One Minute Guide

Learning from a Staffordshire Safeguarding Children Partnership Serious Case Review – Family F

November 2020

Overview

In February 2019 the Staffordshire Safeguarding Children Board (SSCB) commissioned a serious case review in respect of four children (aged 8, 6, 4 and 3) who died in a house fire on 5th February 2019. There were five children in Family F, the youngest child (aged 2) survived the fire. Following the children's deaths, the parents were arrested on suspicion of gross negligence manslaughter. In August 2020 the Crown Prosecution Service advised that no further action would be taken against the parents.

Key Findings and Themes

- The family had been known to Children's Services for a number of years prior to the death of the children and the children were on a child protection plan from 13th July 2017 until the time of their death. The family was described by many professionals as "unremarkable" in the context of abuse
- and the cumulative effects of abuse were not considered. All of the children, apart from Child One, showed significant signs of neglect. They all suffered fromdevelopmental delays including extremely limited speech. Parents did not take them to healthappointments. The home conditions were also a concern and professionals working with the familycommented that the mother did not know how to play with her children and saw no value in play.There was considerable evidence that the children were not given sufficient stimulation,supervision or guidance. There were also concerns about the number and type of injuries sustainedby the children.
- During home visits, the social worker noted bruises on the children and described Child Five's expression as "frozen watchfulness and showed no response" and Child Four was described similarly. Frozen watchfulness is usually a marker of child abuse.
- The nursery expressed concerns that sometimes the younger children would arrive in nappies they thought had not been changed since the night before.
- The professionals' focus was very much on the parents, and in particular the mother, rather than on the rights, wishes and feelings of the children; there was no evidence that the children being the subject of child protection plans had any significant, positive affect on any of the children's lives.
- The child protection plan did not reflect the positive role the father played and the strength of that.
- There were several core groups that were not attended by the social worker and statutory visits did not take place within required timescales giving extremely mixed messages to the family.
- It was only upon the frontline professionals seeing the timeline in this review that they realised the number of injuries and significant events that had taken place during these children's lives. Not a single professional had that level of knowledge while they were working with the family.

Learning

Understanding of the impacts of neglect

Fundamentally professionals need to understand that neglect is just as damaging as other types of abuse and that injuries that come from accidents or lack of supervision can be just as damaging to children as non-accidental injuries. It is the cumulative effect of all the different forms of neglect that cause significant harm to a child. Professionals need to focus on holistic working, drift and delay, the mental capacity of parents/carers, children with special educational needs and disabilities (SEND), large families, and the balance between analysis of risk to children and supporting parents.

Understanding the child's lived experience

Another reason the professionals were challenged when considering the children's lived experience in this case was because the mother was controlling the relationship that the entire family had with agencies. A lack of professional curiosity and accepting what parent's say rather than looking at the evidence is a common finding from many serious case reviews. Professionals need to keep focused on the children and their lived experience, whether their situation is improving and constantly question the effectiveness of any plan.

Family history

Family history is vital and should be part of any assessment. In this case, although it was recognised that the mother was repeating the childhood she herself had experienced, that did not inform practice as it should have done. Family history should be included in all training for all professionals working with children. It should also be mentioned in supervision sessions, to remind professionals of the importance and should be one of the constants that professionals know is essential to consider.

Multi-agency chronology

A combined chronology would have been extremely helpful in this case because it would have shown professionals exactly what was happening as well as highlighting the number of injuries the children were sustaining and the fact that there were very few changes. Multi-agency chronologies should be used in all cases where more than one agency is working with a child and their family.

Key Contacts and Further Information

Read the full report here

CSCP Neglect Strategy - https://www.coventry.gov.uk/downloads/file/27919/neglect_strategy

CSCP Neglect Conference 2021: Resources - https://www.coventry.gov.uk/info/206/coventry_safeguarding_children_partnership/3369/coventry_safeguarding_children_partnership_resources_and_publications

One Minute Guide: Recognising neglect in older children https://www.coventry.gov.uk/downloads/file/33981/recognising_neglect_in_older_children

Coventry Safeguarding Children Partnership website - https://www.coventry.gov.uk/lscb