E Family Learning and Improvement Case Review Executive Summary

September 2014

Report Authors: Edi Carmi, independent reviewer, experienced case review author SCIE accredited Learning Together author and trainer and Elisabeth Major, Harrow LSCB Senior Professional.

Reason for the Learning Lessons' Review

The IRO (Independent Reviewing Officer) for these children raised this matter with the LSCB, after legal proceedings began for these children. The children were known to a wide number of agencies in Harrow yet their living environment of profound neglect was not discovered, until Police executed a warrant and found them living in squalid conditions.

The LSCB highlighted in 2012/13 that working with families where there are concerns of neglect was a key issue for local practitioners and this case review can be read with the Executive Summaries re Amy (2012) and Ben and Claire (2013). The learning in this case is part of the process to identify where there are weaknesses in the way local agencies work together.

Family History

At the time of the Police raid, the family were involved with a wide local network of professionals, including midwifery, health visiting, GP, adult mental health services, CAMHS and a local school. The family had had a long history of involvement with local services due to a number of concerns for over ten years.

The recognition of the harm suffered by the family of seven children, all aged under 10 years, arose following the discovery by Police of the squalid state of the home environment where the two youngest children of 4 months and 18 months were found home alone in May 2013. There have subsequently been legal proceedings in relation to the children's care and criminal proceedings. The mother was found guilty and given a 4 month suspended prison sentence for neglect and the father received a five year sentence for several offences, including cruelty against two children, as well as to animals, firearms' offences and possession of a controlled drug with intent to supply. The review period was the two years prior to the Police discovery.

Practice recommendations for discussion and application

There were ten priority findings presented to the LSCB, which led to 20 multi agency recommendations:

1. Weaknesses in recording systems can be an obstacle to safe practice, through limiting the accessible information during assessment;

2. The out of hours child safeguarding systems leave children more vulnerable than week day day-time services;

3. The arrangements for child protection medicals in Harrow are not always understood by the agencies involved and may not consistently produce an outcome of the required standard for legal proceedings;

4. DNAs (Did Not Attend) for health appointments and missed prescriptions are not routinely analysed or considered as important indicators of neglect for either children or adults;

5. The lack of any identified lead professional limits the ability to provide overall monitoring of children's welfare;

6. The review found significant differences in how agencies and sector understood and judged risk, especially in the context of large families and parental mental health problems;

7. Continuing weaknesses in information sharing, especially in relation to adult service providers, provides a weakness to the multi agency safeguarding system;

8. Professionals struggle when working with hard to reach families: they need management and multi - agency peer support, time to reflect on patterns and strategies, and considerable ability and skills to persist in engaging families, but also to know when to identify when such persistence has been unsuccessful;

9. Professional recognition of domestic abuse in the widest sense;

10. Professionals in Harrow do not generally link child and animal needs and have identified a need for joint questions in proformas.

Harrow LSCB used a systems' approach for this review so as to enable fuller involvement of practitioners in the learning about the way agencies work together when children are experiencing neglect.