Cheshire West and Chester Safeguarding Adults Board and Multi-agency Safeguarding Children Partnership

Combined Practice Learning Review (Adult) and Local Child Practice Review (Children)

In relation to family X

Final report

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1. Introduction

This review has been conducted under guidance set out in Working Together to Safeguard Children (2018) and the Care Act (2014).

At the time of the events leading to this review the six members of Family X were all living at the same address. This was a multi-generational household i.e. three generations of the same family living together. Family X consisted of:

Adult X1 (Female adult with care and support needs – adopted daughter of Adult X3 and X4)

Adult X2 (Birth child of Adult X3 and X4, mother of Child 1 and Child 2)

Adult X3 (Adult Female, Adoptive Mother of Adult X1 and Birth Mother of Adult X2)

Adult X4 (Adult Male, Adoptive Father of Adult X1 and Birth Father of Adult X2)

Child 1 (Oldest Child of Adult X2)

Child 2 (Youngest Child of Adult X2)

The key subjects of this review are Adult X1, Child 1 and Child 2

1.1. Pen Picture of Family X

All four adults in the family appear to have had vulnerabilities.

Adult X1 has Downs' Syndrome and has ongoing care and support needs. Adult X1 was adopted by Adult X3 and X4 in 1987.

Adult X2 had an ongoing medical condition for which she was prescribed medication by her GP.

The two older adults (X3 and X4) were both in very poor health and suffering from chronic conditions.

Child 1 and Child 2 had been electively home educated since 2013. According to neighbours who made the referral leading to this review, they were rarely seen outside of the family home.

There had been formal and informal complaints about the conditions outside the property however there were no reports of anti-social behaviour made to the police. NB: During the course of the review a member of the local community who made a contact to Children's Social Care (CSC) said that Adult X3 had responded in an aggressive manner to complaints made directly by neighbours in relation to parking, dog fouling, litter and furniture outside the property.

The family had another facility where they spent regular and extended periods of time (i.e. weekends and school holidays) which was situated close to their permanent address. Records show that some professionals conducted contact visits at this facility, although it was not the family's registered permanent address.

1.2 Events Leading to the Review

In July 2019, following a call to CSC by a concerned member of the public (who contributed to the review), social workers visited the family home and found the home conditions to be 'exceptionally poor'.

All six members of the family were living in the property, which was found to have no running water or working toilet facilities. There were a large number of caged dogs in the property, human and animal excrement was present in several rooms and living areas were unclean.

Adult X1 was found to be unkempt and unclean. A subsequent health assessment found that she had a number of physical health needs that were unmet. A capacity assessment found that she did not currently have capacity to make decisions that would safeguard her.

Both children appeared unkempt and, on further assessment, presented with a number of physical health needs that were of concern. Their literacy was poor, and they had poor communication skills.

Information emerging from Achieving Best Evidence Interviews (ABE's) with both children and with Adult X1 indicate that they had lived in these conditions for several years. The home conditions, and the physical condition of all three subjects of this review give strong indications of neglect.

A Section 47 multi-agency strategy meeting took place and both children were removed under Section 20 (this was agreed to by Adult X2).

At the same time Adult X1 was removed to a place of safety.

The three other family members remained in the property.

A police investigation commenced with the aim of establishing whether the children and/or Adult X1 had been subjected to wilful neglect. This investigation is ongoing.

2. Conducting the Review

2.1 Decision to undertake a combined review and methodology

The local Multi-Agency Safeguarding Children Partnership (SCP) met on 2nd September 2019 to consider whether the case met the criteria for a Child Practice Review (previously SCR). It was decided that a statutory review should take place

The local Safeguarding Adults Board (SAB) met on 2nd September 2019 to consider whether the case met the criteria for the conduct of a Safeguarding Adults Review (SAR). It was decided that the criteria for SAR was not met, however it was agreed that there was learning to be derived from the case, and that a Practice Learning Review (PLR) should take place.

The two Boards agreed that it would be beneficial to commission a joint review using the principles of 'Think Family'.[1]

An Independent Reviewer with relevant experience was appointed and a multi-agency panel of senior agency representatives was convened and held its first meeting on 16th December 2019. At this meeting the panel made the following decisions:

2.2 Scope of the review

- The review should primarily focus on the two children and Adult X1 as subjects.
- The review should focus on the period from January 2013 (when the children began elective home education EHE) to July 2019 when the children were removed under Section 20 of the Children Act and Adult X1 was moved to alternative accommodation under Section 42 of the Care Act.
- Agencies should consider the significance of historical events and contacts (these have been included in this report to provide context).
- Family members should be notified of the review and invited to participate as appropriate and according to their individual circumstances
- Practitioners should be invited to participate in the review via a practice learning event, individual or agency interviews and a practitioner feedback event as appropriate.
- The overview report should be a combined report that highlights learning in relation to adults and children.

2.3 Methodology

- The review used a blended approach i.e. a systems review involving practitioners, supported by key documentation
- An integrated multi-agency chronology was prepared
- TORs/Research questions were scoped and agreed at the first panel meeting
- Panel members were drawn from key agencies for both adults and children
- The review adopted a Think Family approach with specific focus on the two children and Adult X1
- A practitioner event was held to seek views early in the review process

[1] Think Family means securing better outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children's, young people's, adults' and family services. 2. Think Family can also be seen as building the family dimension into everything we do. https://webarchive.nationalarchives.gov.uk/20130323053534/https://www.education.gov.uk/publications/eOrderingDownload/Think-Family.pdf

NB: A decision was taken to delay the final report pending an Achieving Best Evidence taking place with both children.

This interview took place in July 2020, having been delayed by the Coronavirus pandemic. Relevant information from these interviews is contained section 3.1.7 of this report.

In October 2020 police conducted an ABE with Adult X1 in October 2020. Relevant information from this interview is contained in section 3.1.8 of this report.

NB: This report uses the terms 'professionals' and 'professional curiosity' to relate to any paid or unpaid worker, in any service, who had contact with the family.

2.4 Key Themes and Research Questions

The panel identified three key themes upon which the review would focus, these questions were refined following the first panel meeting and practitioner conversations.

Theme 1 – Assessing Vulnerabilities and Risks in complex families

- What did practitioners know about the family?
- Was historical information available and did practitioners use it to build a picture?
- Was Adult X1 able to articulate their own needs?
- Was the voice (daily lived experience) of the children sought, heard and acted upon?
- Were issues of childhood obesity responded to appropriately?
- Were any carer's assessments undertaken with Adult X1? If so, did they take into account the wider circumstances of the family?
- Were capacity assessments carried out (in line with Mental Capacity Act)[2], if so did these lead to 'best interest' discussions in relation to Adult X1?
- What was the significance of missed appointments with Adult X1? How were these managed?
- What was the significance of missed and re-arranged appointments with Child 1 and Child 2 and with Adult X1? How were these managed?
- Were safeguarding tools and processes used appropriately and in a timely manner?
- What role do wider agencies play in safeguarding e.g. environmental services?
- What role can/do communities play in safeguarding vulnerable adults and children?
- Were there opportunities to escalate concerns and were these taken?
- Were there any specific health issues or concerns in relation to the children and/or Adult X1?

[2] https://www.legislation.gov.uk/ukpga/2005/9/contents

Theme 2 – Multi Agency working and communication

- How did agencies work together to support the family?
- Were appropriate assessments conducted? What could be done differently?
- Was communication between agencies appropriate and timely? If not, what might be improved?
- Were there opportunities to put a multi-agency plan in place, if not why was this?
- Were any multi-agency meetings held to discuss the whole family, if not what learning can be gained from this case?
- Does the local system support multi-agency working for families with complex needs?

Theme 3 – System Issues

- Are practitioners supported in working with multi-generational complex families?
- Is the national system/guidance for Elective Home Education (EHE) robust? Is there enough focus on safeguarding children contained in the guidance?
- Do practitioners understand and apply principles set out in the Care Act. Is there sufficient focus on safeguarding the index adult and family members?
- What aspects of the local/national safeguarding system (adults, children and families) support good practice? If not, what are the areas in which the local/national system could be improved?
- Are there any 'quick wins' arising from the case (e.g. parts of the local system that could be strengthened immediately)?

2.5 Family Involvement in the Review

At the commencement of the review family members were contacted, as appropriate to their circumstances, informing them of the review, as follows:

Adult X1 was informed of the review via an advocate. Adult X1 said that she did not wish to participate in the review. It was agreed that the opportunity for Adult X1 to contribute to the review should be left open in case she changed her mind.

Adult X2 was informed of the review in writing. Due to ongoing criminal investigations it was agreed that any invitation for Adult X2 to participate in the review would be deferred until these investigations were concluded. Investigations are ongoing at the time of writing.

Adult X3 and X4 were informed in writing that the review was taking place. Subsequent to the completion of the review Adult X3 sadly died.

It was agreed that neither Child 1 nor Child 2 would be asked to participate in the review directly. This decision was taken to minimise the negative emotional impact on the children given the circumstances in which they had been living and their removal from the family home. However, the children's social worker worked in close liaison with the review and ensured that the children were given opportunities to share their lived experience with the review.

It was also agreed that information emerging from further enquiries, including the ABEs with Adult X1 and Child 1 and Child 2, would be included in this report.

NB: ABE interviews have now taken place with Child 1 and Child 2 and with Adult X1 as set out at Section 3.1.7. of this report. These interviews have provided further insight into the daily lived experiences of the subjects of the review.

3. Contact with agencies/Condensed Chronology

3.1 Contextual information prior to January 2013

According to the General Practitioner (GP) record, Adult X4 sustained a head injury in 1974, the cause is not recorded in available notes (it is thought the injury may have been due to motorcycle accident). The injury resulted in Adult X4 suffering ongoing epilepsy for which he received treatment.

Adult X3 and X4 were Foster Carers from 1986. They adopted Adult X1 following her placement with them in 1987.

In 1990 another child in the care of Adult X3 and X4 sustained injuries, which were reported to have resulted from falling from a cabin bed. It was deemed that this was not a satisfactory account of how the injuries had occurred and as a result the child was removed from their care.

As a result of this incident both Adult X1 and Adult X2 (as children) were subject to a case conference and were placed on the Child Protection Register under the category of neglect. In 1991 they were both removed from the Child Protection Register.

Child 1 was born in April 2006. According to health records Adult X2 was married at the time of Child 1's birth. The relationship between Adult X2 and Child 1's father appears to have broken down within a short time and the couple separated.

In 2007 Adult X2 made an application for rehousing due to reported overcrowding at the property the family were living in at that time (not the current family home). It is not clear what happened to this application; however it appears that Adult X2 remained living with her parents and step-sibling.

Child 2 was born in May 2008. The relationship with Child 2's father appears to have been abusive, and Adult X2 sought support from an Independent Domestic Violence Advocate (IDVA) and was referred to MARAC[3]. Adult X2 informed the IDVA that she was concerned about stalking and harassment by Child 2's father.

In 2012 Adult X1 was referred for health appointments, a number of appointments were cancelled by Adult X4 however Adult X1 was seen on 11th June 2012, although the next appointment was cancelled.

[3] A Multi Agency Risk Assessment Conference (**MARAC**) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed.

3.2 Significant Events in the period under review - January 2013 to end of July 2019

3.2.1. 2013

In January 2013 Child 1 and Child 2 became known to the EHE Service following notification from their primary school that both children had been removed from the school roll as a result of a parental decision to electively home educate them.

Prior to the children becoming home educated, the school had recorded concerns regarding the children's level of absence from school. When attendance procedures were escalated with their mother, she advised the school that she was removing the children to home educate them.

In July 2013 a specific health service attempted to make a home visit to Adult X1, however they could not gain access. A further appointment was made for October 2013 (which was not attended).

In July 2013 the EHE advisor made an appointment to visit the children at home for review of EHE arrangements, this appointment was cancelled by Adult X2 the day before it was due to take place. A further appointment was sent which was cancelled by Adult X2 on the day that it was due to take place. The initial visit by the EHE advisor took place on 15th August 2013.

NB: There were two attempted health contacts which were not taken up by the family. Other than this there are no recorded contacts with any service for any member of the family during 2014

3.2.2. 2015

In January 2015 the EHE Advisor wrote to Adult X2 requesting a date for an appointment to review EHE. On 16th February the EHE Advisor received details of education arrangements from Adult X2, who also agreed to a home visit 'in a few weeks' time'.

On 2nd March 2015 a request was received from the EHE Advisor to establish whether the children had been seen by any health services within the last 12 months. The School Nurse advised that the children had been seen within this period as shown on EMIS records.

On 25th May CWAC Regulatory Services (Environmental Health) received a call from a neighbour reporting noise and poor home conditions at the family address. Informal action was taken in respect of noise, accumulations of rubbish and dog fouling. No noise records were returned by the family and the case was closed.

In September 2015 the Community Learning Disability Service undertook an initial assessment with Adult X1 (Adult X3 was present). No role was identified for the service and a referral was made to Adult Social Care (ASC). It was noted that Adult X1's parents were both in poor health. Activities and respite were identified as needs for Adult X1.

3.2.3. 2016

From January Adult X1 was entitled to 13 hours per week support from a personal assistant.

In February 2016 ASC received a call from Adult X3 regarding Adult X1 not being happy with the arrangements made for social activities. The social worker looked into this and identified that further benefits could be claimed to support Adult X1.

In June 2016 police received a call from Adult X2 that she had received threats from a neighbour that they would kill her dogs (this related to disputes in relation to parking). Police attended the address and spoke to all parties. No offences were recorded.

On 22nd June 2016 Child 2 was taken to A&E (this event was noted in the EHE case file). On the same date the EHE case file noted that an appointment had been arranged to make a home visit. The appointment for this visit was cancelled on 13th July and rearranged for 4th August.

The visit on 4th August took place as planned. Both children were seen and evidence of education was provided by Adult X2 and there were no concerns noted by the EHE advisor.

3.2.4. 2017

In March 2017 Adult X1 was discharged from a specific health service due to a change in the services provided. The family were advised on how to access treatment and advice if this was required in the future.

On 8th March Adult X1 was invited to a Learning Disability annual health check, no response was received to this invitation nor to a second invitation in April of that year.

That same day a Care Act Review meeting was arranged to take place with Adult X1 on 14th March (this was subsequently cancelled on 14th March by Adult X3, the reason given was that it clashed with a hospital appointment). A new appointment was arranged for 23rd March, which was subsequently cancelled by Adult X3.

The Care Act review was recorded as taking place on 29th March, following which there were a number of phone conversations regarding Adult X1 accessing activities.

On 9th March ASC reclaimed unused benefits (paid to Adult X3 in respect of Adult X1) in the sum of £8075.

On 11th May health workers attempted an unplanned visit to Adult X3 regarding asthma and respiratory support. They were refused access by a woman who was assumed to be Adult X2.

On 15th May the social worker telephoned Adult X1 and spoke to Adult X3 who informed them that they had decided with Adult X1 that she did not wish to access any day or Personal Assistant services, and that in future ‘things would be organised

by the family'. It was recorded that the case would therefore be closed with relevant advice about future needs being provided.

On 26th May 2017 the case was closed and a closure letter was sent. **NB: This was the last contact with ASC until 26th July 2019 in response to the reported concerns.**

On 9th August the EHE Advisor visited the family home to conduct a pre-arranged visit, however they could not gain access. A calling card was left asking Adult X2 to make contact with the service.

This was followed up in early September by the EHE Advisor with numerous calls to Adult X2.

On 5th September Adult X2 contacted the EHE Advisor to say the family had been away for the summer. An appointment was arranged for 21st September. This appointment was cancelled by Adult X2 the day before it was due to take place.

On 16th October the EHE advisor saw the children at home. It was noted that home conditions were 'concerning but satisfactory'. The property was noted as smelling of animals and there were a lot of dogs in the house. The EHE Advisor asked about the number of dogs and was told by Adult X2 that she was caring for a friend's dogs. It was recorded that the children were spoken to and that there were no concerns noted.

On 30th November Child 1 attended a planned asthma clinic review. It was noted that Child 1 had gained weight and this was raised with Adult X2 as a concern. Adult X2 advised that Child 1 had a treadmill at home and had increased exercise to address this. Child 1's medication was stepped up to a combined inhaler treatment and a flu vaccination was administered. A follow up appointment was made for 28th December (to which Child 1 was not brought).

On 16th December Child 2 was brought to a nurse appointment. Child 2 attended with other family members requesting a flu vaccination. This was declined as Child 2 was not in an eligible group (due to age). It was recorded in the notes for the appointment that Child 2 was home educated.

3.2.5. 2018

On 8th January 2018 the EMIS Health Record noted that Child 1's GP had sent a referral to Starting Well Services requesting school nurse follow up in relation to weight management. Child 1 was reported to be borderline obese.

On 23rd January 2018 Adult X4 attended the local Accident and Emergency Department (AED) with serious medical issues. Adult X4 was admitted to Countess of Chester Hospital (COCH). During the course of treatment Adult X4 was transferred to another hospital and then returned to COCH. (NB During this period, approximately six months duration, neither hospital has any record of Adult X1, Child 1 or Child 2 visiting the hospital or as living at the family home). It is documented in the records at that time that both Adult X2 and Adult X3 visited the hospital(s).

The Starting Well Nurse held a discussion with the Practice Nurse in relation to weight management interventions for Child 1. The conclusion of the discussion was that, as Child 1 was already known to the Practice Nurse (who was monitoring weight and asthma), there was no role for the Starting Well Nurse to offer further advice regarding weight management.

On 25th January the School Nurse responded to the GP referral for Child 1, advising that they would not be able to offer any additional support regarding weight management, other than that which the GP could provide. The letter asked if there were any concerns around the care of the Child 1 and whether weight was a safeguarding concern. The letter also suggested the option of a dietetic referral if deemed appropriate (no such referral was made). The Starting Well service e-mailed the GP to confirm this outcome. The Starting Well nurse asked whether the GP had any additional concerns regarding the child's care, whether his social/emotional need were being met and whether the GP considered there to be any safeguarding concerns. The Starting Well nurse requested that the practice nurse contact her should she have any concerns. It is not clear whether the GP was made aware of the letter.

On 6th July a referral was received by Community Nurses to advise that Adult X4 was to be discharged from COCH with salbutamol nebulisers. It was advised that he would require support with maintaining oxygen saturations and would require monthly blood tests. (NB **There is no record of any further home visits taking place).**

The discharge notes for Adult X4 clearly indicate that Adult X4 was asked who was present in the household to which he was returning. Adult X4 did not disclose that Adult X1, Child 1 or Child 2 were living in the household, citing that only Adult X2 (his daughter) and Adult X3 (his wife) lived with him. **NB: It is important to note that throughout Adult X4's stay in hospital(s) and on discharge professionals were unaware that Adult X1, Child 1 and Child 2 lived with Adult X4.**

On 16th August EHE received a cancellation of a planned home visit which was rearranged.

In November a letter was sent for an EHE home visit appointment to take place on 5th December. This visit did not take place (it was cancelled by Adult X2). Four further appointments were made and cancelled by Adult X2. (NB the review has noted that appointments were usually cancelled by Adult X2 one day before the visit was due).

3.2.6. 2019

On 25th April an appointment for Adult X1's annual Learning Disability health check was cancelled by Adult X3. (NB: From June 2019 the practice has reviewed the attendance and response for the Learning Disability health check and is now following up non-attenders with further written invitations).

On 5th July Child 1 was not brought to an asthma review appointment. There is no record of this appointment being rearranged.

Two anonymous contacts were received from neighbours, as follows:

Following an anonymous call made by a neighbour on 8th July, I-ART (part of CSC) contacted the EHE advisor to ask when the children were last visited and whether EHE 'had any concerns'.

The EHE Advisor said that they had not been in the family home since October 2017. The response by EHE was followed up by an e-mail to I-Art saying that, although there were no concerns at that time, the children had not been seen by the service for more than a year as Adult X2 had postponed numerous visits. I-Art were also informed that when the children were last seen they presented well and there were no concerns for their welfare. Home conditions were said to be 'not great', but 'not to the point where there would have been the need to refer'.

On 10th July I-ART emailed the EHE advisor to inform them that they had spoken to Adult X2 and Child 2 and were closing the case. It was noted that Adult X2 'seemed genuine in her explanations for the skip outside the family home and the cancelled appointments', and had given assurance that she would accept the next appointment from EHE.

The email advised that if the EHE advisor had any safeguarding concerns following their next visit the case could be re-opened to I-ART. (NB the review considers that this was a missed opportunity to hold a multi-agency discussion which would have facilitated a greater understanding of the role of EHE in relation safeguarding).

On 15th July Environmental Services received a call from a neighbour regarding the smell and state of the property in which the family were living. The service responded by removing a skip from outside the property.

That same day an anonymous referral was received by CSC raising concerns regarding the home conditions. The caller reported that the children were home educated and were never seen or heard. The caller said that there were also a number of other adults living in the property and several dogs which were never walked. The caller also informed there was a strong odour coming from the property and that the curtains were never opened.

On 16th July a contact was received from another neighbour raising similar concerns that the children were rarely seen outside the property, and that when they had been seen they looked pale, gaunt and unwell.

The caller stated there were approximately 16 dogs in the property and they would be unable to get out to the back garden as it was not passable due to clutter and rubbish. The caller informed that there was a "stench" coming from the property, both front and back which was described as "horrendous". The caller stated windows were blacked out so that people could not see in. The caller said they had been in contact with Environmental Health due to being so concerned about the health of the children residing in the property. No further action was taken due to previous screening having taken place in relation to the first neighbour report.

A Social Worker from the I-Art team screened the case and spoke with Adult X2 on

the telephone. Adult X2 denied the allegations made in the anonymous referral and said that she was shocked and upset regarding the allegations. (NB the children were not spoken to in this phone conversation). It was deemed by the I-Art social worker that the threshold for intervention was not met and the social worker recommended that the EHE advisor offered further support.

On 24th July the EHE advisor arrived for a planned home visit but received no response and left a voice message. Before leaving the property, a concerned neighbour spoke to the EHE Advisor saying that they were concerned about the children. On returning to the office the EHE Advisor picked up an e-mail and voice message from Adult X2 to apologise for missing the visit.

That same day the EHE advisor made a referral to CSC due to the poor state of the property, the smell and noise of animals. NB This referral led to the Section 47 investigation.

On 25th July the EHE advisor spoke to Adult X2 and informed her that a referral had been made. Adult X2 expressed 'shock' at the referral. Adult X2 offered to meet the EHE Advisor at another location (but not at the family home). This meeting did not take place as child protection procedures were commenced.

On 26th July social workers visited the family home. They found home conditions to be extremely poor and 'uninhabitable'. A Section 47 strategy discussion took place. The outcome of this was that the threshold for significant harm was met. Adult X1 was removed to a place of safety and action taken to accommodate the children under Section 20.

A police investigation commenced, which is ongoing at the time of writing.

3.1.7. Further Information – Child 1 and Child 2

In July 2020, as part of the ongoing police investigation, both Child 1 and Child 2 were interviewed by Police (this interview process is known as an Achieving Best Evidence (ABE) Interview).

During the interview both children spoke about their home conditions and relationships within the family.

Their accounts of family life indicated to police officers that the children appear to have been subject to neglect over many years, and that there were indications that they had been physically abused.

The children's accounts also raised the officers' concerns in relation to their daily lived experience, with detailed accounts of occasions on which they were physically abused, kept in extremely poor home conditions (including not having beds, no facilities for washing or other personal care, and no toilet facilities). They also said that they were not allowed to mix or socialise with peers or other people. The children reported that they were told not to discuss their home conditions or treatment with anyone.

3.1.8. Further Information – Adult X1

In October 2020, Adult X1 was supported in providing an ABE interview with police.

During the interview Adult X1 recounted that she had lived in very poor conditions for a very long time. Adult X1 also said that she had been subjected to physical assault (the inference was that this had happened more than once).

Adult X1 also corroborated accounts given by both Child 1 and Child 2 with regard to their very poor living conditions and reports of physical abuse and neglect.

Adult X1 said that she missed her family, especially Child 1 and Child 2, but that she was happy and settled in her new home and appeared to be enjoying life.

3.1.9. Summary

As these matters are subject to ongoing investigation this review cannot draw conclusions regarding the content of the ABE interviews, however the Review Panel believes that the descriptions of the daily lived experience of Child 1, Child 2 and Adult X1 indicate that they lived in neglectful circumstances and were encouraged to conceal the true nature of their circumstances from professionals, services and members of the public that they came into contact with.

The Safeguarding Children Partnership and Safeguarding Adults Board have committed to ensuring that any additional learning arising from the police investigation will be disseminated (see recommendation 5).

4 Learning from the review

4.1 Analysis of Agency Practice in relation to key events in the period under review

4.1.1. Adult Social Care (ASC)

- Other than specific contact between February 2016 and May 2017 contact with ASC was routine and practice was person centred in relation to supporting an adult with care and support needs
- ASC appropriately advised on additional benefits available for activities
- ASC appropriately conducted a Care Act Review in February 2016 which resulted in additional benefits being repaid, this was expected practice
- ASC appropriately offered further advice and support following repayment of benefits
- In July 2019 ASC acted promptly and conducted a thorough assessment of Adult X1's needs, including a mental capacity assessment
- ASC put immediate safeguarding in place following strategy meeting

In summary ASC provided services to the expected level to Adult X1 given her presenting needs. When ASC visited the family home prior to July 2019 they had no concerns regarding home conditions or personal safety of Adult X1. When seen in July 2019 ASC took swift and appropriate action to safeguard Adult X1.

4.1.2 Children's Social Care (CSC)

- Child 1 and Child 2 were unknown to CSC until the anonymous contact was made in July 2019
- I-ARTs response to the initial anonymous callers contact included speaking to Child 2 (on the telephone), however subsequent contacts did not result in the voices of children being sought.
- Incorrect assumptions were made in relation to the remit of the EHE service in relation to safeguarding leading to the contact being closed by I-Art
- Following the referral made by the EHE advisor appropriate action was taken to safeguard the children

In summary CSC had no contact with the family until July 2019 (although there had been historical contact).

The response to the initial anonymous contact made in July 2019 should have been more robust. The panel felt that this response raises questions about whether contacts from members of the public are given the same weighting as those made by professionals.

It would be good practice to ensure that children are spoken to on every occasion following contacts to CSC, irrespective of the source of that contact.

As the contact related to home conditions it would have been useful to conduct an unannounced visit, this may have resulted in a timelier assessment of home conditions.

4.1.3. Countess of Chester Hospital (COCH)

- COCH provided appropriate care to Adult X4 and liaised when transferred from and to COCH to and from another hospital
- The usual discharge procedures were followed, and relevant questions were asked. It is apparent from reviewing the documentation that Adult X4 did not disclose that Adult X1, Child 1 and Child 2 resided at the family home.

In summary practice in relation to Adult X4's admission, care and discharge from hospital were as would be expected.

It is clear on reviewing the records that Adult X4 was unwilling to share information regarding who was actually living in the family home and did not disclose all the family members living there to practitioners when he was discharged.

This review cannot speculate as to Adult X4's reasons for not making full disclosure however this highlights that self-report information may not necessarily reflect the true home circumstances. However, in the absence of any other safeguarding concerns practitioners could not be expected to probe further into this self-report information.

4.1.4. Cheshire and Wirral Partnership (CWP)

- CWP had contact with Adult X1 in relation to a health need**.** This contact began 2012 following referral by the GP. There were several non-attendances and cancellations, although Adult X1 did attend some appointments. Adult X1 was discharged from the service in 2017 with the offer of accessing treatment if required, which was expected practice.
- Whilst the service attempted to rearrange cancelled appointments, there is no indication of any policy in relation to scrutiny of cancelled appointments of an adult with care and support needs (i.e. no evidence of a 'was not brought' approach as Adult X1 was known to have care and support needs).
- In 2015 the Community Learning Disability Service attempted to engage Adult X1 following referral by her GP. Following several cancelled appointments the service conducted an assessment in September 2015. The service demonstrated good practice in continuing to follow up missed appointments.
- CWP also had contact with Adult X3, this is not analysed as X3 is not a key subject of this review, however, the review notes that service did try to make a home visit following a cancelled appointment.
- CWP received a referral in relation to concerns about Child 1's weight which was assessed and discussed appropriately, however obesity as an indicator of neglect could have been further explored.

In summary CWP practice was as expected in relation to Adult X1. Whilst Adult X1 was deemed to have capacity to make decisions regarding her own care, there may be an opportunity to review frequent cancellation of appointments under the 'was not brought' policy which should have equal weighting in relation to adults with care and support needs and children who are 'not brought' to appointments.

In relation to Child 1's weight management there may have been opportunities to consider alternative services (e.g. dietetics) and to exercise greater curiosity in relation to home circumstances (consideration of obesity as an indicator of neglect?).[4]

4.1.5. Elective Home Education (EHE)

- The service was involved throughout the period under review
- The EHE advisor worked within national guidance in relation to monitoring the children's education at home
- Managerial supervision and oversight were not evident in the period under review. NB This has been recognised as an area for improvement and will be specified in a revised operational policy
- The national guidance in relation to EHE is not explicit in relation to the requirements of Working Together to Safeguard Children (2018), a national recommendation is made in this regard

In summary the process of approving and monitoring EHE provision was in line with national guidance, however, the review concludes that this national guidance needs to be strengthened in relation to safeguarding children, and that the policies and procedures for the local service should be reviewed **NB the local review has now been completed.**

Staffing issues within the service impacted some aspects of contact and managerial oversight.

Safeguarding supervision and pathways for escalation could be strengthened.

Awareness of the role and remit of the service amongst other professionals was not evident (particularly in relation to safeguarding) and this should be strengthened.

4.1.6. General Practice (GP)

- The GP saw individual members of the family according to their health needs and had no safeguarding concerns about any member of the family. All members were known 'as a family' to the GP who noted that they were 'unusual' but not a cause for concern
- The GP noted weight gain in Child 1 and referred to CXP which was good practice
- The practice uses the 'was not brought' policy which the GP felt worked well. However, there are a number of missed appointments with the asthma clinic which do not appear to have been followed up.
- Adult X1's Learning Disability Reviews were cancelled – this was not picked up by the practice (however a system is now in place to do this). **This is an area for development, an opportunity to notify other agencies.**
- Health clinic appointments for Adult X1 were frequently cancelled (usually by Adult X3).
- Adult X4 identified as having chronic health needs. The GP observed that discharge information from COCH is generally very good. The discharge documentation was not available (it could have been noted that Adult X4 did not disclose who was living in the family home at the time of his discharge).

In summary the GP responded appropriately to the presenting health needs of individual family members. When contributing to the review the GP stressed there were no apparent safeguarding concerns with the family as a whole, although family members had individual vulnerabilities and medical conditions which were addressed by the practice. Some health records were not available as they were being transferred to electronic records system.

With hindsight there were numerous missed, re-arranged and cancelled appointments and 'was not brought' occurrences for the children and Adult X1.

In contributing to the review the GP noted that it would not be feasible to cross reference all missed appointments across the entire family, particularly as there were no safeguarding concerns identified. The GP emphasised that actions in relation to safeguarding need to be proportionate to presenting issues.

4.1.7. Regulatory Services had two contacts with Family X when they responded to calls made by neighbours complaining about rubbish and smells on the outside of the property lived in by Family X. These complaints appear to have been responded to appropriately according to local practice.

The review raises the question as to whether there is a wider role for such services in recording safeguarding concerns and sharing information, and whether staff in these services currently receive safeguarding awareness training.

4.2 Learning from the Review - Themes

Theme 1 – Assessing Vulnerabilities and Risks in complex families

Despite several agencies having contact with the family throughout the period under review, it is apparent that no single agency had an overview of the whole family.

Historical information was not collated in one place and therefore not available to all practitioners, leading to only a partial picture of important aspects of the family history. The review recognises that this is not unusual and that there is not a single data capture system that records information on whole families. Whilst the review recognises that it would be beneficial for practitioners to have access to integrated records, it is acknowledged that a single system is, at this time unachievable. However, the role of professionals in sharing information and exercising curiosity is critical to increasing professional awareness and understanding, and mechanisms for this should be supported.

Practitioners told the review that Adult X1 was able to articulate her own needs and she spoke freely to practitioners in ASC when she had contact with them. However, when assessed in July 2019 it was deemed that Adult X1 lacked capacity, at that time, to make decisions regarding her own wellbeing. This led to appropriate action being taken to safeguard her.

The voices and daily lived experience of the children is not evident in professional contact with them from 2013 onwards. The primary contact with the children during the period under review was through the EHE service. The review has identified a need to strengthen the EHE service in relation to safeguarding practice.

The GP identified concerns regarding Child 1's weight gain and made an appropriate referral, however this did not result in Child 1 receiving any specific interventions in relation to weight management, as it was assumed that services that he was already in contact with would be able to raise this with him, when in fact he was not always brought to appointments with this service.

With hindsight, there is a clear pattern across the family of frequent missed and cancelled appointments. It is not possible to say with certainty whether this pattern is indicative of attempts by the family to stay out of sight of services, or whether it is an indication of increasing vulnerability and lack of coping skills.

Whatever the reasons for the large numbers of missed and cancelled appointments, there is no single system, across agencies, that can track and share information regarding these patterns.

Whilst practitioners involved in the review felt it would be desirable to have a complete picture of missed appointments, it was recognised that this would be unrealistic. However, there is no barrier to professionals sharing information about missed appointments where they have safeguarding concerns.

Theme 2 – Multi-Agency working and communication

There is good practice evident in relation to inter-agency working i.e. between health services and social care in relation to Adult X1, however, the review has identified opportunities to strengthen communication around cancelled and missed appointments (particularly for Learning Disability reviews) and the potential impact on Adult X1.

Multi-agency working took place in relation to Adult X1, Child 1 and Child 2 at the strategy meeting that took place in July 2019.

Information was shared on health systems about the children's health needs and contacts with them, which is expected practice.

There were missed opportunities to exercise greater professional curiosity about aspects of the family's daily lives however, as no safeguarding concerns were ever raised by professionals (until July 2019). This mitigated against professionals making enquiries into family life (which some professionals felt could be construed as being intrusive and unsubstantiated).

Following ABE's with both children and with Adult X1 it is clear that the conditions in the family home were extremely poor and that even the most basic of facilities such as access to clean water, clothes and toilet facilities were denied to the children and to Adult X1.

Their accounts of daily life and home conditions illustrate that they were encouraged to hide the nature of their circumstances from others, including professionals that they came into contact with.

Theme 3 – System Issues

The case highlights that there is no single system in place that supports professionals who are working with multi-generational families with a range of complex needs. The case specifically highlights the following barriers impact joint working where:

- Safeguarding concerns have not been identified
- No single agency has oversight of the whole family
- There is no statutory right of entry to the family home

The review panel are concerned that the current national guidance in relation to EHE does not fully address the safeguarding needs of home-schooled children and their families.

The local system in relation to Care Act principles and practice appears to be sound and robust. Learning in relation to delayed Learning Disability reviews has been identified by the review and is referenced above.

5 Conclusions and Recommendations

5.1. Families who avoid services

Although not apparent at the time to professionals involved with the family, it is clear with hindsight that the family avoided some services and stayed 'below the radar' with other services.

Whilst this is not the case for all services, it is clear that Adult X2's repeated cancellation of appointments and contacts with the EHE service effectively meant that the children were 'hidden' from professional sight for long periods of time. There were a number of occasions on which the children were not brought to medical appointments, or their medical appointments were cancelled or re-arranged at short notice. The review believes that that this had a negative impact on the welfare and wellbeing of the children.[5]

There are also a number of occasions on which Adult X1's medical appointments were cancelled or re-arranged by Adult X3, and on which either Adult X1 was not brought to appointments, or the family was not at home when professionals visited.

Whilst the review cannot draw firm conclusions (because the family has not participated in the review) the review saw indications that, with hindsight, Adult X1 may have been coerced and controlled (see footnote)[6] in relation to attendance at appointments, withdrawal of activities and aspects of her personal care (this has become evident in recent contact with Adult X1 and in the ABE with Child 1 and Child 2).

This may not have been apparent to practitioners at the time; however, the Review recommends that practitioner awareness of coercive controlling behaviour could be strengthened (see Recommendation 1).

[5] https://www.gov.uk/government/speeches/social-care-commentary-hidden-children-the-challenges-of-safeguarding-children-who-are-not-attending-school

[6] The definition of domestic abuse includes coercive controlling behaviour in relation to family members as follows: *'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality'.* Both the March 2016 statutory guidance in relation to sections 42-46 of the Care Act 2014 (DH, 2016) and the April 2016 guidance in relation to section 7 of the Social Services and Well-being Act Wales 2014 (Welsh Government, 2016) includes coercive control. This means that a local authority's duty to make (or ask others to make) safeguarding enquiries and determine what action is needed to protect 'an adult at risk' are triggered by 'reasonable cause to suspect' that an adult with health and social care needs is experiencing coercive control (where their needs prevent them from protecting themselves).

The Review also notes that, whilst professionals may not have witnessed overt evidence of neglect (see earlier definitions), the subsequent ABE interviews provide strong indications of Child 1, Child 2 and Adult X1 living in neglectful circumstances.

NB: Accounts emerging from the ABE interviews with Adult X1 and Child 1 and Child 2 further strengthen this finding.

Recommendation 1

The SAB and SCP should be assured that partner agencies are able to demonstrate a commitment to supporting staff in exercising professional curiosity and respectful challenge.

The SAB and SCP should be assured that local safeguarding training and support is available to practitioners in non-traditional safeguarding services (e.g. regulatory services, environmental services and other placed based services as appropriate) to develop and maintain skills in safeguarding.

5.2 Safeguarding Adults with Care and Support Needs

Adult X1's care and support needs were appropriately met, and professionals worked with X1 and Adult X3 to ensure that she had access to services.

Practice in relation to Learning Disability Reviews has already been reviewed and changes have been made in relation to following up cancelled review appointments.

No recommendations are made in relation to this aspect of the review.

5.3 Safeguarding Children who are Home Educated

There is a need to strengthen the focus on safeguarding in the EHE service in relation to practitioner contacts with home educated children.

Recommendation 2

The SCP should be assured that the recent capacity and skills review of the EHE service is successfully implemented.

As a result of this review understanding and awareness of the service should be raised with professionals in other agencies, particularly CSC.

Recommendation 3

The Safeguarding Children Partnership should share the findings of this review with the Department for Education, highlighting the specific concerns raised in relation to the primacy of the safety of children who are educated at home.

5.4 Childhood obesity as an indicator of neglect

There should be a local Childhood Obesity strategy which ensures that there is a whole system approach to childhood obesity and that professional understanding of the links between childhood obesity and neglect is strengthened.[7]

Recommendation 4

The SCP should review policy in relation to childhood obesity to ensure there is sufficient focus on the potential for this to be a safeguarding issue linked to neglect [8]

5.5. Outcome of Criminal Investigation

Recommendation 5

Any pertinent new information in relation to other previously hidden harms that may emerge from the criminal investigation should be shared with LSCB and SAB and disseminated in the usual way.

[7] https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/obesity.aspx

[8] http://orca.cf.ac.uk/27859/1/Viner%202010.pdf