



# **Serious Case Review**

## **Child B**

**April 2021**

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# 1. Executive Summary

- 1.1 The publication of this Serious Case Review (SCR) was significantly delayed as a result of a number of unforeseen circumstances. A first draft of the report completed by the independent reviewer was subsequently finalised and approved by the SCR review panel overseeing this process.
- 1.2 The SCR makes six findings and nine recommendations for improving multi-agency safeguarding practice. These have particular relevance for those working with children who have complex needs and disabilities.

**Finding 1: Children not being brought to appointments is an indicator of potential neglect.** This is a clear finding of the review and one that has been seen in other SCRs. Child B, whilst being offered many appointments by different services, was not brought to a significant number of these. The hypothesis that these were as a result of neglect was not robustly pursued and there was little practical support offered to help the family manage these.

**Finding 2: Effective and child focused safeguarding practice with disabled children ensures they are seen, heard and helped.** Whilst Child B was seen on many occasions, there was limited evidence that his voice was consistently heard or that he was directly engaged by involved professionals. However, some professionals, particularly school staff were able to effectively engage and communicate with Child B.

**Finding 3: The focus on engaging parents and carers to support disabled children is key, but this should not dilute professional challenge when needed.** Parental involvement for disabled children with communication difficulties is especially important. However, practitioners had no real clarity or guidance within the system about when non-engagement should be a '*red flag*'. This lack of clarity is likely to have been a reason why the identification of potential neglect to Child B took so long to action.

**Finding 4: Multi-agency working, information sharing and understanding the responsibilities of others can be complex. Clear systems and processes can support effective child focussed safeguarding practice.** It is clear that no agency involved with Child B had a clear overview of the family history, its dynamics or a complete picture of Child B's needs. Even professionals who knew Child B well were learning new information as part of a practitioner workshop convened for this SCR. A strong view expressed was that the lack of this complete picture can often arise in the system supporting children with complex health needs and disabilities when so many different agencies are involved. This is a known feature and a challenge for both professionals and parents alike.

**Finding 5: The need for professionals to think family and think fathers.** It was accepted that there was no clear picture of the dynamics of Child B's family. Professionals should have been thinking (and acting) beyond the individual they were working with. There was a need to Think Family.<sup>1</sup> There should also have been a greater focus on Child B's father. The SCR recognised an over-reliance on contact with mother and not enough questioning of the dynamics of the relationship with Child B's father and what his role was in supporting his child's care.

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<sup>1</sup>[Think child, think parent, think family: a guide to parental mental health and child welfare; Social Care Institute for Excellence, 2011](#)

## 2. Introduction

- 2.1 Child B was born with a disability that led to urological problems and mobility difficulties. Child B has reduced sensitivity in the lower limbs (which means pain is not felt in the same way as other children), speech and language delay and learning difficulties. Child B has required surgical intervention to address a range of health complications.
- 2.2 Despite daily challenges, Child B is an active, friendly and happy child who can make good relationships with adults. Child B is able to express themselves well and say what they like and want.<sup>2</sup> Throughout childhood, Child B has required significant support from a range of health specialists<sup>3</sup>. This has included routine care from a specialist children's hospital (Hospital 1), a local hospital (Hospital 2) and occasionally the services of the local emergency department or outpatients (Hospital 3). Child B is also known to different community-based health services. Child B attended a children's centre and later a mainstream school. Child B has also received social work support as a disabled child and due to concerns about their welfare.
- 2.3 For the period under review, Child B lived with mother, father and older siblings. One of the siblings was also in receipt of services as a disabled child and subsequently as a disabled adult.
- 2.4 In May 2015, Child B was admitted to hospital to have a toe amputated. The opinion of health practitioners at the time was that the infection that led to the amputation was preventable. Child B had not been brought to a significant number of health appointments. Had they been, then it is likely that the infection would have been treated and managed. On a number of occasions, concerns about Child B's welfare were raised internally by health practitioners. Whilst these concerns focused on possible neglect, there was no action until the case was

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<sup>2</sup> As described by Child B's mother and school to the Independent Reviewer.

<sup>3</sup> Neurosurgeons, Orthopaedic Surgeons, Plastic Surgeons and Urologists at different hospitals and from community paediatrics, therapists and nursing, as well as Emergency Department care and GP primary care.

formally escalated to senior managers in late 2018. Child B was then aged 10 years. In February 2019, Child B was made subject of a child protection plan.

### **3. Key Circumstances, Background & Context**

- 3.1 In 2002, Children's Social Care (CSC) became involved with the family due to concerns about domestic abuse and the capacity of the parents to meet the needs of their children. Assessments undertaken by CSC at the time resulted in either no further action or the provision of support from early help services, charities and education.
- 3.2 In 2007 another incident of domestic abuse was reported and in 2008 (the year of Child B's birth), there were reported concerns about physical chastisement involving one of Child B's siblings. Assessments were once again undertaken by CSC, with no further action being considered necessary. There were noted pressures in the family as a result of financial difficulties and caring responsibilities for the children.
- 3.3 In 2010, all the children were made the subjects of child in need plans as a result of one of them sustaining a burn injury and ongoing concerns about their collective welfare. In the same year, Child B was seen by the GP and referred to the local Emergency Department for a serious abrasion and ulceration to a toe
- 3.4 Throughout 2011 and 2012, several health practitioners identified that Child B was 'missing', had 'failed' or 'did not attend' appointments. Routine letters were ordinarily sent to the GP and the parents were regularly advised of the need to take Child B to scheduled appointments.
- 3.5 Child B started to attend education at the age of three. The assessment process for a statement of special educational needs commenced.<sup>4</sup> Child B's needs at school were monitored through termly and annual reviews. The school remained concerned about Child B and agreed to provide one to one support.

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<sup>4</sup> Later an Education, Health & Care Plan

- 3.6 In early 2013, a meeting was convened by the Disabled Children's Service (DCS) to review the care package for Child B's older sibling. Professionals reported finding it difficult to engage and communicate with the parents. The DCS advised the professional network that it was '*closing the case*' for Child B as there were no concerns and appropriate services were being provided by health and education.
- 3.7 Over the subsequent years covered by the review's terms of reference, there were two main strands of professional involvement with Child B which highlight a repeating pattern of concern.
- 3.8 The first was that Child B sustained a number of toe injuries and on occasions, was brought late to the local emergency department of Hospital 3. Child B's disability, lack of sensation in the lower limbs and general footcare complicated the wound which did not heal well. This subsequently affected Child B's ability to wear special aids such splints and shoes.
- 3.9 The second strand was that both acute and community-based health services were seeing a growing number of incidents of Child B not being brought to appointments. The nature of Child B's disability meant that ongoing support was essential for specialist aids and therapeutic services. At times, practical aids were missing or broken, putting Child B's limbs under additional strain and potentially at risk.
- 3.10 The following narrative provides an overview of the significant events involving Child B. Whilst comprehensive, it remains a summary and does not set out every occurrence recorded in agency files. This should be taken into account when considering the overall context of Child B's lived experience and the complexity arising from the number of professionals involved over this time.

### **Child B: Five to Seven Years Old**

- 3.11 In late 2013, Hospital 2 noted that Child B's toe required treatment. This led to Child B having successful operations, but they were not brought to a number of follow up appointments, including those arranged for physiotherapy. Child B's mother was reporting that she was finding it hard to manage all the appointments

for Child B and her other children. At the time, none of the missed appointments were considered as potential safeguarding concerns. The condition of Child B's toe subsequently deteriorated.

- 3.12 The community nurse contacted the DCS<sup>5</sup> recommending that Child B's mother needed additional support managing appointments and that a special needs keyworker<sup>6</sup> may have a role to play. This was subsequently considered at a multi-agency meeting, although it was agreed that the DCS social worker would provide this support (given their ongoing involvement with Child B's older sibling). At this meeting, the question was raised as to whether Child B was being neglected.

**Critique of Practice**

*This appears to have been the first time that the concerns relating to Child B were expressed using the term neglect. The DCS was tasked to undertake a 'child in need' assessment in respect of these concerns.*

*The meeting held to discuss the keyworker did not have access to information about the different hospitals' services to Child B or those from the GP Practice. This would have indicated an even greater pattern of 'was not brought'.*

- 3.13 Shortly after this meeting, Child B was not brought to a clinic at Hospital 2 to dress their toe. This was not escalated. At a multi-agency school review meeting held in April 2014, the parents mentioned that Child B's siblings were helping with physiotherapy.

**Critique of Practice**

*Child B's siblings should have been considered as possible Young Carers. They weren't.*

- 3.14 The following month, Child B was brought to the Emergency Department at Hospital 2 following a deterioration in their toe. Child B was scheduled to have surgery the next day (unrelated to the toe) and it was agreed the toe would be

<sup>5</sup> A social worker from the Disabled Children's Service was involved with the family, although there was noted confusion in the network about whether the social worker was for Child B or the older sibling.

<sup>6</sup> from the Centre for Integrated Services for Disabled Children



reviewed then. However, as a result of confusion over appointment times, this did not take place.

- 3.15 The planned surgery was rescheduled and Child B's toe eventually examined. A decision was made that it needed to be partially amputated. The wound was to be re-dressed by mother prior to the operation the following week.

**Critique of Practice**

*The Hospital team dealing with Child B's amputation were unaware of the concerns in the community network of missed appointments and possible neglect.*

*Erroneously, it was assumed that mother was a nurse and could appropriately dress the wound (and so may not attend the planned dressing clinic). Child B was not brought to the clinic.*

- 3.16 On meeting with the physiotherapist, mother expressed her concerns that she was unclear of the hospital's plan for the partial amputation of Child B's toe. She also mentioned that Child B's wheelchair strap was broken. Mother was advised to contact the wheelchair service. The physiotherapist contacted the hospital on behalf of mother to check arrangements about the planned operation. They were advised by the Doctor's secretary that Child B was not booked for surgery. The secretary advised that mother needed to contact the appointments section.

**Critique of Practice**

*This above narrative shows some of the complexity of what Child B's mother was having to negotiate across services.*

- 3.17 Following surgery, a review was scheduled at Hospital 2. Child B was not brought to this appointment. Separately over this period, Child B was not brought to a routine orthopaedics appointment at Hospital 1 and the physiotherapist continued to have difficulty contacting mother.
- 3.18 As part of a plan to support the parents, the DCS social worker was monitoring missed appointments and requested other services provide information about

future scheduled appointments as necessary. However no contact was made requesting this information from the three hospitals or the GP.

- 3.19 The child in need assessment was completed by the DCS social worker, although this was several months overdue. Despite identifying the frequently missed health appointments, the assessment did not conclude these were safeguarding concerns or make any recommendations for ongoing support. Whilst Child B was placed on a child in need plan, this did require regular visits to be undertaken to see Child B.
- 3.20 In November 2014, Child B was not brought to appointments at Hospital 1 or to a community paediatrics appointment. Child B was also not brought to a re-arranged appointment by Hospital 1 to complete an orthopaedics review. Hospital 1 was also unaware of a recent operation undertaken at Hospital 2.
- 3.21 The school, social worker and physiotherapist exchanged emails about Child B missing appointments. The school's Designated Safeguarding Lead noted that there was a risk of this becoming a safeguarding issue. In late January 2015, Child B was not brought to Hospital 2. The physiotherapist sought to escalate this to the DCS, but was told that the case was now 'review only' and that there was no active social work role.

**Critique of Practice**

*Not all partner agencies were advised that Child B's case was now for 'review only'. Practically, this meant that the only function of the DCS was to coordinate reviews of Child B's care package. The agreed role of the DCS social worker as a coordinator of appointments had lapsed, but no contingency arrangements were put in place, such as considering whether a special needs keyworker should now take up this role.*

- 3.22 In February 2015, the school was concerned as there was poor communication with the parents. The school believed that Child B's physical and health needs were not being met and asked for a DCS social worker to follow this up.

### **Critique of Practice**

*The DCS engaged with the family and noted that there was a risk of Child B's missed appointments becoming a 'safeguarding matter'. A DCS social worker discussed this with Child B's mother over the phone after she had missed a planned appointment to meet them. No practical help or solution was offered to support this problem. Child B continued not to be brought to a range of appointments and mother was not responding to several services' attempts to discuss this.*

- 3.23 In March 2015, Child B was not brought to a routine developmental review at the Community Paediatric Service. As this was the second missed appointment, Child B was discharged to the care of the GP. This meant that Child B was longer receiving general paediatric oversight for their specialist health needs. Child B was not brought to a follow up fitting for new splints and also missed an appointment at Hospital 3.
- 3.24 At the end of April 2015, Child B was taken to the emergency department of Hospital 2 after injuring their toe. This was a late presentation. The wound was weeping and discoloured and Child B had difficulty walking without support. The delay in seeking treatment for Child B was not immediately recognised as a safeguarding concern or referred to CSC. However, after discussion in the hospital's psychosocial meeting and escalation to the hospital's safeguarding nurse, the Disabled Children's Service was notified of this concern.
- 3.25 Child B was later found to be suffering from an infection in the bone and was admitted to hospital. Child B was given intravenous antibiotics and it was decided that further amputation was required. Child B was an in-patient for ten days. Following discharge, Child B was brought back to the emergency department by mother as the wound was not healing. It was recorded that Child B was not compliant with advice about weight bearing.

### **Critique of Practice**

*Child B was six years old and had learning and communication difficulties. Recoding 'non-compliance' with weight bearing advice does not appear to have considered Child B's age and specific needs. Specialist communication may have been required to assist Child B understand what was being asked. There is no evidence this was offered.*

- 3.26 In May 2015, a review at Hospital 2 established that Child B had not been taking the prescribed antibiotics. Child B was not brought to the next appointment.
- 3.27 In June 2015, Child B was back at school, using a wheelchair. The school advised the community physiotherapy service that there were difficulties contacting mother and she was not responding to written communication.
- 3.28 The physiotherapist was concerned about the healing of Child B's toe and who was changing the dressings. They contacted Hospital 2 and left messages on two occasions to seek clarification, with no response. In conversation with the DSC social worker, mother said that Child B's wound was being dressed once a week at the hospital. This does not appear to have been the case. By the end of June 2015, Child B's wheelchair was broken and they were using a walking frame and hopping.
- 3.29 Child B subsequently missed an appointment with the community physiotherapist, the third missed appointment in six months. A '*Did not Attend*' letter was sent to the parents, but it was agreed that despite the policy (which suggested closure), the service would be continued.
- 3.30 Child B was also not brought to Hospital 1 for a neurosurgery appointment. Hospital 1 closed this service to Child B and informed the GP that a re-referral could be made if necessary. Later in the month, Child B was not brought to an appointment at Hospital 2. Child B was also not brought to a community physiotherapy appointment and it was decided that if any more appointments were missed, Child B would be discharged. In late October 2015, after not being brought to three appointments, the wheelchair service closed Child B's case.

3.31 The DCS social worker visited Child B's parents and raised the issue of Child B's missed appointments. The parents reportedly became angry saying that they found taking Child B to so many appointments difficult and that they couldn't leave Child B's disabled sibling at home alone. Both parents were working. Despite the obvious challenges this presented to the parents, no solution was agreed or plan developed to support the parents in this respect.

#### **Critique of Practice**

*Despite the significant number of missed appointments, this was not yet seen as meeting the threshold for neglect. The seriousness was again stressed to the parents (referring to the possibility of using child protection processes), but the failure to take any subsequent action lacked any authority or decisiveness to resolve this issue in Child B's interests. Previous 'warnings' to the family had yielded no results. Neither had the assistance of the DCS social worker to help the family manage Child B's appointments. The next day B was not brought to the GP for a planned flu vaccination.*

#### **Child B: Seven to Eight Years Old**

3.32 From the ages of seven to eight, the pattern of concerns about Child B missing appointments continued. Key events included the following:

- In April 2016, after attending the emergency department of Hospital 3 with an injured toe, Child B was not brought to a follow up appointment. Mother was still being seen as competent to dress Child B's toe at home.
- At the same time, community health services noted that Child B had broken splints and that they were too small. Mother had been previously reminded of the need to inform services when this happened.
- The condition of the wound to Child B's toe was a continuing concern for community health and school staff and mother was advised to take Child B to the GP.
- At school, Child B disclosed that father was hitting mother. A DCS social worker visited, and denied there was any domestic abuse. During this engagement, mother explained that Child B's wound was being followed up at the clinic and by the GP, although this was not happening.

**Critique of Practice**

*There was regular communication between the school, community nursing, community physiotherapy and the social worker about Child B. Professionals believed that they were regularly raising concerns about possible neglect via the social worker. However, the DCS had no remit to pursue these concerns under child protection procedures. In the absence of the DCS recognising a child protection response was required, other agencies were likely to have been falsely reassured they had reported their concerns via the correct pathway.*

- 3.33 In June 2016, Child B was seen at the GP for foot pain. The GP took the opportunity to raise the issue of the number of missed appointments. Mother said that it was hard to take Child B to so many appointments as she had other children and Child B's sibling also had special needs. The GP suggested that the family may wish to find a surgery closer to their home.
- 3.34 The following month, Child B was admitted to Hospital 3, having been brought in by ambulance due to breathing difficulties. Child B had viral induced wheezing for two days, was unkempt and their eczema was being poorly managed.

**Critique of Practice**

*A referral was appropriately made by Hospital 3 to the paediatrician to consider Child B's social situation. Mother was reported as being uncooperative as she felt that she had already told the emergency doctor about Child B's needs on admission. Hospital 3 noted that Child B was an 'open case' to the DCS and that the social work team had no safeguarding concerns. Child B was discharged home the same day, after several hours monitoring.*

- 3.35 The next professional contact was again at Hospital 3 due to a worsening in the condition of Child B's toe. The hospital discussed this deterioration as a possible safeguarding issue.
- 3.36 An X-ray of Child B's toe (referred by the GP) was undertaken at Hospital 2. This confirmed the toe was in a poor state. Hospital 2 also noted potential safeguarding concerns, although no referral was made to CSC in respect of these.

3.37 The concerns of Hospital 3 were shared with the DCS social worker. They were informed that the DCS social worker was seeking to support the parents in meeting Child B's needs. The plan was for the DCS social worker to again meet with the parents to raise the issue of missed appointments. This was the fourth such meeting.

3.38 During an appointment at the foot clinic in Hospital 3, a new and open wound to Child B's foot was observed. Child B was referred immediately to the emergency department at Hospital 3. Mother reported she had been abroad and was not fully aware of the circumstances of the injury. She had not sought medical help as she felt that she was looking after Child B's foot appropriately. Hospital 3 discussed this possible safeguarding issue at a paediatric psychosocial meeting. It noted the concerns and also that the community physiotherapist had already made a referral to CSC<sup>7</sup> in the light of these new (but repeated) developments.

3.39 Other significant event around this time included the following:

- Mother was seen by the GP and alleged that father had slapped her and that the police were involved. There is no evidence that they were.
- On meeting with the CSC social worker (following the referral by the community physiotherapist), mother told them that she had not been given any advice about the care of Child B's toe. The social worker was not aware of the allegation of domestic abuse made to the GP. No further action was deemed necessary by CSC.
- At the end of 2016, Hospital 2 reviewed Child B's toe and found multiple ingrowing toenails. This was not seen as an issue relating to parenting capacity and a plan was made to review Child B in six months.
- It was agreed at a Care Package Review Panel to extend Child B's support (direct payment for seven hours of care) until 2017. There was no discussion about potential safeguarding risks and no advice on how support could be arranged to help the parents manage Child B's appointments.

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<sup>7</sup> As a child protection concern, the referral would have been made to the First Access & Screening Team, not to Disabled Children's Services.

## **Child B: Eight to Nine Years Old**

- 3.40 In March 2017, the school was concerned that Child B needed glasses and contacted the DCS social worker. The DCS social worker visited Child B at home. Child B's care package had now ceased based on the rationale that Child B had two parents and needed no additional support.
- 3.41 Later that month, mother contacted the police following an argument with father over money. This information was passed to the CSC immediately by the police, although it was not followed up for two months. At this point, mother was engaged and declined any further assessment.
- 3.42 Other relevant events over this period included:
- In May 2017, the community physiotherapist considered calling a professionals' meeting as she felt that Child B's needs were not being met. The meeting was not convened for a further four months.
  - Child B was brought to the emergency department of Hospital 3 with toothache and was given antibiotics. The toothache was not seen as a further potential symptom of neglect.
  - Child B was recorded as a '*did not attend*' to the follow up meeting at Hospital 2 for the review of their toe. Child B was discharged from the service.
  - In June 2017, the community physiotherapist saw Child B at school. She contacted the DCS social worker as Child B had missed all the physiotherapy sessions since January 2017. Mother was reported to have regularly cancelled the planned sessions.
  - A planned meeting with mother, the community physiotherapist and the school was cancelled by mother as she was going away for a month. She also asked for all appointments for Child B to be postponed, even though Child B was not going away with her.
  - The community nurse reviewed Child B's toe at school at the end of June 2017. Child B had pain, possibly as a result of their shoes which were too large and rubbing the feet.
  - At the beginning of July 2017, the physiotherapist wrote again to the DCS social worker to say that Child B still had no glasses and that their footwear



was inappropriate, asking for these to be taken up with the family as they were significant health needs.

**Critique of Practice**

*The community physiotherapist had formally referred similar concerns as a safeguarding issue only a few months prior, but these had not been accepted as concerns indicating neglect. It is, perhaps, not surprising, therefore, that she did not make a further safeguarding referral.*

- 3.43 The community physiotherapist was also concerned about Child B possibly experiencing back pain and the risk to their hip, questioning whether this was as a result of Child B's disability and gait, and perhaps not using the required aids. She referred to Hospital 2 asking for Child B's hip to be reviewed.
- 3.44 At the end of July 2017, the community physiotherapist rang the home to remind the family of an appointment the following day. The phone was answered by a young child and there appeared to be no adult at home, in the school holidays. The community physiotherapist rang the DCS social worker and was advised to refer the concern to CSC. On doing this, CSC advised her to ring the police.

**Critique of Practice**

*The police established by phone (but did not check) that a 15-year-old had answered the phone and that father was reported to be present but asleep. The police told the community physiotherapist that this was not a matter for them to follow up and she agreed to discuss it with CSC.*

*The importance of a home visit was not recognised in this instance. Someone in the professional network should have taken the initiative to visit the family home to assess what was happening and who was looking after Child B. This was particularly relevant in the context of Child B's complex needs and the care they required.*

- 3.45 The next day, the community nursing team decided to discharge Child B from their care as they could not see Child B (as the school had closed for holidays) and the

parents were not responding. The GP was informed. The day after, Child B did not attend an appointment at the Foot Clinic.

3.46 In September 2017, there was a Team Around the Child (TAC) meeting at the school. Some improvement was noted in attendance at some appointments, but mother was reminded of the continuing need for Child B's foot and leg care. Child B was missing a splint and specialist shoes. She re-stated the difficulty that she had with the large number of appointments. Support plans, including appropriate physical activities for Child B were to be put in place. However, no contingency plan was agreed should the situation deteriorate and no review date for a further TAC Meeting was set.

3.47 Other events over this period included:

- Child B had to have some teeth removed. Child B was almost nine years old. The possibility of neglect was not considered.
- Child B had not been brought to several appointments at the Foot Clinic.
- In November 2017, mother was admitted to hospital for several weeks with a serious health problem. Professionals supporting Child B were unaware of this. At the time, there were signs that Child B was not being looked after properly and that they were hungry. When it came to the attention of the DSC social worker (just as mother was being discharged), seven hours additional support in the home were arranged for a month.

#### **Child B: Nine to Ten Years Old**

3.48 In January 2018, Child B was not brought to a GP appointment and one of their siblings was discharged from another service for not attending appointments.

3.49 Child B's mother called CSC asking for Child B's father to be removed from the home. She described an acrimonious relationship, but said there was no domestic abuse. She said that he was not supporting her. Mother was advised to call the police if necessary. CSC took no further action.

### **Critique of Practice**

*This is one of the few times that father featured in the records in any context. He was largely absent from the records and from the professional engagement with the family. Research is well established in this respect, with the need for professionals to actively include a focus on fathers as part of multi-agency safeguarding practice. It is clear that father's role was never really explored in any depth, or what his role was in respect of supporting mother manage the care of Child B and the other siblings.*

3.50 Other events of note over this period include:

- Small improvements in Child B's attendances at appointments were observed.
- Some of Child B's equipment was noted as being 'lost'. Child B was not wearing the correct shoes and could not attend school as a splint was broken.
- Ongoing tensions in the parental relationship were noted.
- Child B was not brought to the gait clinic on three occasions despite reminders and also missed a GP appointment.
- At the school annual review, Child B said that they did not want to be seen as disabled. It was noted that Child B had experienced a deep pressure sore on the ankle. Child B said they had injured it on the stairs.
- The annual review noted this was evidence that the family was still not coping with Child B's needs. Appointments were being missed, even though they had been reduced in number. It was recorded that '*crucial health needs were not being met*' and that there was a '*serious risk to Child B's wellbeing*'.

3.51 In June 2018, Child B's mother again called CSC asking for father to be removed from the home and alleging physical and verbal abuse. She was again advised to call the police. She later denied the alleged physical abuse and there was no further exploration of the reported domestic abuse. The parents did not attend a meeting with a social worker from CSC to discuss this further.

3.52 In September 2018, Child B was not brought on two occasions to ophthalmology and was discharged from this service. A new DCS social worker was appointed to assess concerns about non-attendance at appointments and Child B's needs not being met. The same month, the school reported that Child B's shoes were

broken, and their feet were exposed. The parents were not responding to the school's request to deal with this or contact them. Mother was thought to be away at the time. A few days later, Child B was noted to be unkempt and dirty and their behaviour had changed. It was questioned whether Child B was being fed at home. A request was made to the DCS for an urgent TAC meeting, but there was no response.

#### **Critique of Practice**

*This would have been a further opportunity to consider a child protection referral.*

- 3.53 In late October 2018, Child B was seen at Hospital 2. It was agreed that hip-reconstructive surgery was required. This was scheduled for the Spring of 2019. Child B was subsequently not brought to two orthotics appointments in November 2018. As a result, the case was escalated by Hospital 3 to the Named Safeguarding Lead for the Health Trust. The case was subsequently referred to CSC as a safeguarding issue of neglect.
- 3.54 In parallel, Child B also disclosed to the school that they were being physical harmed at home. The school made a referral to CSC. A child protection enquiry under section 47 of the Children Act 1089 was subsequently initiated. This resulted in Child B being made subject of a child protection plan in January 2019.

## **4. Views of the Family**

- 4.1 Both parents were invited to participate in the SCR. Only Child B's mother engaged. She met with the Independent Reviewer and the Head Teacher of Child B's school.
- 4.2 Mother's expressed her concern about the injury to her child's toe and the subsequent treatment this required, including amputation. She said she was told by health professionals that the toe should heal and she did not understand why it had not. She was shown how to manage the dressings by health staff, but says that she was not confident with this and may not have done it correctly. In

retrospect, she thought that it would have been helpful if a nurse had visited to help.

- 4.3 She also found the need to take Child B to the many appointments hard to manage. This was compounded by her own health needs (which had at times involved hospital admission) and her caring responsibilities for her other children. One of Child B's siblings also required significant support due to disabilities and another had health problems, which meant that mother sometimes had care of her grandchild. Child B's mother felt that professionals were not listening to her when she told them how hard it was to take her child to all the appointments. She said they just told her '*you have to take Child B*'.
- 4.4 Helping Child B manage their physical difficulties had been a challenge as they liked to be active and do things such as play and swimming. Child B found walking to be painful. The direct payments for respite care helped as mother was able to engage a relative to help take Child B to leisure activities and to pay for cabs.
- 4.5 Mother questioned whether more could have been done by professionals at Hospital 2 to prevent the infection and avoid the amputation of Child B's toe. However, she believed that overall, the hospital had provided care. Mother noted Hospital 1 as being very supportive in helping Child B with walking when younger.
- 4.6 Child B's mother also felt well supported by the Children's Centre and school. She named a senior teacher who had been very helpful to the family. Child B was and remains very happy at the school and likes the teachers.
- 4.7 Community Health staff, particularly the Physiotherapy Service and the Speech and Language Service were also noted by mother as being very helpful in their support of Child B. She also appreciated the provision of transport to school even though they did not live far away. Child B's mother confirmed that she was not a nurse but had worked as a healthcare assistant. She juggled her work hours around the needs of the children.

## 5. Findings & Recommendations

- 5.1 At the time this SCR was initiated, similar concerns about safeguarding practice had been identified in other cases held by the DCS, albeit not the same extent as those seen with Child B. This resulted in the management arrangements for DCS moving to CSC in 2018, as part of a plan to strengthen social work practice and the identification of safeguarding concerns for children known to this service area.
- 5.2 This plan was considered as part of Ofsted's inspection of Hackney in 2019, with its impact being noted as *'beginning to have some positive impact in improved safeguarding practice and more robust management oversight of the progress of children's cases'*.
- 5.3 Whilst recognising the historical context of this SCR (and acknowledging a number of improvements made since the period under review), there are nonetheless important messages for contemporary safeguarding practice. These derive from the main question that the SCR has sought to answer, namely why it took several years of multi-agency involvement with a disabled child to recognise that they were experiencing neglect?
- 5.4 The messages of this SCR mirror those of a number of other reviews undertaken in respect of children with disabilities and referenced in the NSPCC briefing: *Deaf and disabled children: learning from case reviews - Summary of risk factors and learning for improved practice when working with deaf and disabled children*; 2016<sup>8</sup>.
- 5.5 Finding 1: Children not being brought to appointments is an indicator of potential neglect.**
- 5.6 This is a clear finding of the review and one that has been seen in other SCRs. Child B, whilst being offered many appointments by different services, was not brought to a significant number of these.

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<sup>8</sup> <https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/deaf-disabled-children>

- 5.7 Some of these were routine for a disabled child, such as regular developmental monitoring or therapeutic support. Some could, at times be made as much as six months in advance, and reminder systems were not always in place. Some were in response to new crises or problems. On occasions, long-standing appointments were also changed due to the needs of the particular service. At times, appointments for Child B were made by different services in the same week or on the same day.
- 5.8 The SCR found two issues of relevance in this respect. Firstly, there was no effective multi-agency co-ordination or oversight of these appointments. Secondly, the missed appointments failed to be seen in the context of potential neglect and as an indicator that the parents' were unable to meet the needs of their child.
- 5.9 In respect of the coordination of health appointments, there was no evidence of any systematic planning of these or effective information sharing across the three hospitals and the range of community health services. For example, practitioners did not always know what treatment and support was being offered by others. As an example, Hospital 3 referred Child B to community nursing for follow up care to the toe. When it later became infected, Child B was referred to Hospital 2. Hospital 2 assessed the toe to be healing and, unaware of the community nursing involvement, decided to monitor Child B directly and to train Child B's mother to dress the toe. They understood that Child B's mother was a nurse, which was not the case.
- 5.10 Furthermore, despite Child B's mother stating on several occasions that she simply could not cope, the practical response to help her was insufficient. Indeed, Child B's parents were also frequently missing appointments for their own ongoing health problems and the challenges they were facing should have prompted a much earlier and more supportive response.
- 5.11 Whilst the DCS tried to support by requesting professionals share the details of scheduled appointments with them, there was little rigour in this approach. Key agencies weren't approached and as such, this response was always going to be limited.

- 5.12 During the period under review, services were also not using the phrase '*Was Not Brought*' when children missed appointments. The policies and practice in place at the time were mainly in the health services and followed '*Did Not Attend*' procedures. These failed to point to neglect as a potential cause or recognise the responsibility of parents and carers to bring their child to these. The primary contingency plan in procedures at the time for continuing missed appointments was a referral back to the GP Practice for follow up. Services were ordinarily terminated at this point.
- 5.13 A key lesson for the practitioners is that they need to be more curious about the reasons why a child is not being brought and to look for patterns of incidence. They should thoroughly explore potential options for support and have clear mechanisms for recording events in order to identify themes, patterns and trends. This requirement should be reflected in related policy.
- 5.14 Practitioners at the workshop were clear in their view that '*Was not Brought*' should also be embedded in the terminology of agency recording systems, neglect guidance and in the local threshold document. This will ensure that the child's perspective is central.

**Recommendation 1:** The City & Hackney CCG should provide assurance to the CHSCP that all services have access to and use a '*Was Not Brought*' policy across the local health system.

**Recommendation 2:** The Disabled Children's Service should ensure that terms of reference and agenda structures for meetings that they convene (involving a review of disabled children and those with complex health needs) include an analysis of a child's attendance at appointments.

**Recommendation 3:** The CHSCP should seek reassurance from safeguarding partners and relevant agencies that their recording systems are sufficient to identify repeating patterns of children not being brought to appointments.



**Recommendation 4:** The CHSCP should review and update its guidance on neglect and the local threshold tool to ensure this sufficiently describes the risks associated with children not being brought to appointments.

**5.15 Finding 2: Effective and child focused safeguarding practice with disabled children ensures they are seen, heard and helped.**

5.16 The participation of children in decision making about their own welfare and in the services that they receive is a legal requirement. All children can communicate preferences if they are asked in the right way by people who understand their needs and have the skills to listen to them. It is never acceptable to say or write that a disabled child is 'unable to communicate their views'. A disabled child's preferred communication method for understanding and expressing themselves needs to be given the utmost priority. Where a child has speech, language and communication needs, adequate arrangements must be made to ensure that their views and feelings can be obtained.

5.17 Whilst Child B was seen on many occasions, there was limited evidence that his voice was consistently heard or that he was directly engaged by involved professionals. Some professionals, particularly school staff, were however, able to effectively engage and communicate with Child B.

5.18 They understood Child B's limited communication and actively sought to help Child B understand issues in ways that they could – such as why it was important to wear the splints and shoes (which Child B did not want to do). The SCR found that the school proactively accessed the advice of Speech and Language Therapists to support communication with Child B and to suggest ways to talk about complex ideas. Other services did not. Indeed, across services as a whole, there was little evidence of a similar focus. Child B's voice in the clinical notes was notably sparse.

5.19 Barriers to communicating with disabled children were identified by the NSPCC in their 2016 report on learning from case reviews involving deaf and disabled children<sup>9</sup>. These included:

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<sup>9</sup> <https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/deaf-disabled-children>

- *Disability was sometimes linked to impaired speech or comprehension, making it hard for children to express themselves.*
- *Parents were sometimes relied on to interpret what their children were saying, preventing children from confidentially disclosing concerns.*
- *Sometimes children's disruptive or distressed behaviour was interpreted as a result of their disability without consideration of potential safeguarding concerns.*
- *In some cases letters or written agreements were used with young people to arrange access to services or manage their risky behaviour despite them having limited or no ability to read.*

5.20 Potential solutions were also suggested by the NSPCC:

- *Professionals should make sure the child's voice is heard. Where there are safeguarding concerns children should be spoken to alone and parents should not be used as interpreters.*
- *In cases where a child's disability precludes or limits verbal communication efforts should be made to facilitate communication by other means.*
- *Practitioners should also consider how a child may communicate through their actions. Distressed or disruptive behaviour should not automatically be attributed to the disability.*
- *Educational personal safety resources should be tailored to the child's needs. Advice should not be considered to have successfully been given unless there is evidence that the child or young person has understood what they have been told and is able to apply this.*

**Recommendation 5:** The CHSCP should ensure its guidance (and any relevant single agency guidance) for safeguarding children with disabilities is sufficient in terms of setting out the importance of communication and hearing the voice of the child and how this can be effectively achieved.

**5.21 Finding 3: The focus on engaging parents and carers to support disabled children is key, but this should not dilute professional challenge when needed.**

- 5.22 In the practitioner workshop, there was agreement that parental involvement was essential in all services and that for disabled children (with communication difficulties) it is especially important. However, practitioners also stated that there was no real clarity or guidance within the system about when '*non-engagement becomes a red flag*'.
- 5.23 This lack of clarity could have been a reason why the identification of potential neglect to Child B took so long to action. It is also likely to have been influenced by how professionals have historically approached working with disabled children. Indeed, lessons from previous SCRs<sup>10</sup> have shown that parents can often be seen to be '*doing the best they can*'. Because of this, the threshold for a 'red flag' becomes higher. Professionals are unwilling to challenge or appear critical of parents who are looking after children in what are undoubtedly challenging circumstances.
- 5.24 One practitioner at the workshop asked, "*are our expectations too low?*". Many had tried hard to work with Child B's mother, but were clearly frustrated by the difficulties in communicating with her. The attempts at '*authoritative practice*' only appear to have involved repeated warnings about the seriousness of Child B missing his appointments and the possibility of initiating child protection procedures. There was no impact from this approach, no '*difficult conversations*' with the parents, challenge wasn't sustained and the same pattern of Child B missing appointments was allowed to continue without robust action.

**Recommendation 6:** The CHSCP to review related guidance and its training to ensure the issues on non-engagement, professional challenge and difficult conversations are sufficiently focused on working with disabled children.

- 5.25 Finding 4: Multi-agency working, information sharing and understanding the responsibilities of others can be complex. Clear systems and processes can support effective child focussed safeguarding practice**

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<sup>10</sup> <https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/deaf-disabled-children>

- 5.26 It is clear that no agency involved with Child B had a clear overview of the family history, its dynamics or a complete picture of Child B's needs. Even professionals who knew Child B well were learning new information as part of a practitioner workshop convened for this SCR. A strong view expressed by them was that the lack of this complete picture can often arise in the system supporting children with complex health needs and disabilities when so many different agencies are involved. This is a known feature and a challenge for both professionals and parents alike.
- 5.27 Indeed, not only can families be overwhelmed by the number of professionals working with them, but professionals can be confused too. In Child B's case, different information was being shared with different professionals at different times. There was no system to properly coordinate this and engagement was ad-hoc and un-structured.
- 5.28 A core systems issue identified by professionals was seen as there being no defined, 'central place' for all the involved professionals to share relevant information about Child B, especially as the family was accessing services across localities (and from different hospitals). There was also a lack of clarity about who might be a 'lead professional'. Due to these issues, there was too much reliance being placed on the family to be the main source of sharing important information. This hindered the oversight on what was actually happening in the family. For example, it was only through the collation of the multi-agency chronology for this SCR that professionals came to learn just how many occasions Child B '*was not brought*' to appointments. The inability of the network to see the bigger picture masked the growing neglect for Child B.
- 5.29 Despite the view that the system lacked a 'central place' to collate information, there were several meetings where Child B was being considered in a multi-disciplinary way. There were opportunities at these forums to gain a better understanding of Child B's lived experience, but based on the respective focus of these meetings, none did so in any systematic way.

- The termly **All About Me** meetings at the school reviewed progress and noted Child B's needs and concerns, agreed actions and followed these up with the parents.
- The **EHC Plan Annual Review** was also held at the school. Relevant professionals were not always invited to these meetings (or did not attend) which impacted on information sharing and gaining a complete picture of Child B and the extent of the building concerns.
- The **Multi-Agency Referral Meeting** (MARS) brought services together for children with disabilities and could be used for advice and multi-disciplinary thinking about a child and their needs.
- The **Care Package Panel** reviewed the provision of support.

5.30 In respect of a lead professional role, whilst this would ordinarily be a community or local hospital-based paediatrician, practitioners at the workshop reported that there was no clarity about who could or would be a lead professional to co-ordinate the network.

5.31 There was also an assumption by health agencies that if a DCS social worker was involved, that the lead responsibility lay with them for any safeguarding concerns and agreed actions from meetings. However, there was a lack of understanding of the different social work role in the DCS at the time. The team did not hold safeguarding responsibility or for families receiving respite services or direct payments, they was not always an allocated social worker.

5.32 Since this time, a number of changes have been implemented in the DCS. Following an expansion of the scope of the work undertaken in the team, social workers are now undertaking more Child and Family Assessments when safeguarding issues arise where children are known to them. This minimises transitions for disabled children and their families and provides a more consistent approach. However, the challenge of consistently identifying a lead professional is understood to remain. A key systems issue identified by the SCR is that agencies often did not allow staff the time for their staff to be lead professionals and take on the additional tasks this role involves, especially co-ordinating information sharing. A manager at the workshop noted there was no formal local sign-up across services to the lead professional roles in Early Help Services

5.33 Two recommendations arose from the SCR workshop about this issue. These have been included for consideration as part of a review into Early Help services that is ongoing.

**Recommendation 7:** The review of early help services in Hackney should consider how the identification of lead professionals for cases being ‘stepped down’ from social work intervention can be improved.

**Recommendation 8:** The review of early help services should consider the use and involvement of professionals in developing EHC plans and the EHC Plan Annual Review. This should include addressing aspects such as the naming of a lead professional, the sufficiency of information sharing in respect of social care needs and the oversight of whether children are being taken to appointments.

**5.34 Finding 5: The need for professionals to think family and think fathers.**

5.35 It was accepted that there was no clear picture of the dynamics of Child B’s family. Many in the network were not aware when one of the parents was away, unwell or in hospital; nor when another young child was temporarily in the house. This was a family with two disabled children and their siblings. In retrospect there was recognition of the need to Think Family<sup>11</sup> and professionals should have been thinking (and acting) beyond the individual they were working with. For example, this was seen in the failure to consider Child B’s siblings for a young carers assessment when they were reported as helping with Child B’s physiotherapy and the known concerns about the parents’ health needs.

5.36 It was also seen in the lack of focus on Child B’s father. The SCR recognised an over-reliance on contact with mother and not enough questioning of the dynamics of the relationship with Child B’s father and what his role was in supporting his child’s care.

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<sup>11</sup> [Think child, think parent, think family: a guide to parental mental health and child welfare: Social Care Institute for Excellence, 2011](#)

**Recommendation 9:** The CHSCP should promote guidance on Thinking Family and Focusing on Fathers as part of multi-agency practice.