City of York
Safeguarding Children Partnership

7-point briefing Walker-Thompson family Learning from Practice

The family were referred to the Case Review Group in February 2021, due to concerns about long standing neglect (housing concerns, children not being brought to medical appointments, supervision of children) and Domestic Abuse and the multi-agency management of this. Despite the case not meeting the criteria for a Rapid Review or Local Child Safeguarding Practice Review it was decided to undertake a multi-agency reflective review to identify learning.

The family:

The family are a large family from the local Travelling community who at the time of the review had been living in the same family home since 2012. When the family moved into the property Ms Walker was advised by the property provider that the house was too small for their needs as the family were moving from a 3 to a 2-bedroom property. At that time there were five children in the household.

In 2021 when the mother was imminently due her 7th child, professionals raised concerns about the safety for all the children and of an additional new-born baby being cared for in the family home. Following escalation by professionals at the time of the birth of the 7th child the family were moved from their home whilst repairs were made to the property

The family were known to Children's Social Care having initially been referred to Early Help in November 2018 and had also been subject to Child in Need in 2020.

What areas of good practice were identified?

The GP, Practice Nurse and Health Visitor attempted to contact the family on numerous occasions regarding missed health appointments for the children.

The actions of escalation by the local authority Early Help Worker and Health Visitor were significant and commendable to ensuring that issues were finally addressed

What were the key learning points?

Learning Point 1: Recognition and response to possible indicators of Neglect

There were numerous occasions where the children had not been taken for appointments, including dental appointments and immunisations. Personal choice of parents not to have children immunised was cited as a reason for this but when explored with the family this did not appear to be the case. As there was no evidence that this was parental choice, neglect of health needs should have been considered as part of the wider picture of neglect. As a result, the holistic picture of multiple family issues was not identified and managed effectively as a partnership.

Recommendations:

The Neglect strategy will be reviewed to ensure that when medical neglect is identified this will be considered as a potential wider indicator of neglect.

Health providers including mental health services and GP practices should ensure effectiveness of their own organisational ‘Was Not Brought’ and ‘Did Not attend’ processes.

Multi-agency responses to neglect should include an understanding of the lived experience of the child/children.

Understanding the child's lived experience, needs to be encouraged across the partnership and through effective supervision.

Learning Point 2: Housing:

Concerns regarding the family's living conditions were raised numerous times by various practitioners over a significant period of time. The level of overcrowding within the house would have impacted on the safety and wellbeing of all the children. Despite this, the family could not be considered for re-housing until all arrears had been cleared and the home had been made to an acceptable standard for re-renting. The length of time taken to address the concerns regarding the family's living conditions was not acceptable. The focus on the housing issues centred on the rent arrears and repairs needed rather than consideration of safeguarding and welfare of the children.

Learning Point 3: Professional curiosity

Despite professional concerns about the housing conditions practitioners did not always demonstrate appropriate levels of professional curiosity. Had they asked to see other areas of the home including most importantly the children's sleeping arrangements and the kitchen at an earlier point in the case this may have led to earlier escalation of concerns.

Learning Point 4: Referrals

There were multiple referrals into Children's Social care with the assessment outcome resulting in the case being passed onto the Early Help service within the local authority. Early Help had previously had difficulties engaging with the family and it is not clear if this lack of engagement by the family was taken into consideration when the new assessments were completed. Non engagement by the family led to a lack of improvement in family circumstances and drift. Assessment processes have now been reviewed to ensure that all cases where there have been multiple referrals are discussed as part of the MASH screening process.

Recommendations:

Liaison with Early Help when they have had recent involvement and issues with non-engagement should be considered as part of all assessments.

Children's Social Care will review their processes for managing neglect in the context of multiple referrals, and lack of family engagement.

It is recommended that the CYSCP should seek assurance that within partner agencies supervision processes, consideration is given to lack of family engagement and the planning of appropriate actions in order to address risk.

Learning Point 5: Challenge and Escalation processes

There are occasions within this case where partners agencies made referrals to Children's Social Care and there is no challenge by the referrer as to the outcome of these.

A strategy meeting was held where a multi-agency decision was taken to proceed to Section 47 enquiries. This decision was subsequently changed to Section 17 with partner agencies not being informed or consulted. This did not allow for effective multi--agency challenge.
Despite partner agencies concerns that the case should remain open to Child in Need, the case was subsequently stepped down and this decision was not challenged or escalated.

Recommendations:

The CYSCP should ensure that all partner agencies are aware of and understand their responsibility within escalation processes

Partner agencies should review their supervision and escalation processes to ensure issues of drift are avoided. This review of escalation should include responses to such escalation and effective resolution of professional disagreement.

Learning Point 6: Domestic abuse

In January 2021 a referral was made to CSC following an incident of Domestic Abuse during which, the eldest child had called the Police herself, reporting that she was scared and that her mother was being hit and the home being smashed up. At the time it was known that Ms Walker was pregnant. This was a missed opportunity for multi-agency partners in the MASH to assess and plan interventions at an appropriate level given the escalation of domestic abuse in the family.

Learning point 7: Cultural issues

Cultural issues were considered as part of the Single Assessment completed in 2018 and in later assessments where the Social Worker attempted to gain an understanding of some of the issues the family faced in particular choices regarding preventive dental care and immunisations. However, during the practitioner event, it was highlighted that knowledge of cultural diversity with regards to the Traveller community was not thorough or extensive and as such this area of work is worth exploring further.

Recommendation:

It is recommended that the CYSCP explore current workforce knowledge with regards to cultural diversity, particularly in relation to the Travelling community, and undertake work to address any gaps in practitioner expertise.