattended, that there had been no antenatal care, and a belief that the mother had mental health issues for which she was not receiving treatment. These were strong concerns which were exacerbated by the limited engagement of both parents who avoided professionals and were clear that they did not want or need any advice. Within these circumstances it was very appropriate that an ICPC had been called to consider the concerns in greater detail on a multi-agency basis. The professional concerns were rightly heightened by the failure of the parents to attend the ICPC.
- 6.2** An appropriate decision was therefore made to make the unborn child subject to CP Plans, and these detailed a range of actions by professionals to secure the protection of the child. These are referred to later, but one significant part of the Plan was for “legal advice to be sought with a view to initiate Proceedings”.
- 6.3** The decision to initiate Care Proceedings the day after the first ICPC meant in effect that the CP process was not given any opportunity to assess risk, generate sufficient support to the family or to safeguard Levina once she was born. In fact whilst the initiation of Care Proceedings moved the presenting situation onto a higher threshold of concern, it implied that there was limited confidence in the implementation of CP Plans with this particular family.
- 6.4** The legal advice given was that the circumstances of the unborn child met the grounds for Care Proceedings, although not for the removal of the baby at birth, although this remained CYPs’s objective via their Care Plan. CYPs needed to make decisions based on a number of factors, the legal advice being one of them, but this crucial part of the Care Plan remained. Whilst, because of the lack of knowledge about the family, there remained a lack of detailed

evidence to support the concerns, it therefore seemed unlikely that a court would agree to an order which would result in removing the couple's first baby at birth.

- 6.5** At the first hearing no Care Order was made but requirements for a parenting assessment to be undertaken instead. This was appropriate in the circumstances as there was clearly so much of the proposed risk to the new baby and of the parenting capacity which was un-assessed. Significantly the view of the child's guardian was that the threshold for Care Proceedings had not been reached, and therefore challenged CYPS in this regard within the court processes. This was understandable in the circumstances, as the level of concerns were not yet sufficiently coherent or based on detailed evidence to make any application for Care Proceedings a foregone conclusion. This is not to dispute the high level of concerns which professionals felt, and it was a matter of professional judgement to what extent the new baby's situation met the legal threshold for Care Proceedings. Whilst the judge did not grant an order, he did agree that CYPS were right to have concerns, though asked them to file a revised Care Plan, and set a new court date.
- 6.6** Ultimately it was apparent that the simultaneous use of CP Plans and the strategy of pursuing Care Proceedings in the early stages of the case, achieved little in understanding the parenting ability or to what extent Levina was at risk of significant harm at the time of her birth and soon after. However the key question is whether this strong strategy was necessary in these circumstances and at the commencement of the working relationship with the family, and whether a more measured approach utilising the CP Plans only would have had a greater chance of success.
- 6.7** It is not possible to say whether any different approach, for example without the instigation of Care Proceedings, would have had any different outcome or helped to engage the parents more effectively, but if lessons are to be learned, then there is value in considering whether alternative approaches could have been used and whether they could achieve different levels of success in similar cases in the future.
- 6.8** It was understood from discussions within the Learning Events that there was a strong lead from Safeguarding in CYPS in that area which gave limited opportunity for professionals from other agencies to challenge child protection decisions or to encourage a different approach. This might help explain why such a strong line was taken with the family at this early time but which went unchallenged.
- 6.9** As part of his contribution to the SCR, the father recalls this time very well and was clear that CYPS "were trying to take the children off us" but he viewed the concerns they had that Levina would be neglected and then that she was underweight etc., as being unfounded. In fact he referred to them as "lies" which tended to show the strength of feeling that existed between the family and CYPS at this early stage. The father also explained that the mother was even stronger in her negative views about CYPS. This approach to the parents therefore appeared to exacerbate the adversarial relationship developing between the parents and professionals and did not help with the challenge of trying to engage the parents in interventions.
- 6.10** The decision to withdraw the application for care proceedings in November 2009 was an appropriate one in the circumstances, although the process which led to this happening was

unsatisfactory. It was clear that the legal advice to CYPS was that the assessment reports for court did not reflect the level of concerns that had been promoted, were contradictory, lacked analysis and was unable to provide any compelling evidence that the parents would have problems with parenting in the long term, particularly now that Levina appeared to be thriving. The case lawyer expressed a view with the student social worker and the senior practitioner that the case had not been well managed. Also, CYPS had not shared the assessment report with legal services prior to submitting it to court, when this would have been normal procedure. This meant that there was no objective legal oversight of the report and to what extent it was fit for purpose. In fact the legal opinion at the time was that the CYPS evidence required wholesale changes but that it was too late to do so because the documents had already been filed. This reflected a poor communication between the two departments with CYPS seemingly unclear about the expectations upon them.

- 6.11** CYPS clearly had considerable difficulties in completing an assessment because of the parental stance of not engaging and consistently being unavailable for assessment sessions, but numerous contacts were nevertheless made. The assessment however failed to link the CYPS concerns with sufficient evidence or analysis that the child would be at significant harm in the long term. Clearly the fact that Levina was now thriving went against these concerns. The assessment was not of a sufficient depth and analysis to have supported CYPS's request for a Care Order.
- 6.12** One of the reasons for CYPS to have failed to provide a good quality assessment with the depth of analysis that was needed, may well have been the fact that a student social worker was allocated the first key role of working with this family whilst the Care Proceedings were being instigated. This was a most inappropriate decision in the circumstances. It was soon clear that this was a complex case and, whatever the level of supervision and oversight that the student received, it was always going to be a very demanding case which required much greater experience and safeguarding knowledge in order to be able to achieve positive outcomes. If the case lawyer's views of the court assessment were accurate, then it was apparent that the supervision of the student social worker was inadequate for the tasks at hand. In fact two months into the case, the legal officer recommended that a more experienced social worker be allocated. Whilst other more experienced workers were then added and provided some of the direct work with the family, the student social worker still provided much of the CYPS interventions. For example although the student was not formally identified on the CPC minutes as the key worker for the CP Plans, it was the student's reports to the conferences which provided the CYPS contribution to the understanding of family functioning and risk.
- 6.13** To understand how such a decision to allocate a student social worker to the case came about, an unannounced Ofsted inspection in July 2010 of CYPS's contact, referral and assessment arrangements, identified that in the area where this family lived, there were cases with CP Plans which were "carried out by unqualified staff or staff who are not yet registered as social workers. This practice falls well below expected standards and may place children at risk of inadequate protection". Whilst this inspection was undertaken approximately 8 months after these particular Care Proceedings were withdrawn, it does seem to reflect the culture of practice that had developed through 2009 and 2010 in this part of Suffolk. An

internal post inspection review at that time confirmed these findings and had identified that many of the managers had a fatalistic view of working in Lowestoft, and that as the furthest away from County Hall, resources were tight and that other areas were better staffed. It is important to acknowledge that this was a view which was held, and was not supported by the evidence. A lot of support went into this area at this time and it did not compare unfavourably with staffing in other areas.

- 6.14** Management oversight of the case during the early stages of intervention was therefore insufficient to ensure that the correct approach to completion of the assessment for court was made and which allowed a student social worker to take such a key role in the case. There was a lack of consistency in terms of different managers and supervisors which certainly did not support effective management oversight. In June - July 2010, extra management capacity was sought and provided for Lowestoft in response to these inefficiencies, nevertheless by October of that year, concerns about poor quality practice and managers holding cases inappropriately were still evident. (See paragraphs 12.1 and 12.2)
- 6.15** There was a clear link in that whilst there was acknowledgement of the need to withdraw the application for Care Proceedings, it was intended that the CP Plans would remain in place and therefore provide the necessary opportunities to monitor Levina's care and in particular her weight and development. This was a most appropriate decision in the circumstances as there remained concerns about parenting capacity.
- 6.16** There was no evidence to suggest that the application for Care Proceedings led practitioners to put any less commitment into the work with the family as part of the CP Plans, although it may well have impacted upon the parents in that their main concern was no doubt to challenge the Care Proceedings. Interestingly however, this did not encourage them to comply with the CP Plan in an attempt to avoid the need for the legal proceedings. The health visitor, Connexions worker and input from midwives and breastfeeding nurses all made important contributions to the CP Plans although they also tended to suffer from the parental reluctance for professional interventions. It was also useful that the child's guardian attended the first two CPCs which helped to make the links between the CP Plans and the legal strategy.
- 6.17** For the remainder of this period up until the CP Plans were ceased in May 2010, approximately 6 months after the Care Proceedings ended, the general view from professionals involved with the family considered that the care of Levina was generally good with a belief that their living arrangements with extended family supported this. For example, two contacts by the health visitor had confirmed good care by the parents and that Levina's development was as expected. The mother was also attending ante natal appointments as she was again pregnant.
- 6.18** However, between the January and May 2010 CPCs there were only three occasions when the key worker saw Levina although it was said that the parents were engaging better and that they had agreed to a pre-birth risk assessment. However as early as mid-January 2010, a supervision session within CYPS again considered the need for a legal strategy meeting to take place following the refusal of the parents to have contact from the student social worker. However there was no further reference to this, presumably because there was a view

accumulating that the care of Levina was at an acceptable level. However it does demonstrate the fluctuation of concerns and how quickly a legal initiative was suggested to address problems in working with the family.

- 6.19** Despite the apparent agreement of the parents to a pre-birth risk assessment, there was no evidence that this went ahead as a separate piece of work by CYPS. In fact it was the CPC in May 2010 that was also termed a Pre Birth Initial CPC. The input from health practitioners seemed to provide sufficient assurances that the parents were well prepared for the new baby. As had become the norm, neither parent attended the CPC, nor had they attended earlier core groups.
- 6.20** Although there were arguments that the CP Plans could cease at this stage primarily because the level of concerns had not materialised, a new baby was imminent, and in such circumstances there was a clear potential of the need to continue with the CP Plans whilst the care of a new baby was monitored. In the absence of CP Plans it was therefore questionable that no action was taken to initiate a step down process that would have placed Levina and the new baby on Child in Need plans. Nevertheless there was a view that the family were sufficiently engaging in universal services, although to cease any form of coordinated multi agency interventions just at the time of the birth of a new baby, seemed premature. It may well have been the continuing reluctance and avoidance by the parents to engage in services from CYPS which led to this decision, but it has to be questioned whether there was sufficient management scrutiny about this as a way forward. It was recorded that the CPC recommended no Child in Need plan and that the CPC chair said that the case needed to be closed. Although the latter was not the CPC chair's decision, it was no doubt influential. CYPS should however have given this matter more critical consideration, despite the CPC chair's view.

7. The implementation of CP Plans from August 2011 alongside consideration of further Care Proceedings via the PLO process

Implementing the Public Law Outline (PLO)

- 7.1** The reasons for a reinstatement of CP Plans approximately fourteen months later were largely based on similar concerns to those previously, although now there was greater evidence of poor stimulation of the children, their lack of social interaction and the poor development of Levina. The lack of engagement by the parents and their avoidant behaviour was again a consistent difficulty which generated further concerns which, according to the CPC minutes "reduces the possibility of either substantiating or disproving the concerns that the children are at risk of harm". There were also domestic incidents between the parents, on one occasion when the mother was holding one of the children. Therefore the decision to instigate a new set of CP Plans was understandable.
- 7.2** It was during this second period of CP Plans that the engagement of the parents was minimal, and the CP process continued without having any real direct impact on the family, other than to create another period of conflict and disagreement between the professionals and the parents and about the quality of their parenting. Once again a Legal Strategy Meeting followed soon after the ICPC, although on this occasion it was decided to await a paediatric

assessment and to identify what the parent's commitment to engage in the CP Plans would be, before instigating care proceedings. There was also a request of the social worker (no longer the student social worker) to compile relevant assessments and analysis from other professionals involved with the family.

- 7.3** Whilst this seemed a sensible approach to instigate CP Plans in the circumstances, it was questionable whether there was the necessity to again move so quickly into the legal arena, with a Legal Strategy Meeting again taking place within a few days of the ICPC. The legal advice that the CYPS's grounds for concerns were well founded, confirmed that there was some clearer evidence compared to the previous application for Care Proceedings, but in reality much of the earlier concerns remained, and there had been no progress on the ability to engage the parents. Once again for example, the weight of the children was a matter of concern although, as had happened previously, a paediatric assessment failed to provide evidence to support such concerns.
- 7.4** It was not until five months after this new set of CP Plans had commenced that a decision was made to initiate the Public Law Outline. This decision seemed to be informed by some evidence of renewed concerns and it was linked in with the CP process in that a major concern was again the parental avoidance of professional interventions.
- 7.5** There was no inherent difficulty in the CP Plans and a PLO process being undertaken simultaneously, and in fact it would generally be expected that if the PLO process is being instigated in respect of a case of safeguarding, then there should be a CP Plan in place.
- 7.6** However, whilst the children remained subject to CP Plans during this time from August 2011, the PLO process drifted, even though on occasions it was recorded that pre-proceedings needed to be "urgently" held. In fact the parents failed to attend the arranged pre-proceedings meetings and, similarly to the CP process, the parents could not be encouraged, persuaded or cajoled to attend. The reasons for allowing the process to drift was partly due to CYPS awaiting the completion of assessments, chronology updates and medical evidence regarding whether the children were failing to thrive or not. The completion of such work was compromised by the poor parental engagement, and it remained difficult to identify clear evidence to support the concerns. The continued lack of engagement meant that the ability to achieve a range of multi-agency information and assessments proved difficult. Additionally the relevant CYPS report to the SCR noted that the social worker and manager were to a degree inhibited by the outcome of the earlier proceedings which may therefore have been one of the reasons for the failure to progress this work. The CYPS report for this SCR identified that CYPS workers considered that their practice had been questioned surrounding the thresholds for the first Care Proceedings and which had led to no order being granted, therefore they considered that more solid evidence needed to be put before the court on this occasion.
- 7.7** Overall the responsibility lay with the CYPS staff to respond to the legal advice they had been given and to seek out the necessary information and assessment to support their concerns. Further input and advice should have been sought from the legal officers if it was felt that there was a mismatch between what evidence was necessary, and what could be provided, but this did not happen. Also, at the outset in August 2011, the legal advice to CYPS was that

if the mother failed to attend any medical appointments for the children or failed to participate in assessments, then to immediately issue Care proceedings and seek an Interim Care order.

- 7.8** In fact the mother did comply with the first paediatric assessment which did not report evidence of developmental delay of the children, but the legal advice was that evidence of non-engagement and the children's poor emotional development could still be sufficient to support the initiation of the PLO. However it was apparent that CYPS were unclear about the level of concerns and reported back to the legal officer that they would not proceed with the PLO.
- 7.9** Nevertheless, the reference to the need to process the PLO and for further legal strategy meetings to be held, still figured in discussions within the CYPS management/supervision sessions and were referred to in all of the five CPCs held during this period up until November 2012. A completed Core Assessment by the social worker at the end of October 2011 recommended that a Legal Strategy Meeting should be convened due to the non-engagement of the parents and when a pre-proceedings meeting was set up in mid-January 2012, the parents failed to attend. A later response from the legal officer was that the threshold for proceedings had been met because of the continued lack of engagement and of the concerns about the children's health and development. Relevant reports from health services and the children's centre were advised to be collected.
- 7.10** There was no confirmation that CYPS had implemented the advice given about conducting the required assessments and collating the multi-agency information. It was left to the legal officers to chase up CYPS re what their instructions were and there were enquiries made of CYPS in January and July 2012 and again in March 2013 to ask what the current position was with regard to their intentions with the family in terms of the PLO, but no instructions were received as a result. In fact CYPS's confused position was evidenced by a new social worker being appointed in mid-July 2012 who recorded the need to "unpick the case and ascertain if the PLO is still in place" even though this had followed communication from the legal officer and the practice manager a short while earlier which had identified that a new paediatric assessment was pivotal to a decision to proceed.
- 7.11** Clearly there should have been more effective communication between the two departments to ensure that the case did not drift in the way that it did. However responsibility for the drift was with CYPS and one of the main reasons for this was clearly the lack of management oversight. A fairly constant change of social workers and supervisors/managers made this more difficult but there was no evidence of a Service Manager having oversight of what was happening, which should have been the case for a family where the PLO process had been requested to be undertaken.
- 7.12** Whilst acknowledgement that inadequate safeguarding practice, as confirmed by the Ofsted inspection, may have explained some of the practice deficiencies in 2009 and 2010, by 2011 these shortfalls should have been addressed and yet the poor oversight and management of the case by CYPS continued. Whilst the CYPS report to this SCR identified that "there was good evidence of management oversight and supervision by the practice manager, but there was a lack of grip on the case to ensure progress (of the PLO) was made" it is difficult to

reconcile how the two findings could co-exist. Changes in managers and lack of continuity meant that a pattern of starting again emerged. In some respects this reflected the family dynamics of things getting worse, then better, then worse again.

- 7.13** In many respects this strategy of implementing CP plans alongside a legal strategy for Care Proceedings had been tried unsuccessfully previously and so to take this same route was always going to be fraught with difficulties, especially as the type of concerns about neglect were the same and the same lack of definitive evidence existed for these concerns. The muddled process which then followed with the parents being told that legal interventions were being considered, but with no actions following, must have been very confusing for them and certainly did not aid their engagement with professionals, especially CYPS.
- 7.14** The very nature of the PLO meant that it was a Local Authority initiative, and therefore tended to exclude other agencies from the process. It was apparent that other practitioners working with the family did not fully understand the legal processes, and even when the legal advice in 2012 was to seek information and assessments from other agencies, this did not fully materialise.
- 7.15** Professionals trying to work with the family under the auspices of the CP Plans were aware of the continuing expectation that care proceedings were being planned or considered via the PLO process, and from contributions via the Learning Events, it was apparent that this gave some form of reassurance that the challenges of resolving the difficulties of working with the family were being undertaken elsewhere. Additionally, professionals from health and education, were not engaged in the PLO and therefore could not challenge or contribute to it. In this way the PLO process, particularly during 2012/13 was allowed to drift, with no challenge from professionals outside CYPS.
- 7.16** By June 2012, the children, who now included Kyden at one month old, had been subject to CP Plans for almost a year with no significant change in the parenting and diminishing engagement of the parents in the CP Plan. A month later the legal team contacted CYPS to ascertain what was happening but received no instructions back. At some stage, because of the lack of any progress in the case, and based on the apparent continuing strategy to take legal proceedings, then these should have been formally undertaken. At the social worker's supervision in October 2012 it was noted that the "case needs refocussing" and that the PLO had not been progressed. However, as had happened on earlier similar occasions, these acknowledged concerns did not lead to any actions on CYPS's part. A firm decision was needed to either implement Care Proceedings or not, and according to legal advice there had been grounds to do so from the outset of CYPS's new involvement with the family from August 2011.
- 7.17** It is not possible to say what success Care Proceedings would ultimately have had if they had been taken and whether it would have led to the children coming into care, but it was not acceptable professional practice to have allowed this decision to drift for a period of approximately eighteen months. A clear and purposeful stance needed to be taken. The first legal strategy meeting had been held in August 2011 although recommendations from within CYPS or the CPCs to have further legal strategy meetings continued for the next eighteen

months with no outcome. A decision at a supervision session to request such a meeting was still being made as late as the end of February 2013.

7.18 The reasons why the PLO proceedings were not progressed and no Care proceedings were initiated appeared to be primarily because: -

- Changes of social workers and managers failed to generate any consistent plan, with a tendency to “start again” with the family.

- CYPS management oversight was not sufficiently focussed or robust to ensure decisions reached in supervision or in CPCs, were carried through to completion.

- The lack of engagement of the family and their avoidant behaviour made it difficult for practitioners to fully assess what level of risks existed for the children.

- There was a lack of confidence among practitioners about whether there was sufficient evidence to take legal proceedings – this was probably enforced by the experiences in 2009.

- Decisions about legal initiatives were often deferred in order to await assessments (e.g. in February 2013 when there was a decision to await the outcome of an adult attachment interview before proceeding to a legal strategy meeting).

- A failure to collect and collate information and evidence which would demonstrate not only physical neglect but also emotional abuse/neglect.

- Small parenting improvements or agreements by the parents to engage in a piece of intervention were seen in an overly positive light in consideration that this reflected a more fundamental change. In such circumstances, concerns lessened temporarily. Disguised compliance by the mother needed to be recognised when it occurred.

- The Child Protection process failed to provide any objective challenge to the drift of the case in terms of legal proceedings.

- The fact that much effort was being made by a range of practitioners to work with the family and effect change, may have given a sense that the high level of work being undertaken would ultimately achieve some positive outcomes.

Implementation of the Child Protection (CP) Plans.

7.19 Generally the five CPCs which occurred between August 2011 and November 2012 had very similar CP Plans attached to them, reflecting the overall lack of progress of the case. The need for legal strategy meetings, to continue to try to engage the family and to monitor the health of the children were always included in some form within these plans. In effect the family had completely disengaged from the process and failed to attend all of the CPCs apart from one attended by the father. Similarly the vast majority of the Core Groups went unattended by the parents.

7.20 The role of the CPC Chair was pivotal in this situation, in that clear recommendations within the CP Plans regarding the legal strategy were not being progressed. Alongside the fact that

CP Plans were simply being repeated without any achievements, then the CP Chair had a key role in terms of their objectivity and independence to make strong challenges to CYPS about the lack of progress in the case. In her contribution to this SCR, the CPC Chair said that she was concerned about the lack of progress regarding the legal issues and had raised the matter in supervision and had spoken with CYPS managers on occasions outside of the conferences to try to gain further progress on the legal initiatives. The CPC Chair said that the changes in social workers (there were three between August 2011 and April 2012) and their managers made it difficult to successfully challenge CYPS's lack of action and decision making. These discussions and any actions agreed within them were not recorded and so it would have been difficult to hold managers to account unless the discussions had been more formalised.

- 7.21** Also the lack of progress of the CP Plans could have been challenged by agencies engaged in the CPC process, other than CYPS, but this did not happen. It was as though this was not expected practice and to some extent that the different professionals were all in the same situation of trying to engage the family, and so no one stood outside the process in order to make effective challenges to the lack of progress. This is more understandable when looking at the attendance of the different CPCs in that all attendees were those directly involved in working with the family. This had the potential to make it more difficult to be objective. At only one of the CPCs is there a record that a CYPS practice manager attended and although safeguarding nurses had been consistently invited to the CPC's, none of them attended. This also applied to the community paediatrician. *(NB; Due to staff ill health, there were no minutes produced of the June 2012 RCPC, so the Overview Author has not been able to confirm who attended on that occasion).*
- 7.22** The CPCs were therefore missing any real objectivity or challenge to what was happening. In this scenario of a lack of progress, then an initiative should have been taken to ensure that managers attended, especially with regard to CYPS, but also that other specialists such as within health, who had not had any direct involvement, should have been encouraged to attend. If any case required a fresh set of objective eyes to view what was happening, it was this one, which was generating so much frustration for the professionals involved. There seemed little point in repeatedly inviting line managers and health specialists, if their continued response was to send their apologies. It may have been that a practice had developed whereby these additional invitations were automatically made so as they would have sight of the minutes, but where there was no real expectation of their attendance. If that was the situation then this should have been challenged– in this case there was a clear need for objective, management or specialist input, but it was not achieved.
- 7.23** It was not apparent that the professionals recognised when a stage had been reached by the involved agencies to identify that “enough was enough” and that a position had been reached when a different set of strategies was needed. During this second period of CP Plans, it was apparent that they were not able to be progressed, and yet this was not seen as sufficient reason to acknowledge the impasse that was now well entrenched, and to formally cease the multi-agency discussions and review what was happening from an objective standpoint and in so doing, to take a fresh and innovative stance with the family. This would need to have been done in conjunction with the family, but if there had been a clearer agreement among agencies when this stage had been reached, and that concerted actions were needed, a new

joint and different approach could have been considered. Escalation to senior managers to address the problem at a more senior level was not referred to as an action in the CP minutes although this would have been necessary in order to review the progress formally. Although the parents did not attend the CPCs or the vast majority of Core Groups, the CPC process was unable to change this. This must have given the parents the view that they had control of the situation – and in many ways they did.

- 7.24** Also the fact that the parents, by failing to attend, negated not only the work of the CP Plans but also the legal process when threats of legal action were made in 2012 but did not materialise, must have given them a sense of control. One potential message this also gave to the parents was that the concerns that the different professionals were expressing, were not in fact as worrying or significant as they were saying, otherwise the formal CP and legal processes would have been more vigorously enacted.
- 7.25** There were examples of some good inter agency communication within this case in terms of commitment of involved professionals to attendance at CPCs and Core Groups as well as communication between meetings about developments or new concerns within the family. This was clear evidence of a multi -agency approach to working with the family.
- 7.26** It is now understood that a process has been developed locally whereby if CP Plans are continuing with a family for fifteen months that an exception report needs to be produced for safeguarding managers in order to consider what actions are needed to cease the need for continual CP Plans. However at the time of these particular CP Plans, the cut off period was eighteen months and this stage was therefore not achieved until early in 2013. However this process was apparently less embedded in practice then and not known to the CPC Chair and so it was unfortunate that no formal review or exception report regarding the case took place.
- 7.27** Whilst it is an appropriate principle for more senior managers to review a case that continues to be subject to CP Plans for a prolonged period of time, in this particular case it was not just that the children continued to be subject to a set of CP Plans, but that the plans were basically unchanged. In this respect the CPC system failed to be responsive to continued concerns about the care of the children. The current practice is that two processes are now said to be embedded in practice and that this includes an expectation of the CPC Chair to formally raise concerns to the social worker and manager when the CP Plans have not been progressed leading to the possible audit of the work and the need to identify the patterns of the case. The second process is that the safeguarding managers (who supervise the CPC Chairs) throughout Suffolk meet with equivalent Service Managers to review concerns about the lack of progress of CP cases and review the supervision records to help identify what has transpired and potentially blocked progress, and to consider an appropriate way forward.
- 7.28** There were infrequently some discrepant views between professionals about risk and concerns about the children, and the parents, especially the mother, used these discrepancies in their arguments that they were meeting the children's needs. This was certainly the case with the different stance being taken by the child's guardian at the outset of interventions with the family. Paediatric assessments generally gave the evidence of the children meeting their developmental milestones, but there seemed to be no agreement about whether there needed to be different areas of focus, e.g. the children's social and emotional development.

There was also some disagreement between the health visitor and a paediatrician on one occasion about whether the child's weight was sufficient. It was not apparent that additional meetings or discussions took place to resolve some of these discrepant views when this would have been helpful. There was one occasion however when the health visitor sought the additional advice from a community paediatrician – this was good practice.

- 7.29** There was just one occasion when one of the children, Levina, presented with some facial bruising in the nursery school in November 2012. The school appropriately made contact with CYPS but were told to seek information from Levina and gain her explanation, which they duly did. With it being later confirmed that the GP had seen the child and reported no concerns, no further action was taken. However, in trying to engage with hard to reach and avoidant families, it is important to utilise opportunities or crises when they arise, as a means of fresh intervention. Whilst it clearly would have been most challenging to have made the necessary enquiries with the mother and Levina regarding these injuries, to have done so would nevertheless have clarified that concerns did exist and that as the children were subject to CP Plans, that any new concern needed to be investigated.
- 7.30** This was a missed opportunity not only to address potential and specific child protection concerns, but also to have a different sort of intervention with the family. Procedurally a social work enquiry should have been undertaken as a minimum, or a strategy discussion held with the Police to help to decide the response needed. It was through the health visitor, rather than directly by the social worker, that the GP had said that there was no reason to believe there had been any non-accidental injury. The detail of the medical examination was not recorded when as a minimum it should have been. The fact that it was not a formal child protection medical may account for this although in the circumstances it would have been relevant to undertake this type of medical as part of a formal child protection enquiry. The reasons for CYPS not responding more robustly to this incident seemed to be that the social worker did not consider the injury to be significant or to potentially reflect abuse, and although the first impressions from the telephone call might have given this suggestion, it still needed more detailed enquiry as the child was subject to CP Plans. Interestingly, the RCPC soon after this incident commented that the nursery school needed to review its child protection procedures as a result, although it should have been CYPS who needed to make a direct response to the family at this time rather than identify that the nursery should have responded differently.
- 7.31** Similarly, the CP Plan did not address Levina's very poor attendance at nursery, when although this was seen as an important component of support to the family and to aid Levina's social development, it was not sufficiently challenged by the CP process. Despite nursery attendance not being compulsory, this issue could have been agreed among the professionals as the priority to formally and consistently address to the parents, and to try and achieve a good level of nursery attendance. However, whilst the mother was advised and encouraged about the nursery involvement, the CP Plans were unable to be utilised as effectively as possible in this regard. Also there was a capacity issue within one of the schools which was unable to follow up every child that was absent, particularly when they were not of compulsory school age. Nevertheless the nursery provision for the children provided in two locations, particularly for Levina, was very good and despite the poor attendance, had shown

themselves the sort of experience that the children needed to provide some important compensatory experience to their home life.

Understanding by professionals of the characteristics and dynamics of physical and emotional neglect of children, and how to intervene effectively.

- 8.1** Whilst concerns about physical neglect of the children related to low weight, poor food intake and poor physical growth, emotional neglect was more about parental unavailability and lack of response to the children's emotional and social needs. In this way it was considered that the mother's focus on her own needs, her obsessive talking, and her refusal to accept advice about parenting or to allow the children to socially interact, meant that they were emotionally neglected. This was considered to be a significant theme for the practitioners and their managers working with this family and yet there was a difficulty in building a full picture of the level of any neglect because of the inconsistencies of engaging the parents and the inability to document the home life, particularly from the children's perspective. In this way there tended to be an over-emphasis on looking for quantitative signs of physical neglect.
- 8.2** Even though the very first ICPC referred to the parent's "substantial history with Social Care Services" it was not apparent that the details of this background was ever formulated or put together in a chronology as requested by the CPC Chair. If this had happened, it would have helped to understand the mother's and father's own experience of being parented and in turn how this could have influenced their own parenting abilities.
- 8.3** The urgency of the concerns at the presenting situation with the family, especially at the time of Levina's birth, and the need for a speedy response, seemed to mean that less attention was given to accessing past information about family background. However this needed to form part of later assessments, but within the SCR process, none of the practitioners involved with the family, knew with any certainty what the parent's, and particularly the mother's, own experiences of family life were.
- 8.4** It was stated in the very first Core Group that "information from Norfolk Social Services about mother's background was shared". The detail of this information is unknown to the SCR process and it did not appear to inform any assessments at the time. There was some knowledge of the father's background, but it was not apparent how this was used to formulate any assessment of parenting. In part the family background, particularly the mother's, was to be addressed by the planned Adult Attachment Interview, but this was in early 2013 whereas there had been professional involvement since 2009.
- 8.5** It may well have been that there was no significant history known to CYPS or that the information was not accessed at the early stages of interventions for the reasons identified above. It may also have been that background information was only known by professionals who worked with the family at the time, had been working in the area a long time, but were no longer involved. Whatever the reason, this lack of clarity about the parents' past experiences, compromised the ability to generate a full understanding of the possible impact this might have had on the children.

- 8.6** Many of the professionals within the Learning Event held the view that the children were living in an environment of continued neglect and that their belief was that this in turn had a significant impact on their overall development. There were clear occasions when there was evidence of this, although much of the concerns were based on professional instinct and sensitivity to the family situation and in particular the mother's very challenging presentations. This placed more pressure upon professionals to try to intervene and to bring about the necessary changes as quickly as possible, but then was frustrated by the lack of parental engagement. Generally the mother's response was to ignore professional advice about child care issues and decide that she knew better. This meant that there was often the need to challenge or disagree with the mother, which from her perspective would not have been conducive to establishing a trusting relationship with her.
- 8.7** There was clearly a disconnection between the professionals and the parents about the quality of care of the children. It was not apparent that the parents saw any need for intervention and that their parenting was perfectly adequate, whilst at such times there were high levels of professional concerns. Apart from the period of time when there were no CP Plans in place, these different views appeared to become further entrenched as time went on. This was certainly true during 2012.
- 8.8** It was easier to seek evidence of physical rather than emotional neglect, although even this proved difficult to substantiate when concerns about low weights, lack of growth and development were never really supported by the evidence from the health assessments carried out. This in turn made it easier for the mother to claim that her parenting was good enough. Also the predominance of tasks within the CP Plans related to aspects of physical neglect – e.g. the need to monitor weights, implement a feeding chart, ensure attendance at health appointments etc, and when the CP Plans were discontinued in May 2010, it was reported that the "basic care was fine and the children clean and well fed". When CP Plans were re-introduced in August 2011, it was then apparent that there was a greater focus on concerns about emotional neglect. By this time the children were older and in particular there was evidence of the lack of social development. For example, the August 2011 CPC minutes still had a greater focus on the physical neglect concerns but also identified that "the children do not have adequate stimulation, either cognitively or socially, as they have very little in the form of toys and books and do not have contact with many other children".
- 8.9** Emotional neglect was felt by those involved with the family to be particularly challenging to evidence and identify, although there were clear concerns about the mother's approach and attitude to the children, and these were challenged when appropriate. Whilst these observations were raised and discussed within the later CPCs it was not apparent that these were collated as part of a multi-agency assessment to inform the legal initiatives.
- 8.10** However there were examples of emotional neglect which emerged – for example, Addy being restricted to one toy, dressed in girl's clothing, professionals viewing the children as "frozen" in their responses, long periods of time in the play pen/pushchair, a sense of "learned helplessness" in their behaviours, etc. Although the possibility of emotional neglect was raised in the second period of CP Plans (from Aug2011), it was only at the last RCPC in November 2012 when the CP Plans gave a clearer set of actions in respect of addressing

emotional neglect. This appropriately included funding for Addy at Nursery and focussed on the general need to get the children into nursery much more regularly in order to meet their emotional and social development needs. However, this tended to falter because of the mother's lack of intent to send them, on one occasion saying that she did not want to send the children to nursery and that it was not a legal requirement that she had to.

8.11 Overall, the professional interventions appropriately focussed on the neglect of the children, but with physical neglect being difficult to consistently evidence and limitations to when the children were seen to consider the impact of emotional neglect, then the professional interventions, largely via CP Plans, were compromised.

8.12 It was appropriate for professionals to be concerned with the family situation that they were being presented with, but it remained difficult for professionals to articulate concerns that were often based on intuition, even if this was supported by professional experience of working with similar families. Perhaps a different multi-agency initiative to the CPC process, to unpick these concerns may have clarified their relevance and how they could be more appropriately formulated as evidence of concern. A greater focus on the children's experiences, even if this required professional judgement, about the likely impact on them of their parenting, could have given further clarity about potential future risks if their level of care continued in the same vein. The difficulty was that the mother usually took up much of the energies of those who worked with her, and she would usually disagree and reject advice about avoiding or desisting from behaviours which had the potential to be emotionally neglectful or abusive.

8.13 Ultimately, little appeared to change in the parenting that the children received, so the professional interventions in the way that they were developed were unable to address these concerns and generate much change. The main examples of emotional neglect cited in a recent NSPCC publication¹⁴ identify "ignoring the child's need to interact", "failing to express positive feelings to the child, showing no emotion in interactions to the child" and lastly, "denying the child's opportunities for interacting and communicating with peers or adults". There was some evidence that these examples existed in the care that these children received. To have viewed the situation from the children's perspective and of their day to day experiences might have given a stronger insight into the level of emotional neglect they were suffering and potentially informed some of the interventions that were needed. Nevertheless, the professionals all remained concerned, but the system which focussed on the implementation of CP Plans or in identifying evidence to support applications for Care Proceedings, did not easily enable the impact of emotionally neglectful care on the children to come through within the concerns.

9. The challenge of working with families where there are child protection concerns, who are very difficult to engage in professional interventions.

9.1 The parents, and particularly the mother, were clear in their wish not to have intervention in their family life from professionals, and these feelings were particularly strong in respect of CYPs. The parents therefore refused to attend meetings, if they did were often very late, and

¹⁴ "Emotional neglect and emotional abuse in pre-school children" – Information leaflet, NSPCC – May 2012

did not make themselves accessible to home visits, sometimes refusing to allow entry or allowing one preferred practitioner in and leaving another outside. This challenging behaviour by the parents placed considerable demands on the professionals who were endeavouring to understand the adequacy of the care of the children and to deliver services to address these.

- 9.2** The family remained very difficult to engage because of their avoidant behaviour throughout the full period under review. Because for much of the time, the children were subject to CP Plans, the most used strategy to engage the family was to use greater insistence with the parents, with the backdrop of legal action, to achieve this. As the children were considered to be at significant risk of harm, then there was a reasonable perception that the lack of access to them reflected increased risk.
- 9.3** The main strategy therefore was to threaten to escalate the situation to the parents for example via instigating Care Proceedings (or the PLO process) when the lack of engagement was seen as exacerbating the child care concerns. In fact the early proceedings were taken partly as result of the parent's initial refusal to engage with social workers and other professionals. With hindsight this early authoritative stance meant that there was nowhere to go once the Care Proceedings were withdrawn when the evidence in the social work assessment did not support the concerns about parenting. The dynamic which followed was that CYPS were then identified by the parents in a very negative and distrustful light. This was certainly the view of the father in his contribution to the SCR in that he considered their approach deceitful in their desire to remove Levina at birth. Whilst there was certainly no suggestion or evidence from the SCR process that CYPS in any way tried to mislead the father, this was nevertheless his view that he wanted represented in this report. It was this view which then coloured his and the mother's later responses to CYPS.
- 9.4** Whilst social workers were strongly rejected by the parents at the outset, this did not mean that other agencies were readily accepted as an alternative. One of the reasons for this was that, with the children subject to CP plans, this had multi agency support, and therefore quite rightly professionals from other agencies had to challenge the parental non engagement just as vigorously as CYPS. They certainly did this and it was important that they retained a joined up approach to the parents in this regard.
- 9.5** Whilst one strategy could have been for the non-statutory agencies, such as the health visitor, Connexions or children's centre staff to take the lead in work with the family, the fact that the case was dealt with primarily within the CP system and also the potential for Care Proceedings, meant that it would have been difficult to have given the lead to another agency who did not possess the necessary authority to do so. The child's guardian did attend three Core Groups during the initial period of CP Plans in which there was an intention to support an improved relationship between CYPS and the family, but this was not successful. Once started, it was difficult for CYPS to draw back from their stance, and in fact when the application for the Care Proceedings was withdrawn, the parents appeared to consider it a victory for them, and so this did not dispel the adversarial relationship which had developed and which then continued into the next set of CP plans over a year later. If greater attempts had been made by CYPS to engage more positively with the parents, focussing on offering

support and help, then this might have had a better chance to achieve an effective early working relationship with the parents.

- 9.6** Despite their clear anger and distrust of CYPS in respect of the Care Proceedings, It was apparent right from the outset that these parents were not generally prepared to engage with a number of professionals – the lack of acceptance of ante natal services at the outset was one of the major reasons for the first referral to CYPS. Non engagement then became a major focus of concern for professionals from the beginning, but it might have been more helpful to have focussed on it as an issue about understanding the best way to intervene, rather than as a safeguarding issue in itself. For example it would be perfectly possible for a parent to be extremely hard to reach or who wishes to avoid professional interventions, but also to be a capable parent. There were however some clear concerns, but these had not been assessed or understood, so to inextricably link the lack of engagement with poor parenting may not have been the best early strategy. To separate out the concerns about parenting from the parent’s unwillingness to engage would undoubtedly have been challenging, but a different approach may have had a better chance of success. For example to promote a stance with the parents about the importance of their input to help the professionals correctly understand their circumstances and their parenting, might have generated a culture of undertaking the work with the family rather than to them. Whilst it is often the case that a CP Plan identifies the need for announced and unannounced home visits by the lead social worker, and as was promoted regularly with this family, for example, a strategy of agreeing a compromise with the parents to initially undertake announced but very regular visits only, may have given an indication to the parents of a willingness to work with them on their terms. “Parents who felt that professionals shared power with them tended to engage in work, rather than fighting workers by openly opposing them or “playing the game” by feigning cooperation”¹⁵
- 9.7** It is apparent that professionals did work hard to engage the parents and were persistent in undertaking home visits and in doing all they could to gain access to the family home. The health visitor was described by the CPC Chair as being “100% committed to engage with the family and was relentless in her attempts to do so”. With such a difficult family, this was praise worthy. There was evidence of creative attempts to engage the family, for example by joint visits undertaken between professionals from different agencies, utilising different venues, trying to use one professional as the main link, and line managers making visits with the practitioner. Additionally the children’s centre did enjoy some success in engaging the family and worked hard to achieve this. Their input provided much needed information to inform assessments and considerations of risk when discussed in CPCs or Core Groups.
- 9.8** Overall however, the main thrust of the approaches to the parents from the child protection perspective did not significantly change over time. The most interventions in terms of generating positive change in parenting relies on getting the balance correct between providing support on the one hand and exercising authority and control on the other. Balancing these two concepts is very important in order to effectively engage with a family.

¹⁵ “The carrot or the stick – Towards effective practice with involuntary clients in safeguarding children work”, Calder M,C et al – Russell House Publishing 2008.

“Outcomes are improved for involuntary clients when workers focus on helping them to understand the role of the worker and the role of the client in the direct practice process. This involves ongoing discussions about issues such as authority and how it might be used, the dual role of the worker as helper and social controller, the aims and purposes of the intervention from both the client and worker perspectives”¹⁶ .

- 9.9** In this family’s circumstances it appeared as though the authority/control aspect of the relationship with CYPS was the major component from the outset and that it was difficult to move away from this and generate a more appropriate balance. The child’s guardian, in her final position statement in 2009 supporting the CYPS’s decision to withdraw from their application, expressed hope that their intervention “will be more focussed on supporting the family without the pressure of the proceedings”. However this did not happen and in fact when support services were offered, although not necessarily by CYPS, the mother tended to refuse this help or accessed it inconsistently. This reflected how extremely difficult the mother was to engage in any meaningful way. Nobody really understood why the parents were so adamant about not wanting professional help and without this, the practitioners wouldn’t have known the best way to address the problem.
- 9.10** To look at the situation from the parent’s perspective can give a different understanding. It was apparent that there were many professionals who were involved and their intensity at the time of the birth of the couple’s first child must have been difficult for the parents to understand or appreciate. The majority of the early CP Plans were about control rather than support – e.g. legal advice to be sought, daily checks to the home, the landlord to be encouraged to exercise his rights to inspect the home, the parents to attend all relevant appointments etc. Despite them being well intentioned in trying to address worrying child care concerns, this may well have generated more mistrust rather than enabling the parents to view interventions as a source of support or help. This reflects the recent view that “unintended consequences” of professional interventions can occur when a prescriptive approach is applied other than one which is freed up to use greater professional judgement.¹⁷
- 9.11** Although both parents had experienced previous involvement with agencies when younger, as a couple and new parents, their involvement with the helping professions had been almost non-existent and yet within a matter of a few days around the birth of their first child, there was involvement from midwifery services, the health visitor, the hospital, CYPS and mental health services. This may well have been overwhelming, and once it was quickly decided that this case met the threshold not only for CP but also for legal intervention, then the professional involvement intensified, so much so that the Police were involved to ensure access and to convey the seriousness of the situation to the parents.
- 9.12** One component of the first set of CP Plans, which was repeated until the CP Plans ceased some 10 months later, was for the parents to “access and engage with appropriate support services” and it then listed six different agencies “and other support as identified”. Even if it was not realised at the outset that it would be unachievable for these parents to engage with

¹⁶ “Working with involuntary clients – A guide to practice”, Chris Trotter, Sage Publications 1999.

¹⁷ The Munro Review of Child Protection – Part one – A Systems Approach – Eileen Munro 2011

six different services, it should have been recognised by the next RCPC that these expectations needed to be reframed and made more realistic for the parents to be able to accept.

- 9.13** Despite the pressures upon them, the parental resistance did not waiver, and during the first period of CP plans and Care Proceedings, their strong stance was indirectly supported by the child's guardian and by the outcome from the paediatric assessment, neither of which supported the level of concerns being expressed by other professionals at that time. Therefore this gave the parents the "evidence" to deny professional intervention especially from those who represented the most authoritarian stance being undertaken, i.e. by CYPS. In fact the parents were quite clear in telling CYPS and others that this was proof of their good parenting. For the second period of CP Plans this same process existed.
- 9.14** Within these scenarios, it was still nevertheless important for social workers and other professionals to gain involvement with the family and it was apparent that there was significant commitment and energy for the task, to try to achieve this. In fact it created high levels of frustration for professionals in having to repeatedly try to gain access to the home or to speak to the parents. Whilst it was of course important to be clear to the parents what the sanction or outcome would be if they failed to engage, these became ineffective, as the Care Proceedings were withdrawn in the acknowledgement that there were insufficient concerns presented in the social work assessment to warrant continuation. Therefore there was little further sanction or pressure that could be placed on the family to get them to engage during the 2009/10 period of CP Plans.
- 9.15** After August 2011 when the children again became subject to CP Plans, a letter was sent to the parents saying that there would be a move to legal proceedings if they did not engage with the CP Plan. This approach had already been applied previously and there was no greater evidence that it would work on this occasion, in fact there was probably less, particularly when there was no follow through in respect of the legal initiative. In this way the same dynamic was promoted from the outset between the parents and key professionals of the parents being defiant in not wanting to accept interventions, and the professionals working hard to change this, usually by the suggestion that legal interventions would follow. No alternative strategy was developed, promoted or introduced.
- 9.16** Because this non-engagement issue became such a focus of concern and priority for change, then there was the likelihood that simply getting into the home was seen as a success in itself. For example in this case it was acknowledged by practitioners that on occasions the children were not always seen when access was gained to the home. In other respects there was some evidence that there was greater focus on the professional relationship with the mother and in trying to maintain this, leaving insufficient focus on the children. There was also the potential that once in discussion with the parents, it felt more difficult to challenge them on their child care, and there were descriptions by practitioners about the delicate nature of discussions that needed to be had with the mother in particular, in order to have any chance of getting the appropriate message across and to be able to gain access to the home on the next occasion.
- 9.17** In the father's contribution to the SCR, he said that whilst he was clear that he did not want CYPS involvement, he recognised that it was the mother who was the most adamant about

not accepting help from professionals. He said that he did try to convince her to accept help, for example regarding the nursery placement and to accept a mental health assessment, but she was adamantly against these. He explained that the difficulty was that if he disagreed with her too much, she would not allow him to see the children, so in this respect he felt that there was little he could do. He described how he attended one RCPC on his own but that the outcome was that he became the link with the mother and that the professionals mainly wanted to communicate with her, and that he felt he couldn't help with this.

- 9.18** Therefore it was recognised that this inability to effectively engage the parents in the child protection process was an issue that permeated much of the professional working relationship with the family. Despite this, there were some interventions, particularly to monitor weight gains and the mother's feeding regime, which did provide important knowledge about parenting. Much professional and personal energy was needed by the health practitioners to achieve this with any consistency.
- 9.19** Overall therefore, despite considerable concerted attempts by practitioners to engage these parents, this was never really achieved with any consistency. There were probably a number of reasons why this was, the first being that even before safeguarding issues were raised, the mother failed to engage with ante natal services, which showed that in principle, she was not happy about accepting professional intervention. And then, when concerns were raised, all the practitioners had little choice but to commence their work with the family in the context of child protection and legal processes, thereby presenting an authoritative stance without the balance of welfare and support provision.
- 9.20** Clearly the personality, background and strength of conviction of the parents on this matter, particularly from the mother, made it very difficult to change their strength of feeling. When some objective evidence of the children's care emerged as generally being satisfactory (e.g. as from the paediatrician), this simply made it much more difficult to convince the parents that they were nevertheless in need of professional interventions and support. Furthermore there was a high turnover of staff among the agencies involved and this meant that the establishment of meaningful relationships with the family was very difficult with each new practitioner who became involved, and this process was strongly confirmed by the father as very frustrating for both parents.
- 9.21** Without the problem being sufficiently escalated to senior managers, they were not in a position to create the necessary environment to generate an innovative process that would cease current thinking and objectively review what was needed. Alongside recognition that the case had become "stuck", this meant that without any objective input and force for change, that the situation continued in an unhelpful way for much of the time of involvement with the family. The lack of objectivity within the CPC process, the fact that the process of exception reporting to senior managers was not embedded in practice, and the poor management oversight all played a part in making it difficult for a fresh and objective review process to take place. In effect, the continuing CP Plans were being repeated without actions taken against them, and this in itself was providing evidence that despite their existence, the children were continuing to be subject to abuse. Calling a strategy meeting would have been unusual in such circumstances, but the situation called for innovative strategies to solve the

problem. One component of the CP Plan for “all agencies to continue to try accessing the home to see the children” was identified in all of the five CPCs undertaken between August 2011 and November 2012. The child protection system should have been used more flexibly to accept that the process was not working and needed a fresh, different and innovative approach to address the prevailing situation.

10. The impact on professionals and agencies of working with a very complex family alongside high levels of child protection concerns.

10.1 The degree of drift in the management of this case, particularly during 2012 and into 2013, reflected a degree of frustration by the workers, in that no matter what attempts were made to engage the parents, these were generally unsuccessful. When interventions did seem to be successful or generate an action from the parents, these were limited and short-lived, no doubt leading to further professional frustration.

10.2 It could be argued that a change of worker is sometimes a useful strategy to generate a more positive response from parents, but these occurred too frequently and were unable to build on any previous achievements with the family. In fact from 2009 there were three CYPs service managers, six practice managers, three senior practitioners, seven social workers, two student social workers and four family support workers involved, as well as staff from the children’s centre. This high turnover clearly had a significant impact upon management of the case for example in respect of the failure to progress the PLO and CP Plans. The circumstances of this case needed a consistency of practitioner so as effective working relationships could be built. Information from the SCR process identified that the changes to CYPs staff was beyond senior management control and reflected staffing and retention difficulties in the area. However neither was there evidence in the case of a senior manager becoming involved to help select a social worker who was likely to be in the area long term.

10.3 All of these changes of practitioner must have had an impact on the parents in terms of generating a level of apathy in that they already had little commitment to want to engage with social workers, but to have to do so repeatedly was hardly going to achieve success. In the father’s contribution to the SCR he described how social workers seemed to be always changing, and felt that just when there was some connection with the worker, that they were replaced. His perception was the change seemed to take place soon after a social worker began to understand their perspective better. In this way he felt that the work had to start all over again and that he and the mother did not have the inclination to continue to do this. Additionally, it needed to be considered what sort of message this might have given to the parents, and whether they perceived this as a lack of interest in them and that they were on the receiving end of a bureaucratic process. They certainly held strong views that they were capable parents and that there was no need for concerns for the care of their children, and the regular changing of workers may well have given them an unintended message that the concerns were not in fact high and did not warrant greater consistency of worker.

10.4 It was apparent that the continuing pressure of trying to engage the parents as effectively as possible was very challenging and had the potential to be overwhelming. “For every

frustration on the part of a fearful parent with an open child protective case, there are a multitude of frustrations that workers experience as well"¹⁸

11. The extent to which the mental/emotional health of the mother was a key factor and needed understanding in terms of the assessment of risks to the children and the family's ability to engage with professionals.

11.1 For the duration of professional involvement with the family, there was no diagnosis of any mental health difficulties and although the mother did access support from the mental health services soon after Levina was born, this did not identify any mental health issues or depression. All of the Edinburgh Postnatal Depression Scores¹⁹ were low and the last entry just a month before the mother and children's death, was a score of 1, which was exceptionally low, (no indicators of depression) and brought in to question the validity of the mother's answers to the questions. This reflects how, even at this late stage, there remained professional uncertainty about the mother's emotional health at the post natal stage. It is important to note that the Edinburgh score only deals with the symptoms of depression post birth and does not assess all types of mental illness nor personality disorder which may have been a factor in this case.

11.2 There were various incidents which led professionals to have some concern for the mother's mental health, and these included the very highly anxious state in her presentation to the A&E to have Levina examined, her irrational concerns about the nursery reflecting an apparent fear of the outside world, single mindedness and inability to listen to others or accept any sort of advice.

11.3 Because professionals were unable to get close to her, it was difficult to understand the mother's fears and anxieties and to what extent her background experiences had had upon her. When anxious, it was reported how incessantly she spoke, making it very challenging to engage her in any meaningful way. It also reflected the anxiety she felt and her inability to express this coherently. Clearly if this was a persistent personality trait, then it would have impacted on the children and made communication with their mother extremely difficult. It was a noted success to get the mother to agree to attend an adult attachment interview, but the health visitor had tried to do this for some time and reported that in the last interview in respect of this, it took 1 ½ hours to reach this stage by constantly challenging the mother to look at the family's home life from the children's perspective.

11.4 No detailed mental health assessment was proposed or set up for the mother, and it would have been very difficult to get her to agree to this anyway. However, psychological assessments were identified as being necessary within the CPC process, but these were not

¹⁸ "The carrot or the stick – Towards effective practice with involuntary clients in safeguarding children work", Calder M,C et al – Russell House Publishing 2008.

¹⁹ The **Edinburgh Postnatal Depression Scale** (EPDS) is a 10-item questionnaire that was developed to identify women who have post-partum depression. Items of the scale correspond to various clinical depression symptoms, such as guilt feeling, sleep disturbance, low energy, and suicidal ideation. Overall assessment is done by total score, which is determined by adding together the scores for each of the 10 items. Higher scores indicate more depressive symptoms. The EPDS may be used within 8 weeks postpartum and it also can be applied for depression screening during pregnancy.

processed and as previously discussed, reflected the impotence of the CP Plans and Core Group processes.

- 11.5** As part of his contribution to the SCR, the father acknowledged that he did not initially see that the mother had any sort of mental health problem, but that as time went on, he said that he felt she needed some help and that he wished some sort of assessment could have been set up. He said that he tried to convince her but that she never really listened and always thought she was right. However, it was identified in the November 2012 CPC minutes that the mother had expressed a desire to the health visitor that she wanted to parent more effectively but required psychiatric help to do so. It was in this context that the adult attachment interview was eventually set up and agreed to, but her death occurred before it could take place. Clearly knowing the background, it was questionable whether the mother would in fact have taken up this interview.
- 11.6** The question of whether the mother suffered with any mental health problems or whether there was any form of personality disorder therefore remained unanswered. The very early assessment suggested that there were no mental health issues, but there was no later clinical assessment to confirm whether this was the case later on as a parent of young children. Those practitioners working with her were unable to convince her to attend any assessment and clearly there was no way that the situation could have been forced without some form of legal process to support its necessity.

Organisational and Contextual Factors

- 12.1** The latest Ofsted Inspection in June 2013 found that the overall effectiveness for arrangements to protect children in Suffolk was “adequate” and there was no specific reference to any concerns about the north area of the county where this family resided. However, although there were initiatives to address the problems identified in this area in 2010 by increasing the management capacity, and a two day Ofsted visit In July 2011 confirmed issues were improving within Lowestoft, unfortunately there was little evidence within this case to suggest that the improvements had been made. The poor management oversight which allowed such drift to occur with the case from August 2011 to March 2013 was concerning.
- 12.2** Following the 2010 Ofsted Inspection, the internal post inspection review in October of that year showed serious shortfalls in practice in Lowestoft but that these were not reported to senior management. Also the role of Northern Area Safeguarding Children Committee appeared to be compromised when reports to them in September 2009, February and May 2010 were “surprisingly positive” in that for May 2010 it was reported that “the teams continue to demonstrate good performance in all areas” even though about sixty cases were being held by Social Care Managers. This analysis of practice in the Lowestoft area and a description of the culture of sorting things out locally meant that the feedback process of any poor practice to the wider Local Authority and to the SSCB did not occur. “Caseloads were

also too high to ensure that social workers could undertake meaningful work with all the children allocated to them”²⁰

- 12.3** In July 2011 a new Operating Model was implemented within the Local Authority which encompassed significant organisational change leading to changes for staffing and to team boundaries. This was likely to have had an impact on operational stability. Social work salary levels in Lowestoft were not competitive with their geographic neighbours in Norfolk at this time, although this has now been addressed. However the situation in 2011-12 may well have impacted on staff commitment and sense of recognition. Within the particular social work staff in this case, three of them who held case responsibility had high levels of sickness and some others who were allocated were not established or experienced. This may help to explain why achieving consistency of social work allocation to this case was so problematic and the case allowed to drift.
- 12.4** Coupled with these organisational issues was the fact that this case was a very demanding and complex one. Although it had a high priority because of its CP status, the challenge of the persistent non engagement of the parents meant that within the context of high caseloads, significant energy would have been needed to effect change in this case. Also the fact that the case presented with chronic concerns over time rather than significant individual events or crises, meant that it presented with a more diffuse set of concerns which did not always immediately identify the need for robust intervention.
- 12.5** There were numerous contextual factors which had implications for the health visiting services in the Lowestoft area, with some staff sickness issues and budget restrictions meaning that covering arrangements were quite challenging during 2009/10 and that there was some uncertainty for staff at this time. This was also at a time when there were increasing numbers of young families subject to CP Plans. The launch of the East Coast Community Healthcare CIC in October 2011 brought in numerous changes to practice as well as new training and staff support processes. The same health visitor remained with the family from 2011 and worked to achieve one of the more effective relationships with the mother.

13. SUMMARY

- 13.1** None of the professionals who had worked with the family would have been able to prevent or predict the final tragic outcome. There was never any evidence to suggest that the mother would harm herself or the children, and without any letter or definitive statement of intent by the mother, it remains unclear why she took the actions she did. During 2013 there was no new initiative or different sanction which was being utilised at this time which would have generated a significant negative reaction from her. In some respects therefore, the analysis of the professional practice in this case goes little way to understanding the final acts by the mother.
- 13.2** It was apparent that in respect of the incidents which ultimately led to the death of the mother and the children, that neither parent had been honest with professionals, namely the Police, at this time. The father did not tell the truth that the mother was the person who had

²⁰ Suffolk post inspection review – internal review process – Kathy Bundred October 2010.

stabbed him,(in order to protect her), and she was not truthful to the Police about her recent contact with the father, when they called that night to check out the father’s story regarding a local assailant who had stabbed him in the street nearby. The Police were not able to gain access to the flat as the mother would not allow them in. This was accepted by the Police and was understandable in that it was late at night and there was no reason to request to see the children as no concerns had been raised about their care in respect of this particular incident.

- 13.3** There is a body of research that has considered the issue of filicide, (the act of the murder of a child by a parent), and one of the most influential pieces of research has classified six different sets of characteristics of child murder²¹. Of these characteristics, it is challenging to identify which might apply to the acts by this mother but two of these may have relevance. The first would be in relation to “Altruistic Filicide - where the parent kills the child because it is perceived to be in the best interests of the child”, and the second would be “Spouse Revenge Filicide - where the parent kills the child as a means of exacting revenge upon the spouse, perhaps secondary to infidelity or abandonment”²². In fact the most common motive found in the original research was that of altruistic filicide and the least common that of spousal revenge. It may have been significant that the mother allegedly made a statement to the father that he would not see his children again after he had said that he would be commencing a relationship with another woman. Whilst it can only be conjecture what she actually meant by this, it could suggest that both of the possible motivations identified above could be relevant in this case. These issues will of course more appropriately be a matter for consideration at the Coroner’s inquest.
- 13.4** The predominant feature of this case was the challenge of how to engage this hard to reach family, and especially the mother who specifically avoided professional interventions. Whilst some creative and committed approaches were made by practitioners, factors such as staff changes had a considerable impact on achieving success. Whilst some alternative approaches to engage the family have been suggested within the report, it is not possible to say whether they would in fact have made any real difference as it was very clearly a strong personality trait of the mother not to accept any help unless it was on her terms. Nevertheless in terms of future learning, it is appropriate to give consideration to how other forms of intervention could be used in the future and which may prove to be successful.
- 13.5** The determination of the mother not to accept help was considerable and unwavering although whether a completed PLO process or an application for Care Proceedings at some stage from August 2011 onwards would have changed this, was never tested. Clearly if the children had been placed in care, this could have avoided the tragic outcome, but there was never any guarantee that an application for a Care Order for the children would have been successful, or that the children would not again return to her care even within the context of successful Care Proceedings. It was nevertheless concerning that a clear decision was not made by CYPS in respect of the need for a legal intervention and instead allowed the process to drift in a most unconstructive way.

²¹ Resnick, PJ, “Child Murder by Parents: a psychiatric review of Filicide. American Journal of Psychiatry 1969

²² Sara G West, “An Overview of Filicide” – Psychiatry MMC – February 2007

- 13.6** Overall, the child protection process in terms of the requirements for CPCs and Core Groups to be held and for them to consider the risks to the children was fully adhered to. It was not apparent however that these processes were flexible enough to change a pattern of poor parental engagement and their avoidance of professionals, and to affect unchanging CP Plans. Lack of objective input to the CPCs and poor management oversight impacted on the ability of the CP processes to create a more challenging environment in which to monitor and improve the care of the children.
- 13.7** Other challenges for staff that emanated from the difficulty of engaging the family, was being able to secure appropriate assessments either for the children or for the mother. Although psychological and psychiatric assessments of the mother were proposed and discussed with her, unfortunately these were never achieved because of the mother's reluctances. She had the right to choose not to accept that she needed a mental health assessment and there was no legal order in place to help secure such an assessment.

LESSONS LEARNED

- 14.1** Working with hard to reach and avoidant families is very challenging for professionals and has impact upon the parents in the anxiety it creates for them and for the loss of the benefit of receiving supportive services. Innovative multi-agency interventions and new initiatives are likely to be required to engage parents in a more constructive working alliance. There is considerable research and literature on this subject which can give direction to practitioners and managers on how to attempt different strategies and achieve effective outcomes.
- 14.2** An effective way to identify whether emotional abuse or neglect exists within a family is to focus on the experiences of the children and identify what the impact of any emotional neglect might be. Practitioners need effective supervision and support to enable them to retain a child focus and assess their behaviours and development within families where the parents have high levels of need.
- 14.3** To allow CP Plans to continue unaddressed throughout a number of CPCs means that the children will continue to be subject to significant harm whilst still within the child protection process.
- 14.4** The role of the CPC Chair is a pivotal one in challenging the management of a case which is not achieving CP Plans and by inference it is maintaining children in at-risk scenarios.
- 14.5** For CPCs to only include those professionals directly working with the family will deprive the CPC of objective input by managers and specialists to help progress the case and reduce safeguarding risks of the children.
- 14.6** All professionals have the responsibility to challenge inappropriate or ineffectual practice, which has become intransigent and is not protecting children. This does not solely apply to CPCs and should include the need to escalate concerns to senior managers when necessary.
- 14.7** In demanding child protection cases, robust management oversight of the progress of the case is essential and should be shown to have a direct role and impact on the professional interventions.

- 14.8** To generate the appropriate response and relevant assessment of parents when there are concerns about possible adult mental health issues will prove to be very difficult when the parent does not see the need for any such assessment and is avoidant of any assessment activity focussed upon mental health. It nevertheless must remain on the agenda for multi-agency discussions in consideration of any changing family circumstances, and whether this might enable pertinent mental health assessments to be newly progressed and offered to the parent in question.
- 14.9** When cases are not progressing in terms of the protection of children, and the multi agency process has become entrenched, if there is no separate process utilised to objectively review why the case has become problematic, then the children would continue to be at risk of significant harm, and the multi-agency interventions become further entrenched.
- 14.10** Background information of a parent's own childhood is essential to understanding their own parenting capacity, and if this information is not collected and shared among professionals, it will limit the accuracy of any parenting assessment.
- 14.11** Drift of the Public Law Outline process must be avoided by strong management oversight and via an effective working relationship between CYPS and legal services. This can only be achieved if there is a shared understanding and clarity about the separate roles, responsibilities and accountability for decision making.
- 14.12** If there is a shared understanding by non CYPS agencies of legal processes instigated for children, then they are more able to contribute and challenge the process when appropriate, as part of partnership working.
- 14.13** To fail to record important discussions and agreements reached between CPC Chairs and managers outside of the CP process, will mean that any actions agreed to ensure that a case is properly progressed, cannot be effectively reviewed or monitored and could enable management drift to occur.

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5.12.13