Integrated Child Safeguarding Practice Review & Safeguarding Adults Review Report
Family T

Together everyone achieves more.

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1. Introduction and background to the review

1.1 Introduction

Luton Safeguarding Children Partnership (LCSP) and Luton Safeguarding Adults Board (LSAB) commissioned this Integrated CSPR/SAR report following serious concerns about the neglect of two children and the lack of an effective multiagency coordinated response to working with their parents who are both disabled and who were also experiencing the consequences of self-neglect. The Review has considered agency involvement with the family and any potential learning for the partnerships.

There is a long history of concerns over more than a decade stretching back to Arnie's very early childhood about the parenting of the children and the neglect they were experiencing.

At the same time, the health and parenting capacity of mother and father to care for the children have declined considerably over those years. However, the capacity of the parents to care safely for the children and to promote their welfare has been an issue throughout the history of the case.

During the last few years, the family was living in cramped, unsafe, unclean conditions. At times, when support was provided, the living conditions did improve but only briefly and the improvements were not sustained.

1.2 Background

In the summer of 2022, there was continuing concern regarding the welfare and safety of the children and the parents' apparent increasing vulnerability and inability to cope. Adult safeguarding services were also involved and Ruby's school continued to raise concerns. The Community Health Adult safeguarding team referred to Children's Social Care; there were concerns about the unclean, unsafe, cluttered/cramped conditions in the home; it was stated that the children were young carers for the parents and were undertaking household chores & responsibilities. A single assessment was commenced by Children's Social Care (CSC) in January 2022 and completed in April 2022 with delay despite further concerns being raised by other agencies. This led to the children becoming subject to Child in Need (CIN) plans. There was professional disagreement about whether a higher level of intervention through child protection plans was required with CSC view being that, at this stage, the parents were cooperating. Some professionals felt that child protection plans were required because the circumstances of the children were causing them significant harm and as there was no indication of improvement to resolve this despite these escalations of concern.

In August 2022, health professionals escalated their concerns further. A strategy discussion was held at the end of August 2022. At the beginning of September, there was a crisis when father became acutely ill and he had to be admitted to hospital and mother was moved to respite care; an older half-sister cared briefly for the children.

At the Initial Child Protection Conference (ICPC) held in mid-September due to escalating concerns, the children were placed on child protection plans under the category of neglect. The day after that meeting, father agreed to the children coming into care under section 20 and they were placed with foster parents. Since that time, the Local Authority has issued care proceedings in relation to the two children and they have remained in the care of the local authority.

2. The Review Process and methodology

2.1 Joint Purpose of the Review

This is a Joint Safeguarding Review which brings together and investigates the concerns about the multiagency practice for both the adults and children of the family.

This review has been conducted in line with the statutory guidance under Working Together (2018) and the Care Act 2024 section 44 SAR Guidance.

- A Child Safeguarding Practice Review (CSPR) aims to identify improvements to be made to safeguard and promote the welfare of children. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is crucial to the system being dynamic and self-improving.
- The aim of a Safeguarding Adults Reviews (SAR) is to determine what relevant agencies and individuals involved could have done differently to have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again, and for agencies to work together to aim towards positive outcomes for the adult and/or family involved.

2.11 The purpose of this joint review has been not just about gathering the narrative of what happened, but more importantly it has been to gain an understanding of the root cause and contributory factors of why those things happened in the context of a systems-learning model. The aim has been to understand why decisions were made and actions taken and to identify the key learning for individual agencies and multi-agency working both locally and nationally.

2.12 One of the challenges of this joint SAR CSPR is achieving the correct balance between the focus on Adult E and the focus on the children Arnie and Ruby. There are learning points in relation to the way services were provided to Adult E but also in relation to the practice with the children.

2.2 Review process

This Review has drawn analysis from the detailed chronologies and the summary reports provided by each agency for the Rapid Review, as well as the discussions at the Joint Review Panel and the Practitioner Events which have been held in the summer of 2023.

The Independent Reviewer has requested additional reports and information, as necessary, from the agencies involved to gather further insight or information. She has also undertaken some separate focused discussions with some of the key professionals who were involved with the children and the parents.

The Review has sought to identify and acknowledge good and positive practice in the case as well as learning for further improvement.

2.3 Time Period for the Review

The Review has covered the period from January 2020 until January 2023. Given that there have been many years of involvement with the family, the review has included consideration of any relevant information prior to that period.

2.4 Parallel Investigations/Processes

There are care proceedings in relation to the two children Arnie and Ruby.

2.5 Reviewer and Panel

A Joint Review Panel of senior managers was established to support the Independent Reviewer.

Amy Weir was appointed as the Independent Reviewer and Report Author. She is an experienced safeguarding professional and reviewer with experience of working in both adults' and children's services.

2.6 Voice and Experience of the Children and the Adults

The review has a responsibility to seek the views of the children and the adults in this case so that their experience can be understood through their eyes.

The review has sought to elicit the views of the children and relevant family members. It has not been possible to obtain the wider family view as the adults have not agreed to or been able to speak to the reviewer.

The children's social worker has been able to share the views of the children. In addition, the younger child, Ruby, consented to meet the reviewer supported by her foster carers. Ruby shared some of her experience of living at home and reflected how content she was now living with her foster parents. She described the tiny room which she and her brother shared and how she felt she was never listened to when she did share how she was feeling. She talked about having a small corner of that room as her special place where she had a poster saying, "together everyone achieves more". Her key messages for those who were involved with the family were that she could not understand why it had taken so long for the family situation to be understood or for action to be taken to provide her and her brother with the care and attention they needed. She said that she realised how difficult she found it to share when she did not know who to trust.

3. The Review's Scope

The Joint Review has focused on the following key lines of enquiry:

3.1 What were the barriers to practitioners appreciating and acting upon the extent and degree of the squalor and poor home conditions within which the family were living and to understanding these as a key safeguarding issue? How well was the role of mental capacity assessments in preventing unwise and risky decisions by vulnerable adults understood and acted on? Were appropriate tools such as GCP2 and the hoarding pathway and clutter scale used and utilised to benchmark and assess conditions in the home?

3.2 Was there an over empathic and optimistic approach? How was the parents' capacity and willingness to change tested and challenged? Why did the needs and views of the parents appear to be the primary consideration to such a degree that the harm being suffered by the children was under considered? Were the children's needs the paramount focus of intervention?

3.3 What assessments were made of the children's needs and of their progress and physical and emotional development? Did all practitioners seek out the children's views, were they seen alone and did practitioners really consider how it was to be "living in their shoes'? What assessment was made of the caring roles they were fulfilling within the household as young carers? Were tools such as a day in the life of used?

3.4 What assessments of the adults were undertaken? What assessment was made of the parents' capacity to care safely for the children and to meet their needs? What functional assessments were made of the parents' ability to live independently and to meet their own and the children's physical needs? Was the mental capacity of the parents considered or tested?

3.5 Is there sufficient clarity about parenting requirements and what is an unacceptable level of parenting within the levels of need in the local threshold document? Are the routes to seeking consultation and / or escalation of concerns within each agency and across the partnership clear?

3.6 What consideration was there of health and safety in the home and of the risks to the physical safety and health of all occupants from electrical system overloading as well as the cramped and unhygienic conditions? How did practitioners work to overcome the complications of the joint tenancy and to secure appropriate accommodation for all members of the household?

3.7 Why was there a lack of decisive intervention at an earlier stage after all efforts to effect improvement and change had failed? Was there a tendency to start again every time there was a serious deterioration in the circumstances?

3.8 How effective was leadership in the management of and effective decision-making this case? What was the role of management oversight, decision making and supervision in this case? Was legal advice sought about the thresholds for intervention?

3.9 How did agencies and professional work together to ensure that the needs of the whole

family were addressed? Were there any joint plans in place to ensure the children's needs were met and to identify and address the physical support the parents needed to manage their health and disability needs? Were practitioners clear that the children's needs and welfare were paramount?

3.10 How well does the Adult Gare and housing commissioning function across the partnership to facilitate identification or creation of accommodation-based family and disability functioning support that can meet complex needs and how responsive is this to periods of crisis?

3.11 How did local availability of resources impact on consistent casework and joint working with the children and the parents to ensure that there was thorough and effective assessment, planning, review and decision-making to ensure that the children were safe, and that their welfare was being promoted?

3.12 In correspondence in July 2023, the National Panel recommended that the safeguarding partnerships should consider the effectiveness of risk assessment and case management for vulnerable families and how professionals listen and respond to the voice of the child to take forward the key lines of enquiry. The need to consider the issues around parental disability and young carers.

4. Brief Family Background and History of the case

4.1 There has been a long history of agency involvement with the family. The case relates to Family T: Mother *Adult E* (aged 51); Stepfather/Father *Adult F (*aged 40); *Arnie* (15) and *Ruby* (9) at the time the children came into care. Both parents have disabilities – Mother A has been diagnosed with a chronic degenerative condition. Adult E was supported by a care provider due to her progressive chronic medical condition which left her bedbound and in poor physical health. Adult E was according to information she shared continuing to experience intense feelings of loss following the death of an older daughter who had been murdered by her husband a few years earlier. Stepfather / Father Adult F suffers from Crohn's Disease - a chronic medical condition that reportedly left him at times bedbound and unable to care for Adult E and the children. Both parents were experiencing ill health and disability which impacted on their ability to parent, both practically and emotionally.

4.2 There had been longstanding concerns - throughout the children's childhoods - of serious neglect, emotional abuse and some allegations of physical abuse. In response, there was a long history off episodic intervention which was not effective in supporting the parents to change and prioritise the children's needs or in securing the care the children needed to thrive.

4.3 Also living in the household was Adult G, the ex-partner of Adult E. He is the father of her older grown-up children. Adult G appeared to have led a separate existence within the house within his bedroom which was padlocked. There was a joint tenancy between him and Adult E. This was said to be a barrier to the family being rehoused to more suitable accommodation.

4.4 By 2022, the home conditions were described by professionals as very poor, the home as dirty and cramped, bathroom described as unusable; there was also a lack of food available as well as health and safety concerns about the accommodation. During the review period

and prior to that, there is evidence of chronic neglect experienced by the two children Ruby (aged 9) and Arnie (aged 15) while living with Ruby's parents Adult E (aged 51) and Adult F (aged 40). Arnie has no contact with his birth father. Both the adults have a disability through long term chronic conditions and they require physical care and support. Adult E has been bed-bound for several years and had not left the home. There have been continuing concerns about poor home and unsanitary conditions and clutter living space over several years.

4.5 The children were sharing a small bedroom which was inappropriate given their ages. The children were acting as carers for the adults though this was not recognised and it was the children's expectation that this was their role. The children provided a significant level of care to the parents. The children did not receive the care they required and their presentation, physical condition and emotional wellbeing were affected.

4.6 The parents' capacity to parent was not fully assessed and the lack of sustained improvement in the living conditions and in their care of the children was not challenged. There is also evidence that the parents' need for physical support and care to enable them to parent successfully were not fully addressed.

5. Summary and Analysis of agency involvement with Arnie and Ruby and Adults E and F.

Many different agencies were involved with the family. Both children's and adults' services were involved. The agency involvement is considered here in relation to the Key Lines of Enquiry for the review.

5.1 What were the barriers to practitioners appreciating and acting upon the extent and degree of the squalor and poor home conditions within which the family were living and to understanding these as a key safeguarding issue?

5.1.1 A lack of full consideration of the historic background of this case was a serious barrier to the more recent concerns being managed effectively by services. In the review period, the significant past concerns were not taken fully into account. There were very significant historic concerns about the neglect of Arnie as a very young child when he was subject to a child protection plan and these should have been a major concern in terms of the likelihood of change and improvement occurring.

5.1.2 Even when tangible improvements to the home conditions did not happen consistently, there was a reluctance to challenge and to apply professional curiosity and imagination to consider fully what it was really like for all those in the family to live in such appalling conditions. Despite various efforts made by CSC and the Family Partnership Service at times to improve the living conditions for the family with help to remove clutter and funding for bedding for the children.

5.1.3 Adults and children's services were not operating in a concerted way to address the needs of the whole family. The children's assessments did not consider in any detail what support mother needed to parent and assumptions were made that Adult F was looking after the children. The adult social care assessment of Adult E did not fully address what support she needed to be able to care for the children. It was assumed that Adult F was the main carer but he too had physical limitations.

5.1.4 For a long period, there appears to have been a preoccupation by some professionals with the tenancy problems. For some there was the belief held that Adult G's consent was

required to end that tenancy – apparently following a meeting when a Housing Officer had given this view - and that this was an insurmountable problem. However, disappointingly it is not clear that any strategy to address this was taken forward in terms of seeking legal advice or in meeting with the ex-partner. One practitioner who attended the meetings held at the time has shared that most of some meetings about the children were side-tracked into discussion about the practical barriers, particularly the unsuitability of the accommodation, which were identified for the parents to care for the children. At times, information was being shared that there would be a house move arranged which provided further distraction from pursuing improvements in the state of the property. There should have been more curiosity around the living arrangements and clarification sought about the housing position given that Adult E needed personal care and support which was hard to deliver in the house with its unusable bathroom which the nurses could not even use to wash their hands. The housing was also unsuitable for the children.

5.1.5 Adult E and Adult F were not always open to making changes. Adult F was described as aggressive and evasive at times. In meetings about the children which they often attended remotely by phone, Adult F was said to be distracted, jokey and unfocused. The parents tended to understate the problems the children were experiencing and to deny the concerns raised. On several occasions they refused support and assistance from adult services as well as children's services. Even when suggestions were made about how to overcome the difficulties, these were not followed up by the family. For example, the bathroom was described as "unusable". Ruby could not wash her hair. An elaborate plan was made to enable Adult F to wash her hair but it was still not washed.

5.1.6 It appears that there was too much focus on the adults and their views. The adults' lived experience and circumstances were given a higher priority over that of children. One of the practitioners involved commented that it seemed that the adult's personal and physical circumstances were being used as an "excuse" for or reason to explain away the neglect of the children. For example, at a strategy meeting held at the end of August 2022, a senior health professional was informed that he should not be making comments about Adult B's lack of capacity as a parent to care for the children as comments concerning parenting were not relevant.

How well was the role of mental capacity assessments in preventing unwise and risky decisions by vulnerable adults understood and acted on?

5.1.7 It is not until 2022, that there is a mention that there is a need to gain a better understanding of why the parents were behaving as they were and why they were able to tolerate the cluttered and dirty conditions in which the family were living. However, despite comments by the MS Team that they believed that mother's mental state was deteriorating there is no evidence that this was acted upon. It may be that more practical support could and should have been provided to the parents but there is no evidence that this would have made the required difference for the children to receive the parental care they needed. As noted above, there had been a long previous history of the parents struggling to identify and address the children's needs.

5.1.8 Within the agency records, mental capacity may have been presumed because there is in the main little evidence of consideration as to whether there were concerns present or not about the parents' mental capacity or whether their executive function was sufficient.

5.1.9 In this case, unwise decisions perhaps resulting from impaired mental capacity were impacting on the welfare and safety of the children. Professionals needed to take a holistic view of the whole family and see the needs of the children as well as the adults. The parents were not just adults who were making unwise decisions about their own choices, they were also making unwise choices which impacted on the welfare and safety of the children and causing them significant harm.

5.1.10 The health adult safeguarding team asked the DN Service in mid-August 2022 to ask for an MCA to be completed regarding Adult A's capacity in understanding how she is living and the risks and consequences of this; this was not completed by the DN Service and the reason is unclear.

5.1.11Their parenting capacity was not assessed nor significant harm considered as an impact of the unwise decisions which it was clear they were taking not just for themselves but also for the children.

Were appropriate tools such as GCP2 and the hoarding pathway and clutter scale used and utilised to benchmark and assess conditions in the home?

5.1.12 Graded Care Profile 2 (GCP2), as an effective tool to assess neglect, was completed twice in January 2022 by a Family Support Worker and again in August 2022. Significantly, the GCP2 score was '5' on both occasions, showing that no improvement was being made in securing the outcomes for the children. The second GCP2 was completed by a health adult safeguarding team member and school nurse in the home in mid-August 2022. This produced high scores in all areas evidencing the significant concerns and these results were shared with CSC alongside concern parents are unable to meet the needs of the children.It is of note that in 2014 a GCP had been completed by the health visitor and there were equally high scores on each area and it appears that despite some minor assumed improvements, the problems continued for many years and continue to affect and harm the children.

5.1.13 There was a long history of clutter and hoarding in the home. This posed risks to the children and the adults. There does not appear to have been any application of the hoarding pathway or the clutter scale until mid-2022. The poor home conditions were a known concern and these were referred to adult social care by other agencies. The conditions of the family home were thought to be a safeguarding concern.

5.1.14 Practitioners may have been complacent about getting changes made to the home on a more immediate timeline because information was being shared that there would be a house move arranged. This house move was deemed to be important from an adult nursing point of view due to Adult A's mobility needs and a need for space to be able to care for her.

5.2. Was there an over empathic and optimistic approach? How was the parents' capacity and willingness to change tested and challenged?

5.2.1 There are examples of insufficient challenge to the parents being made to safeguard the children. There seemed to be a tendency to start again every time there was a serious deterioration in the circumstances without sufficient reference to the history and previously un-sustained improvements. It is not clear who spoke to Adult G or was dealing with this.

5.2.2. For example, there was over-optimism that a move to new housing would change the situation. On several occasions, Adults E and F informed some professionals that a move was

pending. This would have given them more space and greater accessibility for Adults A and B. However, given the history it seems unlikely that this would have solved the family's inability to keep a clean, clutter free home without fire risk.

5.2.3 At the June 2022 CIN meeting - improvements were noted. It was reported that Adult G had agreed to change his tenancy and leave the home. This did not occur probably because Adult G did not want to move and the problems of overcrowding remained unresolved.

5.2.4 At the end of June 2022, a strategy meeting was held following an anonymous referral that Arnie was punched to the stomach by Adult F. The parents and Arnie then denied that this had taken place; the police did not attend the strategy meeting as it was believed that the event may have taken place up to two weeks before. The focus was on this potential significant physical harm rather than the whole context of the overarching neglect issues though a single assessment was reopened. Although the Social Worker agreed to request Child Protection Medicals regarding neglect of the children, these requests were not submitted but there was no formal escalation of this by the other agencies involved in the strategy discussion – though a health safeguarding lead did draw attention to it. This seems to be a weak response without questions being asked about whether Arnie felt able to disclose what was said to have happened to him.

5.2.5 In due course, it was reported that whilst the parents were engaging there would be continuation of the CIN plan. The content of the CIN plan however was not likely to be effective as it did not include the care and support needs of the parents. There appeared to be too much focus on the need to support families through the least intrusive intervention at the expense of the children despite evidence that significant harm was experienced by the children, and therefore, statutory level intervention would have provided a timelier more effective safety planning for the children.

5.2.6 Neglect is a very difficult issue to address and to sustain long lasting change. When considering neglect, regarding home conditions, maintenance and sustainability must be considered. There are indications that a start again approach occurred in this case. New referrals about neglect should have been regarded as a continuing pattern of the parents' inability to sustain changes and form part of the picture of what life is like at home for the children.

5.2.7 Even though the children were older they were still experiencing a lack of care and neglectful parenting. The apparent engagement and responsiveness of the parents at some points is also likely to have resulted in lesser intervention and a more optimistic approach. We know that the neglect of older children is sometimes underappreciated particularly if the focus is on addressing the needs of the adults of the family.

5.2.8 It seems that a start again approach was taken because the parents were not seen to be wholly responsible for the children's experiences due to circumstances beyond their control. Professionals did not want to attribute blame to two vulnerable adults. They did not want to be discriminatory or judgemental. The lack of any assessment of how the children were meeting the adults' needs as young carers meant that it was difficult to challenge that. However, Ruby did tell a professional that she had to do too much to help at home.

Why did the needs and views of the parents appear to be the primary consideration to such a degree that the harm being suffered by the children was under considered? Were the children's needs the paramount focus of intervention?

5.2.9 There were strongly held views amongst different professionals about what the family needed. For the most part, professionals understood that the children's needs should be the primary and paramount consideration.

5.2.10 There were tensions – with some professionals believing that the children could be supported at home, others believing the children should be removed and others advocating for the parents to have more support, and particularly a new home. Most agencies thought that the children should be subject to child protection plans and alternative care arrangements considered for them. At times, it appeared that the needs of the adults and concerns about the impact of criticism on them overshadowed the needs and presenting risks to the children and their poor home life experience.

5.2.11 As a result of the various other barriers mentioned above, there were delays and indecision. lack of persistence perseverance in problem solving tackling the problems. It was only after some joint home visits were undertaken and when Adult F became acutely ill, that a significant shift occurred.

5.2.12 It appears that approach to assessment and care and the paramountcy of the children was not fully understood within adults' services and therefore the impact on the children was not fully considered. In ASC it was assumed that CSC would take the lead and be responsible for the casework as far as the children were concerned. The work of ASC focused primary on Adult A's situation and her needs and no reference was made to how the family lived as a unit and how her needs affected the family as a unit. There was little joint working.

5.2.13 At the beginning of July 2022, the CSC Head of Service acknowledged concerns about the children, and suggested the need for a family network meeting and further work with adult's social care to ensure the children's needs can be met via a Child in Need plan as this had remained the CSC threshold decision.

5.2.14 Practice was affected and focus on the children was lost when professionals were not thinking about the whole family context and they were distributing roles and responsibilities along children or adult agency responsibilities. The professionals and the agencies needed to work interdependently to provide the best integrated and seamless response to delivering the best possible outcomes for the parents and the children.

5.2.15 At the end of August 2022, a senior health manager asked for a strategy discussion to be held because the home remained risky and unsafe for the children and the adults and still no progress was seen to be made. Children's Social Care advised that there was no information to suggest the children should be moved from the home imminently. It was acknowledged that health professionals had shared concerns about the welfare and safety of the children. CSC argued that it was believed that the family have the support of extended family members and there was food and electricity in the house though but no evidence of hot meals for the children. The concerns were noted and it was agreed the case would escalate to Child Protection if not resolved. Two days later the case was escalated following a home visit.

5.3 What assessments were made of the children's needs and of their progress and physical and emotional development?

5.3.1 At various points, the children's needs were considered. A referral in December 2021 resulted in the MASH Team opening a single assessment in January 2022 and completed in April 2022. The response to the referral and completion of the single assessment was outside of timescales and the decision for an assessment to be completed.

5.3.2 The initial assessment provided a basic understanding of the issues. The assessment lacked exploration around the illness of the adults, hoarding in the home, lack of parental guidance and an overall unhygienic environment. This in turn made any plans made for the family weak and insufficient as a catalyst to evoke the required change.

5.3.3 At the CIN meeting in April 2022, the outcome of the single assessment and other information was shared about the family having financial difficulties - stated that they owed £3,000 water bills. There were also concerns about inadequate and inappropriate nutrition for children. The diets of the children appeared to be poor, with much reliance on take-aways and ready meals, tins of food and little evidence of access to fresh foods, fruit or vegetables. Arnie reported that he undertook much of the food preparation.

5.3.4 Ruby had health needs assessments at school. On one occasion she shared that she felt she was doing too much at home. A further health needs assessment was carried out for Arnie and Ruby at school in February 2022. Ruby reported to have commented that she has to answer a bell her mother rings when she needs support and that she thinks she has to do too much.

5.3.5 While Arnie was identified as a young carer by a social worker only after many years of involvement. However, the social worker did not act on this on the basis that Arnie said he did not want support. This is disappointing given that it would have been in his best interests for it to be considered and explored as part of his overall assessment. No consideration was made of Ruby being a young carer in social worker assessments.

5.3.6 In early August 2022, a child protection medical assessment was completed. The children were both noted to have signs of neglect from their physical presentation. However, these findings do not appear to have influenced the need to consider significant harm through either a further strategy discussion or convening of an initial child protection conference which would have been good practice.

5.3.7 Even when the children were measured as part of a medical it does not appear that the full significance and impact of those measurements were fully interpreted or considered as a matter of urgency. The patterns of weight loss / gain against the centiles were not seen / explored. Their GP has since also reviewed their height and weight charts and found that they were slipping down their centiles for both measures in the review period.

5.3.8 When the Graded Care Profiles 2 (GCP2) were completed with very high scores for significant neglect, the reasons and action required were not grasped immediately and nor were the impacts on the children. The GCP2 assessments were also not revisited as should have been required when progress and improvement was not sufficiently achieved. It is

crucial that clear and concrete evidence of improvement is sought and that the sustainability of the changes are considered; parental reassurance is encouraging but direct evidence of action and change is needed over time.

5.4 What assessments of the adults were undertaken? What assessment was made of the parents' capacity to care safely for the children and to meet their needs?

5.4.1 There were assessments completed of the adults. However, Adult E and Adult F did not always cooperate with these and declined health assessment at different stages. It is not clear what the basis of this was or why they did not always agree to be assessed.

5.4.2 Assessments were carried out by the DN team. Health Care needs assessments were carried out from March 2022 onwards for Adult E but these did not recognise the children were providing a great deal of care as young carers. The focus was on the delivery of care to support Adult E clinically. The health assessment was not sufficiently holistic to include her broader wellbeing or the impact that her complex health needs would have on their ability to parent. Concerns were raised about the home environment and safeguarding referrals were made. Children and adult health and social care practitioners were involved in the multi-agency consideration and decision-making process to some degree but there were gaps in how well integrated this planning was.

5.4.3 In February 2022, ASC completed a Section 9 assessment under the Care Act 2014 and support plan was commenced. An emergency package of support was provided. However, there are gaps in the assessment; in particular that it did not include any consideration - as is required by the relevant legislation - of the children carrying out caring responsibilities for the adults as was occurring. It was also noted that Occupational Therapy and Children Services were involved. The assessment stated that Adult E wanted support at home. It was stated that she had mental capacity to make that decision. She needed a two-person care package four times per day to prevent pressure sores from getting worse as she was bed bound and doubly incontinent. The OT had assessed and put in appropriate equipment required. A referral was made to LBC ASC Early prevention and enablement team for help with decluttering.

5.4.4 Adult F was also referred for a carer's assessment and OT assessment. There seems to be the first attempt to find out more about Adult B's health needs required given there were observations about poor mobility previously and known concerns about mental health.

5.4.5 Adult E agreed to be referred to the fire brigade for an assessment and a fire evacuation plan.

5.4.6 The Multiple Sclerosis Specialist nurse shared with the health adult safeguarding team that when she visited in May 2022, she noted fire safety concerns. She also shared that she was concerned that Adult E could be experiencing a cognitive decline due to her medical condition.

5.4.7 In August 2022, a new adult safeguarding referral to ASC progressed to an adult safeguarding enquiry S42 assessment as home conditions remained the same with no improvements noted. It was observed then that the AS Team had received several safeguarding concerns which were not resolving despite referrals to a social worker for section 9 assessment, connections to other agencies and OT support.

5.4.8 There was a third adult living in the household but there was comparatively little information gathered about him or an assessment made of his impact on the life of the family. Adult G lived in the third bedroom which was locked using several locks and a padlock. He cooked in the room and

used a bucket for his bodily waste and had a hob in the bedroom so he had no need to use the rest of the house other than to empty his bucket in the bathroom. There were several computers within the room and Adult G had links to the Philippines. The information known could have and did raise several different concerns about his involvement with the children and about fire safety in the home. These issues were never really considered. His existence was well known amongst services but it remained an unexplored issue within single assessments as they were seen as outside of the family and should have been subject to family assessments of concerns for the wide family.

5.5 Is there sufficient clarity about parenting requirements and what is an unacceptable level of parenting within the levels of need in the local threshold document?

5.5.1 There were some differences in view across the agencies about the level of neglect the children were experiencing. There were also different views about the urgency with which this needed to be addressed.

5.5.2 There are thresholds for intervention within the Luton policies and procedures. Across all the agencies, there does not therefore seem to be sufficient clarity or guidance about what is an acceptable level of parenting.

5.5.3 On some occasions, when other agencies shared some new or additional information, it is not clear that this resulted in decisions being openly reviewed, even considering the new information and issues of concern. For example, a worker overheard a conversation that may have raised new concerns about the closeness of the children's relationship, but it is not clear that this was explored further with them.

5.6 What consideration was there of health and safety in the home and of the risks to the physical safety and health of all occupants from electrical system overloading as well as the cramped and unhygienic conditions?

5.6.1 There were serious concerns about the level of hygiene and home safety over a long period. This was recognised and the CIN Plan specified the need for a deep clean and a plan for future cleaning. However, this did not happen quickly, was only partially completed and there was a lack of a sustainable maintenance plan.

5.6.2 There were also concerns about fire risks in the home particularly given the high level of clutter and untidiness. The District Nursing team made referrals twice to the fire service at the beginning of January 2022. However, home conditions did not improve, and the fire risk remained. The adult safeguarding nurse and Multiple Sclerosis Specialist nurse discussed the fire risk from the electrical system overloading with the adults at the end of August 2022 but Adult F disputed the fact that there was a fire risk.

5.6.3 A housing officer contacted CSC in January 2022, who was worried about the home conditions for the children. Within the referral, the home was described as "unclean and overcrowded". The bathroom and kitchen were described as "filthy". The housing officer also noted that the family were struggling with their medical issues. They had also completed a safeguarding and wellbeing referral form in the hopes the family could be moved from the home. The housing officer stated she would like the children moved to a more suitable accommodation and support given to clean the current house in the meantime. She also made a referral to the Fire Service.

5.6.4 The Fire Service visited in January 2022. Adult F was reluctant to let them in and defensive. Major concerns were raised about various fire hazards and the fact that it would be very difficult to get Adult E out of the home in event of a fire. The environment was unsafe for the children too. Follow up discussions with the family were frustrated as the adults did not respond. These were referred to Adult Social Care; the response was that the case had been "processed". There does not seem to have been any further escalation of joint working on this issue which was widely acknowledged.

5.6.5 In March 2022, the care agency raised concerns about cigarette butts found in mothers' bed as well as the children not attending school due there being no money for taxi. They were clear about the potential risk to life due to fire risk with cigarettes in bed and the cluttered home as well as Adult A's extremely limited mobility. ASC carried out a clutter assessment in 2022 and the house was assessed as level 5 on the clutter scale.

5.6.6 Adult A's health treatment at home was affected by the cluttered, unhygienic home conditions. As it was so cramped and unsafe, appropriate moving and handling care could not be provided to Adult E. This would have had implications for her mobility in the longer term and her independence would have further declined.

How did practitioners work to overcome the complications of the joint tenancy and to secure appropriate accommodation for all members of the household?

5.6.7 As stated above, there was a great deal of uncertainty and confusion about what the options were to deal with the complexity of the tenancy arrangement.

5.6.8 During 2022, a Housing officer had been working with Adult E and family for rehousing and attending meetings chaired by CSC. ASC recorded that the Housing department were supporting the family with the housing situation. CSC had assessed the children and were supporting with the housing situation for the children.

5.6.9 It does not appear that anyone took full responsibility for resolving the difficulties of how overcrowded and unsuitable the accommodation was for both the adults and the children. Several meetings and much time were taken up with focusing on this issue and the needs of the children were sometimes lost in this discussion.

Why was there a lack of decisive intervention at an earlier stage after all efforts to effect improvement and change had failed?

5.7.1 There was significant drift in this case in terms of taking timely and effective action. There were many contributory factors to this. These included a high turnover of staff in CSC resulting in inconsistency in working with the case as well as an apparent lack of respect for the views about safeguarding which were shared by school and health professionals. Within ASC, there was a lack of exploration of the concerns raised and a suggestion that the issues were mainly for CSC to follow upon. There was little linkage or liaison between CSC and ASC.

5.7.2 Throughout this recent period of intervention from January 2020 to September 2022 the only consideration of seeking legal advice as to whether the threshold for legal planning was met, was in mid-September 2022 at the ICPC. The children's circumstances had not improved over the two-year period and there should have been early consideration of whether the threshold for child protection and legal planning was met.

5.7.3 In relation to ASC, there is no evidence that legal advice was sought but it was stated to

other agencies that the service thresholds were being applied.

5.7.4 In mid-2022, the school as well health professionals tried to escalate their concerns about the level of response to addressing the safeguarding of the children which remained at CIN level despite these representations. The health representation went all the way up to a senior manager in CSC.

5.7.5 There appeared to be a lack of insight and curiosity from the MASH, assessment management and social care practitioners. There was evidence of practitioners starting over and each new referral was considered as a "*new event*" rather than a continuation of the same issue. There was a lack of consideration of the history and practitioners should have analysed the repeating pattern of neglect with minimal change made in the home or care of the children. This resulted in the case stepping down to early help services before eventually being closed. If practitioners understood the importance of this history, they may have been more able to consider a different intervention when working with the family again in 2021 and that the children's needs were paramount and that although the parents had health issues they were also neglecting their children.

5.7.6 The quality of assessments overall was not good enough and the absence of a chronology and changes to social workers contributed to the cycle of starting again which frustrated other professionals.

5.8 How effective was leadership in the management of and effective decision-making this case? What was the role of management oversight, decision making and supervision in this case? Was legal advice sought about the thresholds for intervention?

5.8.1 There are many examples of agencies discussing and consulting about their serious concerns. Many of these concerns were escalated to CSC and ASC.

5.8.2 There is evidence of supervision and management oversight in the agencies' case records. There were numerous management oversights notifications on the file within CSC, showing that the management and senior management were aware of the actions or issues on the case. However, this did not result in a focus in understanding the children's lived experience and earlier decision making around the need for an initial child protection conference and seeking a view on legal planning. Further questions surrounding the working of the home and role of the parents would have helped understand the limitations of the family and led to more challenge of the position taken by Adult B. There was a lack of consideration that there was urgent need for intervention for much of the time.

5.8.3 Further management support for the social worker in CSC would have been helpful when she was of the view that the risks were too great to keep the case within CIN processes. Other agencies were raising the need for a higher level of intervention on a regular basis during 2022 because of the comments made by the children about their lived experience and the observations of practitioners in the home. There is evidence of delay in progressing the children from a CIN to CP procedures as it was clear that changes in the home were not taking place nor quickly enough pace to ensure the children were no longer at harm.

How did agencies and professional work together to ensure that the needs of the whole family were addressed? Were there any joint plans in place to ensure the children's needs were met

and to identify and address the physical support the parents needed to manage their health and disability needs? Were practitioners clear that the children's needs and welfare were paramount?

5.9.1This was a challenging and complex case which led to a considerable degree of conflict and unresolved tensions between the agencies involved with the family. This in the end resulted during 2022 in several attempts to escalate the concerns – particularly by health and school. Although the circumstances for the children and the adults were deteriorating steadily, neither the historical background or more recent new information and observations were not sufficiently heard or acted upon.

5.9.2 Health and other professionals were assiduous in making referrals to social care for both the adults and children in the home. School and CAMHs made referrals to CSC. All these agencies followed up the concerns raised but they did not always receive timely responses.

5.9.3 Following a single assessment, a decision was made for the children to be supported by a Child in Need (CIN) plan in 2022. The first CIN meeting was held in April but a copy of the plan was not shared with other services and was only received in July by one agency after this was raised as part of a professional disagreement in June 2022. It would have been difficult for professionals to have understood the content of the plan when they had not seen it and nor had it been signed off on a multiagency basis as would have been good practice. The assessment and the CIN plan did not sufficiently identify the needs of the adults and the care and support needs of Adult E and the known emotional and physical health needs of Adult B. Although the CIN plan included the need for a deep clean, there was no change in relation to this and it was not apparently prioritised.

5.9.4 The CIN meeting, due in mid-May 2022, was cancelled by the social worker for unknown reasons. A practitioner from another agency emailed the social worker a week later to ask for a case discussion, this email went unanswered so another email was sent two weeks later. The next day, the new social worker responded to the health practitioner that she was taking over the case and there would be a CIN meeting later that day, which it appears that this practitioner did not know about.

5.9.5 The newly allocated social worker shared in the CIN meeting held at the end of June 2022 that she had not received a handover on the case and that the previous CIN plan was ineffective. In addition, the social worker said she had raised this issue with her managers.

5.9.6 The frustration on all sides grew as the complexity of addressing the needs of the adults and the children were difficult to manage and contain within a predominantly child framework of CIN.

5.9.7 Overall, the evidence is that across all the agencies practitioners were clear that the children's needs and welfare were paramount. Referrals were made about the safety and wellbeing of the children to CSC. The services outside CSC were frustrated that their belief about the level of intervention required to protect the children was not shared by CSC. The view was that the threshold for child protection intervention had been met because of the ineffective responses and lack of change which had occurred to improve the outcomes for the children.

5.9.8 The complexity of the case and the need to address both the adults' and children's needs meant there was also a mismatch about expectations of what was required. Professionals in the main saw the need to consider the whole family's circumstances. CSC staff and ASC seem to have been more focused on the individual needs of both the children and the adults respectively with ASC deferring at times to CSC to drive the casework for the family. Other professionals experienced what they described as a lack of respect and timely response to their worries about the children even when they presented this clearly to CSC. CSC social workers described feeling overwhelmed by the complex nature of the case and other professionals' efforts to focus on both the adults and the children's needs to deliver better outcomes for the children.

5.9.9 There appears to have been a lot of anxiety amongst all involved professionals, that created an atmosphere of defensiveness, lack of respect for each other's roles and encouraged a blame culture. As a multiagency process, the CIN meetings should have been managed to ensure that the contribution of all professionals was maximised. Although the focus of CIN meetings is on the children's needs, these meetings must consider the needs and capacity of the parents to meet the children's needs. It is of concern that in another meeting – a strategy meeting – a professional was told he should not express a view about the capacity of the parents to care for the children.

5.9.10 There was a lack of a sustained professional multiagency challenge to the neglect the children were experiencing, and CSC and ASC were preoccupied with thresholds and seeking to keep intervention at the lowest level possible with several responses occurring in duty or the MASH. There was a tendency to respond to each issue separately and to keep starting again. A lack of consistency in key professionals in CSC for the first part of the review period and prior to that which in the absence of a good chronology and insufficient good quality assessment added to this. Overall, there was a pattern of stop / start intervention reflecting indecision about the significant harm the children were suffering rather than a consistent approach to identifying and monitoring whether or not improvements were taking place. The triennial review in 2016 outlined the importance of moving from episodic incident-based interventions to more extended models of support that are rooted in a cumulative perspective on safeguarding needs and are informed by a historical understanding of family patterns including how services are used.

5.10 How well does the Adult Gare and housing commissioning function across the partnership to facilitate identification or creation of accommodation-based family and disability functioning support that can meet complex needs and how responsive is this to periods of crisis?

5.10.1 There were difficulties in terms of resolving the family's housing needs due to the joint tenancy Adult E had with her ex-partner. Housing advised they would be seeking legal advice but it is not clear what other steps could or should have been taken to secure appropriate accommodation for the family. None of the agencies seemed to take responsibility for resolving these problems which were much debated over a long time.

5.10.2 It seems that Adult E wanted to continue to be supported at home and expressed her wish to remain in the property. Professionals appreciated her wish too to remain within the property where her deceased daughter had previously lived. This was challenging given the state of the property and the overcrowding and clutter. In addition, given her physical disability,

there was no option in terms of making adaptations to the property in order to resolve all the needs identified.

5.10.3 It does not appear that any other alternative option was suggested or put forward so this may be that there is a need to consider for the future what else could have been done to meet the family's needs.

5.11 How did local availability of resources impact on consistent casework and joint working with the children and the parents to ensure that there was thorough and effective assessment, planning, review and decision-making to ensure that the children were safe, and that their welfare was being promoted?

5.11.1 During the long history of this case, there were some staffing shortages in some of the services involved with the family. In CSC there was a high turnover of social work staff. The assessment in early 2022 was delayed because the practitioners allocated to it left. This turnover led to delayed responses and a tendency to start again when new workers were appointed. The first social worker in this period was in her first year of social work practice and she worked consistently and well with the family.

5.11.2 At that time, LBC CSC was judged to be inadequate by Ofsted and significant changes have since been made to MASH and assessment processes that have a target for completion in twenty working days. Many of the assessments completed in this case were delayed. There was significant delay in the case moving from CIN to Child Protection till September 2022 even though it was clear that changes in the home were not taking place quicky enough to ensure that the children were no longer being harmed. There were seven single assessments between 2012 and 2022 and two of those were completed in 2022.

5.11.3 In Health, the DN team experienced significant staffing shortages whilst supporting Adult E. Despite this her care plan was fulfilled and extra visits fitted in when required to meet her physical needs. However, over thirty members of the district nursing team entered the family home over a 9-month period reviewed.

5.11.4 During the period of this review, it is relevant to consider what the external evaluation of Luton Children's Services was at the time. This shows that some of the issues and learning identified in this review were confirmed. In 2020 the Ofsted Inspection of children's social care services in Luton found them to be inadequate. The areas for improvement which are relevant to this case were - the identification and response to risk and need in the multi-agency safeguarding Hub, the quality of child in need and child protection plans, the rigour and impact of manager oversight in ensuring that children's plans are progressed, and that they are protected from harm, the stability of the workforce and the number of changes in social workers that children experience.

5.11.5 The most recent Ofsted Inspection conducted in July 2022 found that there had been significant improvements in the service and the service was found to be requiring improvement to be good with some relevant areas for continuing improvement. While immediate risk is responded to effectively, assessments undertaken for some children are not sufficiently thorough or completed at the pace needed for the child. For these children, there is a lack of effective management oversight in the period following allocation. *Assessments do not always include sufficient focus on children's histories to ensure an in-depth understanding of children's*

needs and vulnerabilities. Changes of social worker and managers also delay the progress of some assessments, so that they take too long. This makes it harder for staff to be assured that children are safe and well and can delay the support that children need.
(Ofsted July 2022).

6. Findings

The key issue in this case is whether agencies were working together at the appropriate level of concern in terms of the local safeguarding children's arrangements.

6.1 The family and its multiple difficulties and complex needs could be seen as confusing and overwhelming. The family relationships and the household arrangements were complex with a third adult there but seemingly living a complete separate existence. Mother's elder daughter and her child also were involved in the household.

6.2 There were many different agencies and professionals in contact with the family many of them daily. Some professionals such as teachers were very worried about the children. Some adult health care staff also expressed concerns about the children but some of them were more reluctant to step outside their role in providing care to mother. For example, the role the children played in caring for the adults as young carers was not formally identified. The level of worry was less in CSC which had less direct contact and where there was staff turnover and difficulties in recruiting and retaining social workers. This contributed to drift and less of a sense of urgency particularly when attempts were made by school and health professionals to escalate concerns to more senior people. Although neglect is less likely to be fatal compared to other forms of abuse it does nonetheless have serious long-term adverse consequences for children of all ages.

6.3 Arnie and Ruby experienced chronic neglect of over a period spanning several years with no improvement in their lived experience or their daily living needs. The impact of poor parenting and neglect on the children's development and progress was not appreciated or acted upon with urgency. The views and needs of the parents were often given undue precedence over the children's needs because Adult F would seek to control conversations and asserted several times that they saw nothing wrong with their parenting.

6.4 Adult A's and L's needs were partially addressed in terms of her need for physical care but there were gaps in the assessment of their needs to consider their well-being, their mental health and what support they needed to parent the children effectively. Adult services worked in isolation for a significant period focussing on parental physical health needs rather than also considering the circumstances of the whole family unit.

6.5 There was a lack of planned joint working between adults' and children's services which resulted in disjointed practice with gaps in information sharing and follow through when concerns were raised.

6.6 The family were living in housing, which was of a poor standard, cramped, overcrowded and cluttered, unhygienic and unkempt. This had significant impact on their lives with little privacy and the two children inappropriately sharing a small room. The parents seemed to be 'normalised' to this way of living and they therefore may not have appreciated the severity of the risks and concerns seen by professionals.

6.7 It became apparent that neither parent could parent the children safely but there was no consideration of whether mental health or mental capacity was a factor in this or whether they were not prioritising the children's needs. However, professionals were not all fully appreciative of the long-term impact of this on the children as this may have been influenced by a desire not to blame or effectively challenge two such vulnerable adults. All agencies need to constantly question and challenge themselves on how well they understand a family and how effectively they are working, both with the family, within their own agency and with other agencies.

6.8 Although it was apparent that the children were providing an increasing amount of care to the parents, they were not regarded as young carers and nor were their needs assessed to consider how reasonable the tasks they were completing were. In addition, their young nephew also came to the family home to wash clothes and cook for the family but this was never explored.

6.9 Agencies escalated their concerns about the practice in the case and the lack of joint decision-making. The escalation protocol was used to resolve the professional disputes; however, they were single agency responses and there were significant delays in taking them forward and in using the LSCP formal procedures at each stage in the process.

6.10 The recording and consideration of the children's lived experiences, wishes and feelings were not given enough attention. There was insufficient consideration of, and response to the voice of both Arnie and Ruby and to the deprived and stressful circumstances in which they were living. There was little consideration about how free the children felt to be able to share their views. When they did provide their views, they were not acted upon. If professionals are to understand a child's world and their risks and vulnerabilities, they must look beyond the account given by parents and the apparently content presentation of the child and use critical thinking and challenge to reflect on what the child is trying to communicate through their behaviour and interaction with others. The children were seen alone by SWs involved. Ruby's school sought to ensure that her needs were addressed and recorded her views. Arnie was seen but appears to have been far less open to talk to the SWs or his school about what was happening and the professionals could have been more curious and questioning of why this was the case. There was little exploration of the potential for Arnie experiencing torn loyalties towards his parents.

6.11 The adults' voices and views were partially heard. There was very little private space for them in the house and so it was difficult for them to be heard separately. This made it difficult to explore the nature of the couple's relationship as they were always together in the room. Their mental health did not receive enough consideration. There is little recording about Adult A's depression and anxiety and the impact of her loss and bereavement following the death of her daughter, as well as her own feelings of loss in terms of her own situation and disability. It is also of concern that it was difficult for professionals to hear Adult A's views as Adult F tended to dominate the conversation and was always present.

Findings of Positive Practice

- Local agencies – notably the primary school, community health and CAMHS - identified concerns about the neglect of the children and the challenge of the needs of the parents promptly and referred them to CSC and ASC. They also followed them up and tracked progress.
- The primary school, CAMHS and the school nurse provided additional support to the children and gave them space to talk.

- There was some evidence of multi-agency working and collaboration through MDTs between partner agencies and housing was included in this.
- Some agencies promoted the need to consider the needs of the whole family unit and to "think family" and the necessity to look holistically and comprehensively at all the members of the household.
- There was escalation of case concerns by school and community health. Supervision and professional challenge are essential components in effective multi-agency working.

7. Conclusions and Summary

7.1 The children suffered extreme chronic neglect. The parents both had a disability and were also neglecting themselves and apparently tolerating the family living in appalling conditions. The children were providing a significant amount of care to the parents though this was denied. None of the professionals involved identified for many years how much care the children were providing and they did not take action to support them or to relieve them of this responsibility. Each agency tended to focus on its own area of responsibility and focus on either the children or the needs of the adults without due consideration of the whole context of the family unit.

7.2 The impact of neglect is cumulative in terms of the child's lived experience and the impact on their development. The concerns for the family stretch back to Arnie's very early childhood and whilst there have been intermittent periods of time where the family situation seems to have made changes and improved, the overall picture is that the children have lived much of their life in poor circumstances and unsanitary, unsafe home conditions.

7.3 Assessments must be from the perspective of the child and how they are feeling. Are they stressed? Do they feel loved and valued? The quality and style of the respective child's relationship with the parents were not explored despite some flags being raised from what the children were saying and examples of physical injury to Arnie.

7.4 In cases of neglect – both child neglect and adult self-neglect research has shown that there are specific challenges. Some of these are evidenced in this case. There may be a loss of momentum and follow through of plans especially if there are changes of the practitioners involved. There is difficulty joining up adult and children's services to work together. Practitioners may become desensitised and demoralised in the face of the sheer extent of the circumstances in which the children are living and being parented. There may be a failure to track referrals and to look at patterns of evidence about the experience of the children and the adults over time. There are concerns about blame where the parent is not intentionally abusive but is unable to cope because of their own needs and circumstances. As a result of all this, there is shown to be a lack of exploration of legal thresholds and whether legal intervention may be required to effect change.

7.5 In this case, the children's basic needs were not being met and their physical presentation evidenced this explicitly. There were high expectations from the parents about the children providing care to them whilst the children's own physical needs were not being met. This suggest a form of adultification which they experienced as they were responsible for so much in the household and not supported emotionally or to have their own developmental needs met. The children were seen as resilient and coping and loyal to their parents. However, when they had the

opportunity, they did divulge their unhappiness about the amount of work they were doing in the house and for one child an incident of physical abuse was alleged.

Adultification erodes children's rights and leaves them at a greater risk of harm due to a dereliction of safeguarding duty from individuals and organisations. When adultification is present, child welfare is not of paramount concern and professional inquiries and interactions can actively and passively cause harm.
(Jahnine Davis 2022)

Adultification occurs *'..When notions of innocence and vulnerability are not afforded to certain children.'* (Davis and Marsh, 2020)

8. Recommendations for Luton Safeguarding Adults Board and Luton Safeguarding Children Partnership to consider and action

8.1 Develop a Multi-Agency Protocol for working with disabled parents at all levels of intervention. Partner agencies should review and improve the local understanding and application of joint working together to safeguard adults and children. This should include ensuring that the quality of care provided to children is the paramount concern and that when children are carrying out caring tasks, the appropriateness of this should be identified and assessed.

8.2 The LSAB and the LSCP should seek assurance that the partners, understand each other's roles and that they are working collaboratively to ensure that the child is at the centre of all decision making. This should include a strengthening of the current case escalation procedures to ensure they operate only on a multiagency professional basis and are owned by the Partnership with the aim of working together to achieve the best possible outcomes to keep adults and children safe. Professional disputes and differences of opinion need to be resolved at the earliest opportunity.

8.3 Plans to safeguard and promote the welfare of children should be owned and serviced on a multiagency basis. Early Help and CIN meeting and plans should be regarded as multi–agency planning and intervention meetings. They should provide an opportunity for information sharing, development of safety plans, co-ordination of care planning and appropriate professional challenge: Having a plan of any description does not necessarily safeguard a child but in the circumstances of safeguarding they need to be multiagency plans. They need to be reviewed and progress against the plan measured and recorded on a multiagency basis to demonstrate impact and improved outcomes for the child. They need to be outcome focused and constantly reflect on whether their intervention is effective and if not, what needs to be done differently, rather than simply describing children and their families as unwilling to cooperate to justify ceasing the plan. The minutes of these meetings must be shared in a timely way with all agencies as should child and family assessments since they will be supporting children subject to child in need plans as well as Child Protection Plans. There is no justification for not sharing information when there is or has been a safeguarding concern.

8.4. There is a need for the partnership to ensure that there is clarity, guidance and training for all practitioners working locally about the required effective and timely response which is required to address the significant harm caused to children as a result of parental neglect. This should

be an operational action framework built around the established GCP2 model which was first developed in Luton before being disseminated nationally.

8.5 DCS to ensure that independent advocates are appointed and are routinely considered in complex and/or longstanding cases involving neglect to help them express their needs, wishes and views and to make sure that these are taken seriously.

8.6 Safeguarding training for professionals must stress the importance of exercising Professional Curiosity to ensure that professionals consider all the adults in a child's life, both from a strengths and risks perspective from the adult to the child. Adult G was living in the household but no assessment was made of his role there or of any risk he may pose to the children.

8.7 In this case, there was some good practice in seeking out the children's views. However, safeguarding training for professionals needs to ensure that they offer children active opportunities to share their experience at home particularly if older children appear to be quieter, more withdrawn.

8.8 Partnership to consider whether given the importance of housing in this case (and others) housing should be involved routinely in multi-agency arrangements to safeguard children.

8.9 Recommendation to The Child Safeguarding Practice Review Panel to investigate why neglect tools developed over the last ten years are not having the required impact on practice.

Appendix A - Scope and Full Terms of Reference

Terms of Reference
Luton Children Safeguarding Partnership & Luton Adult Safeguarding Board Integrated SAR/CSPR
Family T

Introduction: Luton Safeguarding Children Partnership (LCSP) and Luton Safeguarding Adults Board (LSAB) have commissioned this Integrated CSPR/SAR report following serious concerns about the neglect of two children and the lack of an effective multiagency coordinated response to working with their parents who are both disabled and who were also experiencing the consequences of self-neglect.

There is a long history of concerns over more than a decade about the parenting of the children and the neglect they have experienced. At the same time, the health and abilities of the parents to care for the children have declined considerably over those years although the parental capacity to care safely for the children and to promote their welfare has been an issue throughout. The family was living in cramped, unsafe, unclean conditions though at time when support was provided, it did improve but only briefly.

In the summer of 2022, there was continuing concern regarding the welfare and safety of the children and the parents' apparent inability to cope. A single assessment had been completed by CSC in January 2022 which led to the children becoming subject to CIN plans. There was professional disagreement about whether child protection plans were required as there was no indication of improvement. In August 2022, health professionals escalated their concerns. On 09.09.2022, there was a crisis when father had to be admitted to hospital and mother was moved to respite care; older half-sister cared briefly for the children. A strategy discussion was held on 31.08.2022 and at the ICPC held on 15.09.2022, the children were placed on child protection plans under the category of neglect. On 16.09.2022, father agreed to the children coming into care under section 20 and they were placed with foster parents on 26.09.2022 following legal gateway meeting. Since that time, the Local Authority has issued care proceedings in relation to the two children.

In July 2023, the **Independent Reviewer,** Amy Weir, was appointed to carry out this review.

Membership of the Review Panel / Contributing Agencies: The role of the Panel is to contribute to and scrutinise information submitted to ensure that the review is evidence based and factually accurate. The work of the Panel chaired by the Lead Reviewer, builds on the initial scoping information and Rapid Review already completed in this case. The Panel members need to be of sufficient seniority and not involved in case work or decision making in the case. The Panel need to be satisfied that the appropriate level and quality of information has been provided by each agency and that any analysis provides sufficient insight into the actions undertaken by the agency and possible learning. The Panel will be made up of partner agencies involved in the G Family, specifically:

- Bedfordshire Fire & Rescue Service
- Bedfordshire Hospitals NHS Trust
- Bedfordshire Luton Milton Keynes Healthcare Partnership (especially re GP involvement)
- Bedfordshire Police
- Cambridgeshire Community NHS Trust
- Children's Safeguarding Partnership representative
- East London NHS Foundation Trust
- Education - Queen Elizabeth School and Wenlock Junior
- Luton Borough Council Adult Social Care
- Luton Borough Council Children's Social Care

- Luton Borough Council Housing Services
- Luton Borough Legal Services (as LSAB and LSCP legal advisers)

Information was also sought from, Roses Homecare Ltd and Penrose Housing.

If necessary, the Panel may decide to either request more information from an individual agency or invite them to attend a meeting if further clarity is needed about their agency's role with the children and/or family.

Involvement of family and friends: The reviewer will seek to meet with the vulnerable adults, the children of the family and other family members with the support of their trusted professional.

Scope of the review: The review will cover the period from January 2020 until January 2023.

There will be wide-ranging key lines of enquiry:

- **What were the barriers to practitioners appreciating and acting upon the extent and degree of the squalor and poor home conditions within which the family were living and to understanding these as a key safeguarding issue?** How well was the role of mental capacity assessments in preventing unwise and risky decisions by vulnerable adults understood and acted on? Were appropriate tools such as GCP2 and the hoarding pathway and clutter scale used and utilised to benchmark and assess conditions in the home?
- **Was there an overempathic and optimistic approach?** How was the parents' capacity and willingness to change tested and challenged? Why did the needs and views of the parents appear to be the primary consideration to such a degree that the harm being suffered by the children was under considered? Were the children's need the paramount focus of intervention?
- **What assessments were made of the children's needs and of their progress and physical and emotional development? Did all practitioners seek out the children's views, were they seen alone and did practitioners really consider how it was to be "living in their shoes'?** What assessment was made of the caring roles they were fulfilling within the household as young carers? Were tools such as a day in the life of used?
- **What assessments of the adults were undertaken?** What assessment was made of the parents' capacity to care safely for the children and to meet their needs? What functional assessments were made of the parents' ability to live independently and to meet their own and the children's physical needs? Was the mental capacity of the parents considered or tested?
- **Is there sufficient clarity about parenting requirements and what is an unacceptable level of parenting within the levels of need in the local threshold document?** Are the routes to seeking consultation and / or escalation of concerns within each agency and across the partnership clear?
- **What consideration was there of health and safety in the home and of the risks to the physical safety and health of all occupants from electrical system overloading as well as the cramped and unhygienic conditions?** How did practitioners work to overcome the complications of the joint tenancy and to secure appropriate accommodation for all members of the household?
- **Why was there a lack of decisive intervention at an earlier stage after all efforts to effect improvement and change had failed?** Was there a tendency to start again every time there was a serious deterioration in the circumstances?
- **How effective was leadership in the management of and effective decision-making this case?** What was the role of management oversight, decision making and supervision in this case? Was legal advice sought about the thresholds for intervention?
- **How did agencies and professional work together to ensure that the needs of the whole family were addressed?** Were there any joint plans in place to ensure the children's needs were met and to identify and address the physical support the parents needed to manage their

health and disability needs? Were practitioners clear that the children's needs and welfare were paramount?

- **How well does the Adult Gare and housing commissioning function across the partnership** to facilitate identification or creation of accommodation-based family and disability functioning support that can meet complex needs and how responsive is this to periods of crisis?
- **How did local availability of resources impact on consistent casework and joint working with the children and the parents** to ensure that there was thorough and effective assessment, planning, review and decision-making to ensure that the children were safe, and that their welfare was being promoted?

Methodology: The purpose of a review is not to hold any individual or organisation to account, but rather to inform and improve local multi-agency practice through systems review and by acting on learning and developing best practice in order to reduce the likelihood of similar abuse or neglect occurring again. The reviewers will also highlight any good practice.

This review will be conducted in line with the statutory guidance under Working Together (2018) and the Care Act 2024 section 44 SAR Guidance. The reviewer proposes to use a systems learning methodology. The reviewer will have separate conversations with practitioners working directly with the G family and senior managers across the partnerships to explore what helped or hindered multi-agency safeguarding practices in this case.

The reviewer will produce an early analysis report drawing together information from a composite chronology prepared and any available reports from all agencies involved. Any other additional information required will be sought. A final report and Executive Summary will be systems focused, providing clear findings and recommendations. This report will be sufficiently anonymised to protect the identity of the subject adults and children but to ensure the practice learning and improvements required are clear.

Legal Considerations and parallel investigations: There are care proceedings in relation to the two children Arnie and Ruby.

Timeline and key dates of the review:

04.07.23	First Joint Review Panel meeting to discuss terms of reference, review provisional timeline and confirm the identity and availability of the frontline practitioners and senior managers to attend the learning events.
10.07.23	Any additional documentation to be provided to the reviewer. Letters to be sent to subject adults and children via their trusted professionals
10.07.23	Practitioner learning event (1)
12.08.23	Practitioner learning event (2)
12.08.23	Communication with / Meeting with family - TBC
18.08.23	Agency Report Writers Briefing
05.09. 23	Practitioner Event (3) – Face to face
05.09.23	Senior Manager Event – Face to face.
15.09.23	Single Agency Learning Reports to be completed and sent.
26.09.23	Second Joint Review Panel meeting to review early analysis and findings
24.10.23	Reviewer to produce draft overview report of findings and systems learning for panel.

21.11.23	Third Joint Review Panel meeting to review draft systems findings report.
08.02.24	Case review groups (Children and Adults) review systems report, begin action planning and decide publication strategy.
17.05.24	Report presented to Children Safeguarding Partnership Safeguarding and Adults Strategic Board for sign-off (Joint Meeting)
23.09.24	Report submitted to the National Panel and published on the LSAB and LSCP websites seven days later.

Appendix B - Glossary of Abbreviations

ASC	Adult Social Care
CIN	Child in Need
CP	Child Protection
CSC	Children's Social Care
CSPR	Child Safeguarding Practice Review
DN	District Nursing
FPS	Family Partnership service
ICPC	Initial Child Protection Conference
MCA	Mental Capacity Assessment
MS	Multiple Sclerosis Team
SAR	Safeguarding Adult Review

Appendix C - List of References

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