

## Case Synopsis

This [Serious Case Review](#) examined the agency involvement with **six children in a family from the ages of 2½ to 16½ years**. The eldest child experienced **neglect, abuse and maltreatment**; all children experienced neglect, maltreatment and considerable **instability in their home and school life**. The extent of the harm did not emerge until statutory child protection intervention occurred in March 2018 with the full extent of the harm acknowledged in June 2018 requiring legal intervention.

## Learning Points:

- **When you have concerns about a child's welfare never assume that someone else is dealing with it.** The information you have may contribute to a larger picture.
- The importance of **conducting home visits** cannot be under-estimated. It allows practitioners to **observe children in their home environment, observe family interactions, and assess the standards of the living environment**.

- **Noise and nuisance complaints may be symptomatic of a chaotic and dysfunctional household and referring information from neighbours should be treated with equal importance as those from other professionals.** There may be value in **checking with the local Regulatory/Environmental Health Services** to see if they have been, or are, involved with the household.

- **An assessment of the situation pre-birth is different to a formal pre-birth assessment.** The circumstances of this case would have justified a formal pre-birth assessment, as detailed in the [West Midlands Safeguarding Procedures: Pre-birth assessment](#)



- **Consistency of worker, especially during pregnancy, can aid a more trusting relationship to develop** and may support better outcomes for the mother and baby.
- When the professional network is faced with **complex family dynamics** and there is a need to identify **multiple sources of risk** ensure there is experienced and authoritative multi-agency professional practice which **continually exercises curiosity and scrutiny**.

- **Parental non-engagement**, or failure to enter into a dialogue about the welfare of children, **should be viewed as a risk factor** which may have an impact on a child's welfare and safety. The decision to close a case due to non-engagement, having made repeated attempts to engage parents, should be risk assessed against case history and current circumstances.

- When working with parents who are not living in the same household, or who are separated, **each parent should have the opportunity to fully express and voice their views, wishes and feelings**.
- When individual children have complex needs, and live in a family where there is a level of complexity it will be important for **practitioners to explore the relationship between different professionals that are involved with each member of the family, how they intersect and where the risks lay**.

- It is important to **remain actively curious about the quality of parental relationships when working with expectant women**. When women have known vulnerabilities seek **timely and reflective supervision to critically evaluate case history and case management**.

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## Learning Points continued....

- When there are multiple children in a household, and numerous agencies/professionals involved **create, and maintain, a multi-agency chronology**. This should be reviewed on a regular basis in supervision, and as a multi-agency group, especially when concerns about children's welfare are difficult to evidence.

- **When faced with a parent, or adult, who can be intimidating and controlling it is often helpful to have the support of a co-worker.** This requires joined up working, preparation and management support. **All workers need to be supported by their management structures to feel empowered to confidently discharge their statutory duties** when working to safeguard and promote the welfare of children.

- When faced with **one parent who appears to take control** it is important to explore the **impact of this behaviour on children**.
- **Group think** is a situation that occurs when a **group reached an agreement without a critical analysis of all of the information from all of the participants**. Ensuring good quality chairing is one way to reduce this happening, as is allowing free reign on critical analysis of information shared.

## Messages for managers:

- Read the full serious case review report [here](#).
- Disseminate this learning briefing to all staff.
- Consider these learning points and make the necessary systems improvements.
- Support practitioners with good quality supervision, particularly with regards to complex cases.
- [Escalate](#) any professional disagreements.



- Schools are ideally placed to **hear, understand and explore children's daily experiences** and their contributions should always be sought.
- **Complex situations** in which children are living, **often require critical thinking skills**. Critical thinking can be **supported by good quality reflective supervision** or seeking impartial expert consultation.

## Messages for practitioners:

- Read the full serious case review report [here](#).
- Consider these learning points and implement them in your practice.
- Ensure you discuss complex cases and concerns you may have with other agencies involved in the case and with your manager.
- [Escalate](#) any professional disagreements.

- When multiple appointments are scheduled across different services or agencies **recording systems should capture attendance at appointments** and this be examined at key decision and review points. **Children with complex needs are particularly vulnerable to medical neglect.**
- **Creating a multi-agency chronology, triangulating information and working together** as a tight network is imperative when working with **complex situations and families**.

- When working with families where there are multiple children in the household it will be important to **understand the lived experience of all the children**, particularly when one child, in a household of many children, appears to be treated or described differently to the others.

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