Report of the Commission to Consider Families' Experience of Children's Services in Herefordshire

June 2023

1 Introduction

1.1 Background

1.1.1 Following the publication in September 2022 of Ofsted's report on its inspection of Herefordshire local authority Children's Services, in which it found the authority to be inadequate in all areas, the Secretary of State appointed Eleanor Brazil as Commissioner for Children's Services in September 2022. The Commissioner was given the responsibility of reviewing the Council's capacity and capability to improve its children's services within a reasonable timeframe.

1.1.2 In the course of her work, the Commissioner became aware of a number of families who had significant concerns about their experiences of Children's Services, and the consequences for their families. A number approached her directly with details of their specific circumstances. Many had attended council and public meetings to raise their concerns publicly or had written and made complaints to their local MPs and Councillors.

1.1.3 Recognising the urgent need to restore confidence and learn from what had happened in past years, and to try and resolve issues for families, the Commissioner proposed establishing a Commission to give an opportunity for families to be heard by an independent panel and for their experiences to inform the learning about what needs to improve.

1.2 The Commission to consider families' experience of Children's Services in Herefordshire

1.2.1 The independent commission comprised a panel of three appropriately qualified and experienced individuals, independent of Herefordshire, who were appointed directly by the Children's Services Commissioner. The commission carried out its work in March and April 2023, during which time ten day-long sessions were held.

1.2.2 The terms of reference for the commission set out its purpose as follows:

- To give parents and families an opportunity to tell their story to an independent panel.
- To identify any steps that the Council and partners can and should take as a result of hearing families' testimonies, either in relation to individual cases or in respect of general issues.
- To learn from their experiences and to ensure that this knowledge is used to inform improvements to Children's Services.
- To ensure that, as far as possible, families feel that their concerns have been heard and addressed, and that this is as much as can be done to resolve matters.

1.2.3 The Panel met in private in neutral premises in Hereford and Leominster. The Children's Services Commissioner and the Independent Scrutineer of the Herefordshire Safeguarding Children Partnership (HSCP) attended each session as observers. The Safeguarding Partnership is a statutory forum that brings together the local authority, police and health services to work together to ensure that local arrangements to safeguard children and young people are effective. The Independent Scrutineer provides separate oversight of those arrangements.

1.2.4 Families were identified by the Commissioner in tandem with the Council and were offered the opportunity to present to the Panel in person or to submit written statements. Each parent or carer who wished to address the Panel was able to bring someone to support them. Any children who wished to address the panel were supported to do so. Each individual meeting lasted up to 2 hours.

1.2.5 The terms of reference for the Commission are attached as Appendix A.

1.3 Who was seen by the Commission

1.3.1 A total of twenty individuals attended panel meetings, one of whom was a young person. Six chose to be accompanied by a supporter, three of whom were family members. Some provided written information to the panel following their meeting. A further three provided written testimony to the panel following contact from the Commissioner.

1.3.2 The people who attended the panel had a range of experiences of Children's Social Care, Adult Social Care, police, health and mental health services for both children and adults, and specialised independent services, some of which were outside Herefordshire. They varied in age, circumstances, and in their position within their family. Some described many years of contact with statutory services, some had more recent involvement. The majority of cases were either still open or had been open in the last few years. Most had been impacted by the effect of the Covid 19 pandemic on how services were delivered.

1.3.3 The children of these families again varied in age and circumstances. Some lived with one or both of their parents, some were or had been looked after, were in care or had been or were in the process of being adopted. Many had physical or mental health concerns or disabilities.

1.3.4 All the people who spoke with the panel were well-prepared, articulate, and engaged in good faith, despite their past experiences of feeling discounted and unheard. Many of the individuals who came to speak with the panel described having sleepless nights before coming. Some could not face coming at all, realising that telling their story once more was more than they felt able to do. What was very striking to the panel was how honest and self-aware every person was in recounting their history, despite the extremely distressing experiences that they had had, facing up to their own shortcomings with humility, and reflecting on what was best for their child or children.

1.3.5 What every person expressed was the desire to ensure that their painful personal experiences should be used to improve services for everyone and ensure that 'nobody else should ever have to go through what I have gone through.'

1.3.6 The panel are deeply grateful to all the families for sharing their experiences with such honesty, and recognise that, for every person, telling their stories came at a significant personal emotional cost.

2 Professional Standards

2.1 The three main agencies that have a statutory duty to work together to safeguard and promote the wellbeing of children are health, police and children's social care. Each work to the seven 'Nolan Principles of Public Life,' namely selflessness, integrity, objectivity, accountability, openness, honesty and leadership. Each service also has its own set of professional standards or codes of conduct which expand on these. The Commission kept the Nolan Principles in mind when listening to each family's account of their experiences with the various agencies with which they came into contact.

2.2 Because all the families spoken with had significant experience of Children's Services, the Commission were also particularly mindful of Social Work England's 'Professional Standards for Social Workers,' which are to:

- Promote the rights, strengths and wellbeing of people, families and communities.
- Establish and maintain the trust and confidence of people.
- Be accountable for the quality of one's own practice and decisions made.
- Maintain continuing professional development.
- Act safely, respectfully and with professional integrity.
- Promote ethical practice and report concerns.

2.3 Where relevant, these standards are referred to below, when considering what the families told the Commission. The standards, and the behaviours and activities associated with them, are included as Appendix B.

2.4 The following is written from the perspective of the families, using their own words wherever possible, whilst balancing the need to maintain anonymity.

3 "I was asking for help and it was refused…"

3.1 "I thought Social Services was a support service."

3.1.1 Many of the individuals the panel heard from described approaching Herefordshire Children's Services or its partners for help. Be it struggling with bereavement, demonstrating self-awareness of their own deteriorating mental health, struggling with their child's/children's behaviour, their child's complex medical needs, or a combination of such issues, they were taking positive action to address it. Support was not forthcoming. Requests for help were ignored, and at worse, individuals were told their problems or concerns were not a matter for that department or organisation. When the problems inevitably escalated and resulted in a response from Children's Services, the family was then considered from the point of view of safeguarding.

"Not everyone fits a single pathway…"

3.1.2 If the multi-agency response resulted in immediate action and visits to homes or police protection, which was the position in the majority of the cases, the individuals were met with coldness, at times hostility and were given minimal explanations as to what was happening and why. This was during some of the most difficult times in a family's life.

"I felt so powerless."

3.1.3 The individuals who spoke to the panel were very balanced in their views. They understood agencies had a job to do, especially in relation to ensuring children were safeguarded. How the key agencies undertook those roles though was, in their view, shocking. For example, police officers undertaking police protection being judgemental, abusive to wider family members, not showing any empathy or understanding as to why people were anxious, upset and, at times, shouting; and social workers being unable or unwilling to give explanations as to why things were happening.

"I thought social workers were supposed to help."

3.1.4 Families felt that the professionals' responses exacerbated and escalated the situation, rather than diffusing and calming it down. One recently bereaved family member was reduced to tears by the attitude of a police officer in their home. These poor initial interactions between professionals and families fostered an atmosphere of distrust and a lack of confidence with Herefordshire Children's services and wider agencies.

Question for Consideration

- How will the Council and its partners provide a meaningful and responsive early help service which is accessible to families, regardless of which agency they contact first for help?

3.2 "They [Children's Services] remove a child first, ask questions later."

3.2.1 Many families described having their children removed from their care very quickly after they approached Children's Services for help.

"They didn't understand I needed a break. I lost them forever instead."

3.2.2 Several families believed that no meaningful assessment of individual children's needs was completed to determine the best course of action for the child(ren). They described how their child(ren) were consistently not spoken to or asked their opinion as to the actions being taken, despite some of them being old enough to have a clear voice.

"My children's voices have never been listened to."

3.2.3 In the cases of rapid family separation, individuals described how they were given no explanation as to what was happening at the point their child(ren) was taken away. Family members described decisions being made to the detriment of the child(ren) including placement with extended family the child(ren) did not get on with, or with family members who had their own challenges, or who didn't have the child(ren)'s best interest at heart. Families also described urgent placements that, at times, necessitated the splitting-up of siblings, which caused additional trauma to the children and wider family.

3.2.4 Parents felt pressured to sign documents they did not understand and on occasion lacked the independent support needed to assist their understanding.

"Nothing was explained. We were kept in the dark."

3.2.5 Due to the speed and nature by which a number of families were separated, with little or no explanation, family members described feelings of confusion, anger and upset.

3.2.6 The families described seeing detrimental changes in their child(ren). As parents, they couldn't properly explain what was happening to them and what the long-term outcome would be. Parents described toddlers stopping talking, teenagers' mental health deteriorating, and some children exhibiting self-harm behaviours and/or suicidal thoughts and risks.

3.2.7 Some parents described being encouraged to sign Section 20 papers 'to give them a break,' only to find out later that this would be used against them and, at times, used as a means of longer-term separation. Parents explained how they did not understand the consequences of signing documents and a constant theme of a lack of explanation which continued throughout their engagement with children's social care.

"I was hoodwinked into S20 and then a Care Order…"

Question for Consideration

- How will the Council support its social workers to practise in ways that demonstrate empathy, perseverance, authority, professional confidence and capability, working with people to enable full participation in discussions and decision making?

[Professional Social Work Standard 2.4]

3.3 "I felt like the council were just seeking evidence to reinforce their prior views [which were negative]."

3.3.1 Identifying and assessing both strengths and risks to children's safety within families is a core task of social workers, supported as appropriate by their professional partners. Families described how, without meeting individuals or visiting the home, practitioners produced reports and assessments of poor quality.

"Every time I see a social worker, it's like they're looking for flaws: they're not focussing on the children."

3.3.2 Families described rarely seeing social workers and a high turnover of social worker staff. It was not unusual for a family to experience in excess of five or six social worker changes in less than two years. The changes brought a lack of consistency, or worse, a complete alteration in approach and expectation. Individuals described social workers moaning at them about their high caseloads and lack of time. Families described no rapport building by social workers, especially with their child(ren) and never having the time to properly assess families, or worse, a lack of desire or motivation to do so.

"I thought I'd make an effort; I usually finish at 5." (Said by a visiting social worker at 5.30pm)

3.3.3 Families described how social workers failed to explore or consider information from agencies that could have given an unbiased, factual view of the children, such as schools, GPs, and health specialist reports.

"My views have never been heard."

3.3.4 Families told the panel about the inaccurate documents they saw, including inaccurate family tree details, incorrect ages and genders of children and content of reports being cut and pasted that were factually wrong. Factual inaccuracies of real significance to a given case and that could be shown not to be true were left unchanged despite having been challenged, such as when a person could prove they were in another place to that stated, or independent medical reports could disprove a theory.

"It's laziness… a cut and paste culture."

3.3.5 People described professionals using unevidenced judgements to their detriment. If a family member gave some information about themselves, it would be used to label them and this label would remain on file. Examples included:

- Struggling due to the impact of covid – labelled 'unable to cope.'
- An acknowledgement they were drinking too much – labelled 'an alcoholic.'
- Admitting taking an illegal substance once – labelled 'a drug addict.'
- Asking too many questions – labelled 'aggressive.'

"[They referred to me as] coercive… controlling… aggressive …. We weren't being aggressive, we were worried."

3.3.6 In the cases the panel heard about, there were no examples of early help intervention being offered to families asking for help; on the contrary, the concerns raised by individuals were used in assessments and reports as 'labels' about the parent that would follow them through the system, sometimes for years of social care involvement. 'Overly anxious', 'fabricating and inducing illness' (FII), 'alcoholic', 'drug addict', 'aggressive' and 'parental acrimony' became the regularly repeated shorthand for some individuals.

"It felt like a witch hunt against me."

3.3.7 On too many occasions, the label remained despite independent evidence to the contrary like hair sampling.

"I'm not a liar."

3.3.8 Family members believed these labels became the central 'truth' within reports. The focus of reports was not the child(ren) and their needs, but what were perceived to be the problems of the parent(s) that needed resolving.

"All about what can you put on mum."

3.3.9 Importantly, families felt that any positive actions were not recognised or considered when assessing risk. Records were not updated when significant changes had occurred, such as when police national computer records had been amended or parenting courses had been completed with distinction.

"We'd done everything we'd been asked to do [i.e. parenting classes, etc.]"

3.3.10 Individuals described a feeling of powerlessness with nothing being good enough: assessment after assessment with little or no recognition of change. Then, the social worker would change, no handover would have taken place and the social worker would arrive completely unsighted on the family, care plan or casefile. Rarely would rapport building be done with children or the family and the cycle would start again, frequently with different outcomes set.

"One more issue and it won't be one child we will take, but all of them."

"If you don't take the first house you're offered, the child will be removed."

3.3.11 Due to the non-availability of courses or support agencies, much exacerbated by Covid, a number of families decided to access their own support programmes to try and move their case on to get their child(ren) returned to them. Examples included private medical treatment at significant cost to the family in order to meet assessment requirements to have a child(ren) returned to them, all to no avail.

"I've completed four parenting courses, some with distinction, I've come a long way in five years."

3.3.12 One child old enough to have a clear voice never understood why it took thirteen months in care and a decision to "vote with their own feet" to be allowed back home to the person who meant the most to them. The child was never asked what they wanted.

"I felt persecuted. My child was not listened to."

3.4 'It's like a snowball...'

3.4.1 The talisman of labelling individuals continued within the documentation seen by families. It did not matter if it was an initial assessment, paperwork for conference or court papers, the inaccuracy of content was a major issue to all the people the panel spoke to.

"Be careful to be accurate about the contents of reports."

3.4.2 Families with a child or children with complex medical needs described a process of continually being disbelieved. More than one individual described how they were labelled as 'FII' when seeking to get a proper assessment of a child's health and educational needs. No one listened to the child(ren), despite them being of an age deemed to have a strong voice. The child(ren) were often only seen once or on a handful of occasions by social workers, despite being a live case for years.

"I just want [my child] to be the focus, not me."

3.4.3 The fixation of the 'FII' label, contrary to independent medical and education reports, has resulted in some families spending years trying to get social work files corrected via freedom of information and subject access requests, to show how inaccurate records were or are and that the 'FII' label permeated throughout professional opinion, completely losing sight of needs of the child(ren). In one case, after three major complaints which were found in the complainant's favour, it required the parent to demand an apology and, despite no evidence of 'FII,' the records have still not been amended to date.

"Everything is a fight."

Question for Consideration

- How will the Herefordshire Safeguarding Children Partnership ensure that professionals are working together in the best interests of children and their families, to the highest standards of professional practice, informed by good quality research and evidence?

3.5 "One size fits all' is just wrong in domestic violence cases… It's not about children being exposed to 'parental acrimony."

3.5.1 The consequence of poor assessment and failure to follow proper process carries a long tail, no more so than in the cases which had a significant element of unidentified domestic violence at their core.

"I'm a little woman in the corner with no voice."

3.5.2 The panel heard from a number of individuals who had been in, or were still in, abusive relationships who feel they have been failed by Hereford Children's Services. A failure to complete comprehensive assessments, thereby failing to identify the history and full complexity of the case, has resulted in further damage to families. Individuals described being labelled as malicious complainants, or being part of an acrimonious separation when the reality was or is ongoing coercion and control. The concept of parental alienation appears to be poorly understood.

"I was being accused of a theory [parental alienation]."

3.5.3 The lack of full assessment has had severe and ongoing consequences for some individuals and their child(ren). The risk to the child(ren) was not properly assessed, individuals were left unsupported and physical and emotional abuse was allowed to continue. Such findings of failure have been substantiated through individuals using the Herefordshire Council complaints process, albeit having to wait many months, if not years, to obtain any conclusion.

"I was told I had to support contact [with the other, abusive, parent] or it would be taken very seriously."

Question for Consideration

- What actions will the Herefordshire Safeguarding Children Partnership take to satisfy itself that there is good understanding across all 'frontline' agencies of domestic violence and abuse and its impact on individuals and families?

4 "It was so humiliating… everybody had to give me a score."

[Re: signs of safety]

4.1.1 The majority of individuals seen by the panel described Children's Social Care meetings as having unbalanced representation: sixteen council representatives in one online meeting but not the family health visitor or the key family member labelled as 'the acrimonious parent.' Vulnerable individuals were not supported in the meetings and described how they had to listen to professionals 'scoring' them.

4.1.2 Individuals described being notified at the last minute that a meeting was taking place and that they understandably could not always attend due to work and other commitments. Alternatively, meetings were cancelled at the last minute.

4.1.3 Individuals described paperwork arriving the night before a key meeting with little or no explanation of the content. Many found the contents to be inaccurate.
"The [Child Protection Conference] report was full of lies."

4.1.4 Families described how no one gave any thought to the impact on family members and the stress caused by such poor treatment. The majority of individuals described an unresponsive system. Phone calls were not returned, emails were not replied to and at times responses to families were rude and abrupt.
"I've got more important things to do." (Social worker)

Question for Consideration

- How will Herefordshire Children's Services support social workers to establish and maintain the trust and confidence of parents and families and enable their participation in planning to keep their children safe and promote their wellbeing?

[Professional Social Work Standards 1 & 3]

5 "Nothing was explained. We were kept in the dark."

5.1.1 'Once labelled always labelled.' The inaccurate records, outdated assessments, cut and paste documents found their way into court proceedings.

5.1.2 Individuals described being placed into an alien environment trying to obtain appropriate legal support with an unsupportive Children's Services adding to their problems.
"I met the social worker in court for the first time."

5.1.3 It was not uncommon for parents at the early stages of hearings to be advised to attend the wrong court in a completely different town! This sometimes even prevented parents from reaching the correct court in time.

5.1.4 Families reported how judges would describe Children's Social Care doing everything at the last minute, presenting incomplete documents and inaccurate assessments.
"Forget you've ever seen that letter; you don't want anything affecting your court hearing." (Social worker when an individual advised she had received someone else's paperwork)

5.1.5 Families spoke about social workers not adhering to the directions of a judge by altering the frequency of contact, invariably by reducing it, without explanation. Sibling groups ordered to be kept together were separated. One individual described a social worker who sat with the ex-partner and counsel in court and parroted back the words of the ex-partner, which was experienced by the parent as secondary abuse.

5.1.6 Families described the court process and outcomes in some cases as being unfairly balanced, particularly when one party could not afford the legal representation needed. This felt particularly egregious to individuals in contested child access cases where one party was more able to fund their case. Individuals described feelings of worthlessness, as they were not believed due to their status compared to the other party in the case.
"…trial by over-zealous social workers."

5.1.7 Individuals, some with significant vulnerabilities, struggled to cope with the timescales of court procedures, especially given the impact of Covid and virtual courts. Vulnerable individuals were left with no advocacy or support in very stressful situations and were unable to articulate the issues in their lives that had brought them to where they were that day. They very much feel let down by the system.
"They made me feel like I was Baby P's mum, a monster. I'm not. I was a struggling mum, I needed help. Now I'm broken."

5.1.8 Court outcomes, especially a decision for adoption, understandably have devastating, life-altering consequences for the adults and children involved in the case. To have reached this point after feeling as though you have not had a fair chance, have not been represented accurately and have not been listened to, destroys all faith in that system.
"I'm watching my kids slip away from me."

5.1.9 Thereafter, for goodbyes to be managed poorly is unforgiveable. Individuals described partners not having a goodbye in person and receiving unclear advice as to what future contact arrangements would be and why.

5.1.10 Relationships with professionals have broken down so far by this point that it arguably becomes irrevocable for both sides. Empathy, compassion, and minimisation of damage to the families is lost.

"We've got power over people" (Social worker)

5.1.11 In other ongoing court cases, some individuals are still awaiting decisions on the status of a child or children with no clear understanding of their position. Other individuals have decided to take legal action themselves.

"[The SW made lots of promises of support] …but [they] didn't happen…. The next time I saw [the SW] was the day before court."

5.2 "We've changed our minds; they are not coming home." (Social worker)

5.2.1 The majority of the individuals who spoke to the panel felt they were given false hope. Examples included: being told adoption was not on the table, only for the decision to be turned on its head shortly afterwards; being told children would return home on a certain date, only to be let down again and again; parents being advised they could see a child or children for a special date, such as a birthday or Christmas for it then not to happen.

"[The social worker] kept blaming someone higher up [for decisions]."

5.2.2 The impact of such actions was devastating not only for the children but the adults too. Some particularly vulnerable adults described feelings of despair, loss of hope, deterioration in their mental health and, at worst, suicidal thoughts.

"I was in despair."

Question for Consideration

- What will the Herefordshire Safeguarding Children Partnership do to promote a 'Think Family' approach across the partnership?

6 "No parent should have to fight the system on behalf of their child."

6.1.1 The majority of the individuals seen by the panel had instigated one, if not several, complaints to Herefordshire Council. No individual has had a complaint resolved within the correct timescales. Many reported being 'fobbed off' and felt the need to continually escalate through the complaints procedure and involve their Councillors and MPs to try and achieve some form of resolution. Others spoke about being confused about which complaints procedure they should use and then being directed towards the Council rather than the statutory Children's Service complaints procedure.

"I was told to stop complaining."

6.1.2 Even when complaints have been substantiated, usually following protracted processes, subject access, freedom of information requests and people becoming 'their own researcher,' apologies are taking too long and very little, if any, change is demonstrated to the families.

"I never know if it is cock up or conspiracy."

6.1.3 In some cases, the local authority has failed to implement the findings of a complaint. Some of the historic timelines for stage two and three complaints have taken years and only conclude due to the persistence of the individuals concerned. It is felt that different stories are being treated the same way. A multi-agency coordinated approach was not used during the complaints process resulting in lots of parallel and overlapping activity.

"Toothless tiger of a complaints system."

6.1.4 The reality for some individuals is that they now have no faith in Herefordshire Council: they do not want their complaints resolved internally and believe that the only thing that will satisfy them is an independent review.

"I never wanted to do this, I wanted to work with social services."

Question for Consideration

- What will the Herefordshire Safeguarding Children Partnership do to ensure that the complaints procedures in every agency across the partnership are accessible to families, work well, and findings are recorded and acted on?

7 “The social worker spoke properly with them, didn’t call them weird, gained their trust.”

7.1.1 In telling the panel about their experiences with agencies, families were asked what had worked well for them. Several individuals described pockets of good practice by individual social workers, such as social workers who took the time to build relationships with a child or several children, properly assessed the case and worked with a family. Unfortunately, this was the exception rather than the norm and usually only applied to one social worker amongst the many that a family might have had in their lives.

“Social workers who got to know you well.”

7.1.2 Similarly, individuals mentioned individual contact centre workers who had done a good job.

“Contact centre staff were amazing, well-documented sessions.”

7.1.3 Individuals stressed the importance of independent charities and bodies that had supported them and re-gained some of their lost confidence in professionals. Women’s Aid was positively highlighted a number of times and other charities, including the National Autistic Society, were praised for their help and support.

“Women’s Aid was fantastic.”

“Court approved independent assessment was positive. They listened to my children.”

“Initially didn’t understand the role, but an advocate, truly independent.” (Young person describing the IRO role).

7.1.4 Several individuals praised the vital work of schools in the safeguarding world and the role they performed in providing the day-to-day assessment of the children in their care.

“Schools were very supportive and helpful but were not allowed to be at the core meetings.”

“Education challenged the local authority and then were accused of protecting mum”.

“School brilliant.”

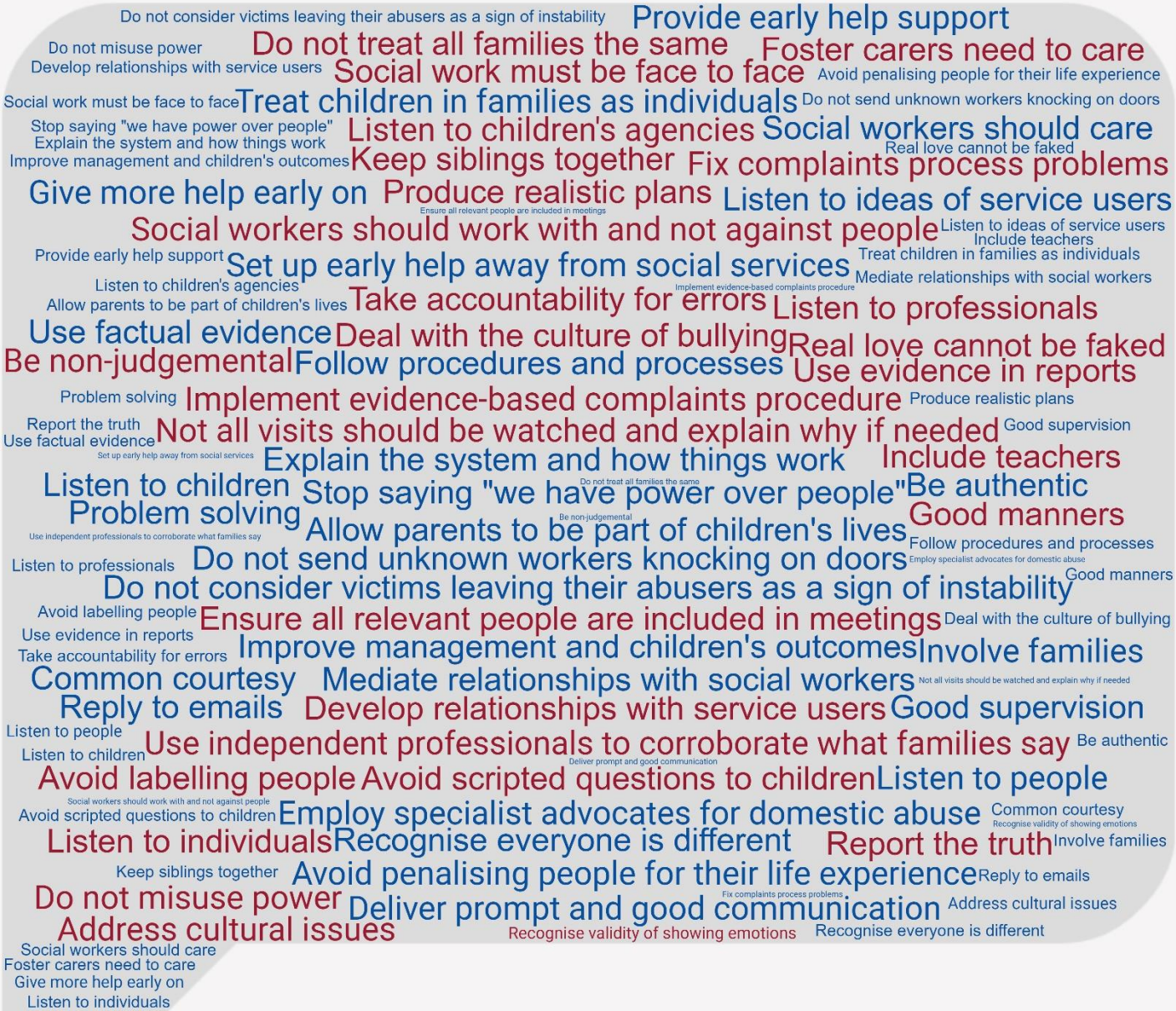
7.1.5 Similarly, individuals within the health sector were recognised by parents for their independence, support and care at very difficult times.

“GP brilliant.”

“I had good rapport with the health visitor.”

7.1.6 Birmingham Children's Hospital specialists were highlighted by parents for delivering high quality patient care and support while producing independent reports of each case's facts. However, the caveat remains that this information was not always used in assessments and social worker reports.

8 What Could Have Been Done Differently



9 Reflections from the Commission

9.1 The commission members are only too aware that the results of their work reflect the significant concerns already raised through audit and inspection of Herefordshire Children's Services sector, and of the potential for the report to be dismissed as yet another in a sequence of equally negative reports. They urge that this does not happen.

9.2 This unique lens for considering the impact of services is powerful, palpable and compelling. The panel members, with nearly 120 years of public service between them, were moved by the accounts they heard.

9.3 The consistent nature of the themes bought out by articulate, intelligent individuals, in a predominantly balanced way, produced credible accounts which the panel believed. There is no doubt that cases of the nature the panel heard will be multifaceted, complex, time demanding, and result in outcomes that can be traumatic for those families involved. However, the panel was compelled by the totality of the examples cited of core failings in the system. This is particularly concerning as most of the cases are still open with Children's Services.

9.4 While the panel was not able to assess to what degree the poor experiences described by the families may be indicative of widespread poor practice, the panel did directly experience delays and poor-quality communication when following up issues directly with Children's Services. This suggests that the issues are significant and systemic.

9.5 For the individuals in question, nothing can change the experiences they have had, and the impact on their families. Their loss of faith in the services and systems that they believed were there to help and support them is profound. They have found the complaints procedures inadequate, not least because, where they have had their complaints upheld, the promised actions have rarely materialised. Neither have they been recorded on case files, meaning that the same injustices can be perpetuated. Whilst some families may well feel that the opportunity to be heard and believed by the panel has been sufficient in itself, there may still be a small number of individuals who believe that a further review of their case is the only way to help them resolve their long standing complaints. For some, such a course of action may well serve to prolong their distress. However, where there remain unresolved issues in respect of open cases, they may well be right. It is the panel's view that any decision about whether or not to proceed with a review should be made with great care, and with the full involvement of the individuals concerned.

9.6 There is no doubt that the period in question included particular challenges given the impact of Covid on both individuals and families, both privately and professionally, and on the ability to deliver services of a consistently high standard. Herefordshire also has unique challenges, including its size and rurality, its distance from large centres of population, with the consequent implications for staff recruitment, and its proximity to Wales. Cross border issues were evident in several of the cases the panel was told about.

9.7 Despite these caveats, the impact on parents and children of not being heard or believed was significant and longstanding. It was a sobering reminder of the importance of treating people respectfully and well, no matter what the circumstances, and of how easy it can be to destroy lives when in a position of power and authority.

9.8 As well as the damage to individuals and families of poor multi-agency practice as detailed above, the testimony of families clearly identified negative impacts for agencies too. These included:

- Loss of confidence in the professional reputation of individual agencies and their ability to work effectively.
- Lack of professional challenge within and between agencies.
- Overall strengthening of poor, negative and damaging culture across all partner agencies.
- High risk of legal challenge.
- High cost of compensation.
- Institutional acceptance of poor practice.
- Reputational damage.
- Professional disrespect locally and nationally.

The work of the Herefordshire Safeguarding Children Partnership will be crucial in providing the leadership to address these issues.

9.9 The panel recognise that this report will be difficult to read for all the dedicated social workers and managers working in Herefordshire, but there were also concerns raised about health and police services. No one comes to work to do a bad job and the panel hope that all practitioners see this report as an opportunity for reflection to improve their own practice. The overarching themes from the interviews with families are clear. It is vital that people are treated as individuals and that time is taken to build a rapport with each family by listening carefully and listening again. Ensuring that all opinions in reports are based on evidence - ideally from several sources - and that they capture the views of each family was also a priority. Families should also expect respectful, prompt and polite responses to calls and emails. Getting all these basics right sets the tone for developing positive working relationships with families.

10 What Next?

10.1 The Commission has posed questions for the Council and its partners to consider. These are included throughout the report. Due to the way in which families were identified to come and speak to the commission though, panel members are conscious that the report focuses predominantly on the Council's children's social workers and managers. However, they also heard of poor practice in other services and departments, including Adult Social Care, NHS settings (including mental health provision) and the police.

10.2 Families were eloquent in describing what they wanted from services (please see the infographic above). This will require wholesale change, which the Herefordshire Safeguarding Children Partnership is well placed to lead by promoting a jointly owned safeguarding culture across agencies, based on clear 'Think Family' principles.

10.3 For Children's Services, relationship based social work can only be achieved within organisations that commit to meaningful and respectful engagement as their cultural norm. This way of working needs to be owned at all levels within any organisation. In times of high turnover of social workers, it is imperative that respect, tolerance and empathy underpins every contact with individuals. The organisation must recognise, own and ensure that behaviours at the front line are consistently maintained.

10.4 All families are unique and professionals who have been given the responsibility to help others adapt and strengthen their parenting need the requisite skills to engage with all family members meaningfully. They need to listen, understand and respond to all participants to ensure sensitive inclusion, to achieve a constructive form of intervention that has the potential to address all the strengths and shortfalls within family units.

10.5 Assessments must be complete, accurate and understandable with the full engagement of every family member. Recognition of individual needs and conflicts of interests need to be openly explored and addressed to seek acceptable solutions. Records must be fully recorded and shared in a timely way with opportunity for ongoing discussion and development of any plan.

10.6 It is evident that this has not been achieved in Herefordshire to date, at least for the families seen by the commission. To achieve such a major cultural change would necessitate all the workforce to understand and work to the basic principles of good practice.

10.7 The questions posed throughout the report are designed to promote this process of change.

10.8 As a final note, many of the parents and family members we spoke with were ambitious for the Council and its partners to deliver excellent services. They have such a breadth of experience and insight that they are willing to contribute. As one parent said: "I want to be proud of Herefordshire Children's Services."

11 Summary of Questions for Consideration

11.1 How will the Council and its partners provide a meaningful and responsive early help service which is accessible to families, regardless of which agency they contact first for help?

11.2 How will the Council support its social workers to practise in ways that demonstrate empathy, perseverance, authority, professional confidence and capability; working with people to enable full participation in discussions and decision making?

11.3 How will the Herefordshire Safeguarding Children Partnership ensure that professionals are working together in the best interests of children and their families, to the highest standards of professional practice, informed by good quality research and evidence?

11.4 What actions will the Herefordshire Safeguarding Children Partnership take to satisfy itself that there is good understanding across all 'frontline' agencies of domestic violence and abuse and its impact on individuals and families?

11.5 How will Herefordshire Children's Services support social workers to establish and maintain the trust and confidence of parents and families and enable their participation in planning to keep their children safe and promote their wellbeing?

11.6 What will the Herefordshire Safeguarding Children Partnership do to promote a 'Think Family approach across the partnership?

11.7 What will the Herefordshire Safeguarding Children Partnership do to ensure that the complaints procedures in every agency across the partnership are accessible to families, work well, and findings are recorded and acted on?

12 Appendix A

Terms of Reference for a Commission to consider families' experience of children's services in Herefordshire

The Commission will be an independent review into the concerns and issues about children's services in Herefordshire that have been raised by a number of parents and families in recent months. This will be an opportunity for families to be heard by an independent panel and for their experiences to assist with learning about what needs to improve.

Background

Herefordshire's children's services have been publicly criticised in recent years. The recent Ofsted Inspection also highlighted concerns about the effectiveness of the safeguarding partnership.

In 2018 a High Court judge published his judgement relating to the inappropriate use of Section 20 for children in long term care in Herefordshire, and in March 2021 the same judge published a highly critical judgement relating to very poor practice regarding a sibling group of four. More recently, in April 2022, the BBC broadcast a Panorama programme, which covered the negative experience of five families who had been receiving social work intervention in Herefordshire.

One of the mothers featured in the Panorama programme, set up a group called A Common Bond. She was and is supported by one Councillor in particular and the local M.P. In October she organised a public meeting for families to present their stories to councillors (about 12 attended this meeting) and myself as Children's Commissioner. About 15 families had prepared statements which they presented. There were some common themes: unsympathetic social workers, lack of knowledge or response to children's special needs, children removed at short notice and wider family not considered. Several of those who presented their story had come to an extraordinary council meeting held a few weeks previously to debate children's services, and have continued to ask questions at subsequent Council meetings.

Managing 'legacy' cases is challenging given the numbers involved, the high profile following the Panorama programme, the historic poor decision-making and the frequent changes in social workers. The publicity following the recent inspection has further increased lack of confidence in the Council and the Safeguarding Partnership. A small number of parents continue to take opportunities to publicly raise their concerns at council meetings and through emails and complaints to the local M.P.s and Councillors.

Given this background and context the Council, with the Children's Commissioner and the safeguarding partners, have considered what more can be done to try to resolve issues for

families, to restore confidence and to learn from what has happened. The proposal to establish a Commission is intended to do this.

Purpose of setting up a Commission

a. To give parents and families an opportunity to tell their story to an independent panel.
b. To identify any steps that the Council and partners can and should take as a result of hearing families' testimonies, either in relation to individual cases or in respect of general issues.
c. To learn from their experience and to ensure that that knowledge is used to inform improvements to children's services.
d. To ensure that, as far as possible, families feel that their concerns have been listened to and responded to, and that this is as much as can be done to resolve matters.

Parameters for the Commission

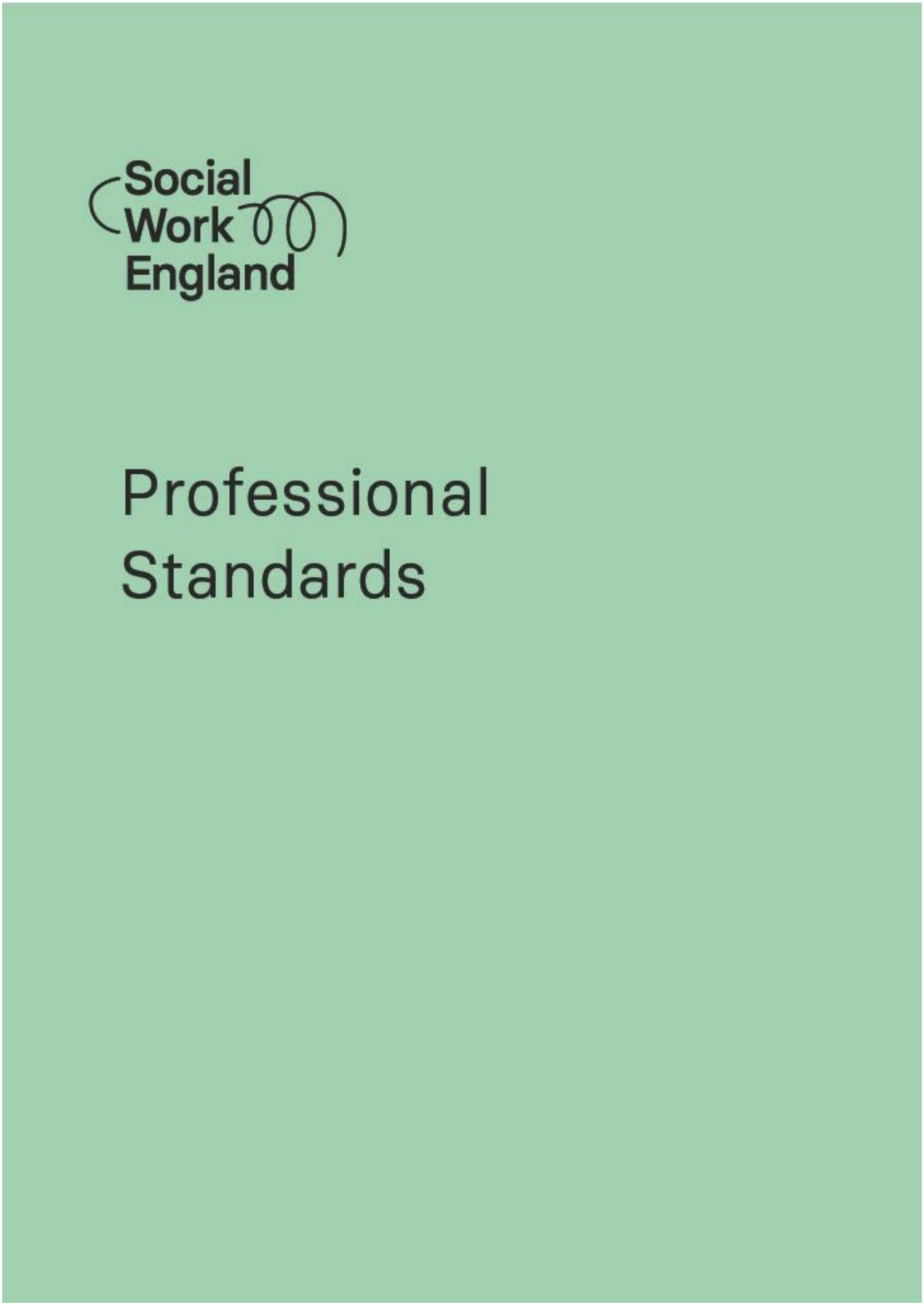
1. The Panel will consist of 3 individuals, not connected to Herefordshire Council, with appropriate knowledge and experience, identified by the Children's Commissioner.
2. The Panel will meet in Hereford in private as circumstances relating to individual children will be discussed.
3. Families will have the opportunity to present to the Panel in person or to submit written statements.
4. Any parent or carer who wishes to address the Panel will be able to be accompanied by someone to support them.
5. If any children wish to address the Panel we will look at each situation individually to ensure that they are fully supported to do this.
6. If any families are currently involved in care proceedings, the Panel will not be able to consider any request to impact on those proceedings, but will hear from parents who wish to tell their story of what led up to the initiation of proceedings.
7. The Panel will not be able to consider any request to review a case where a child has been adopted, but will hear from parents who wish to tell their story of what led up to an adoption outcome
8. Where families have already had their concerns investigated through the Council's complaints process the Panel will have access to all the documentation relating to the complaint investigation and outcome, as well as hearing directly from the families.
9. The Children's Commissioner will support the work of the Panel and will attend the meetings..
10. The Safeguarding Partnership will be represented by the Independent Scrutineer who will attend as an observer. He will follow up any specific issues that are raised in the relation to the Partnership.

Process

- The Council will identify families who have raised their concerns through a number of routes, including directly to their M.P., councillors, Chief Executive, Children's Commissioner, at Council meetings and scrutiny committee meetings.
- If the parameters above are met, families will be offered the opportunity to present to the Panel.
- The Panel will meet for between 3-6 days, depending on the numbers of families who wish to be involved, during March if possible.
- The Council will provide administrative support to the Panel
- The Panel will produce a written report identifying general themes and recommendations, which will be published.
- The report will be received by the Council and the safeguarding partners
- The Panel will write separately to individuals, the Council, and safeguarding partners if there are specific recommendations in relation to their case.

Eleanor Brazil, Children's Commissioner

13 Appendix B



1 Professional standards

Promote the rights, strengths and wellbeing of people, families and communities.

2

As a social worker, I will:

1.1	Value each person as an individual, recognising their strengths and abilities.
1.2	Respect and promote the human rights, views, wishes and feelings of the people I work with, balancing rights and risks and enabling access to advice, advocacy, support and services.
1.3	Work in partnership with people to promote their wellbeing and achieve best outcomes, recognising them as experts in their own lives.
1.4	Value the importance of family and community systems and work in partnership with people to identify and harness the assets of those systems.
1.5	Recognise differences across diverse communities and challenge the impact of disadvantage and discrimination on people and their families and communities.
1.6	Promote social justice, helping to confront and resolve issues of inequality and inclusion.
1.7	Recognise and use responsibly, the power and authority I have when working with people, ensuring that my interventions are always necessary, the least intrusive, proportionate, and in people's best interests.

2 Professional standards

Establish and maintain the trust and confidence of people.

As a social worker, I will:

2.1	Be open, honest, reliable and fair.
2.2	Respect and maintain people's dignity and privacy.
2.3	Maintain professional relationships with people and ensure that they understand the role of a social worker in their lives.
2.4	Practise in ways that demonstrate empathy, perseverance, authority, professional confidence and capability, working with people to enable full participation in discussions and decision making.
2.5	Actively listen to understand people, using a range of appropriate communication methods to build relationships.
2.6	Treat information about people with sensitivity and handle confidential information in line with the law.
2.7	Consider where conflicts of interest may arise, declare conflicts as early as possible and agree a course of action.

3

Professional standards

Be accountable for the quality of my practice and the decisions I make.

As a social worker, I will:

3.1	Work within legal and ethical frameworks, using my professional authority and judgement appropriately.
3.2	Use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk, and to make a professional decision.
3.3	Apply my knowledge and skills to address the social care needs of individuals and their families commonly arising from physical and mental ill health, disability, substance misuse, abuse or neglect, to enhance quality of life and wellbeing.
3.4	Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks.
3.5	Hold different explanations in mind and use evidence to inform my decisions.
3.6	Draw on the knowledge and skills of workers from my own and other professions and work in collaboration, particularly in integrated teams, holding onto and promoting my social work identity.
3.7	Recognise where there may be bias in decision making and address issues that arise from ethical dilemmas, conflicting information, or differing professional decisions.

As a social worker, I will:

3.8 Clarify where the accountability lies for delegated work and fulfil that responsibility when it lies with me.

3.9 Make sure that relevant colleagues and agencies are informed about identified risks and the outcomes and implications of assessments and decisions I make.

3.10 Establish and maintain skills in information and communication technology and adapt my practice to new ways of working, as appropriate.

3.11 Maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions.

3.12 Use my assessment skills to respond quickly to dangerous situations and take any necessary protective action.

3.13 Provide, or support people to access advice and services tailored to meet their needs, based on evidence, negotiating and challenging other professionals and organisations, as required.

3.14 Assess the influence of cultural and social factors over people and the effect of loss, change and uncertainty in the development of resilience.

3.15 Recognise and respond to behaviour that may indicate resistance to change, ambivalent or selective cooperation with services, and recognise when there is a need for immediate action.

4 Professional standards

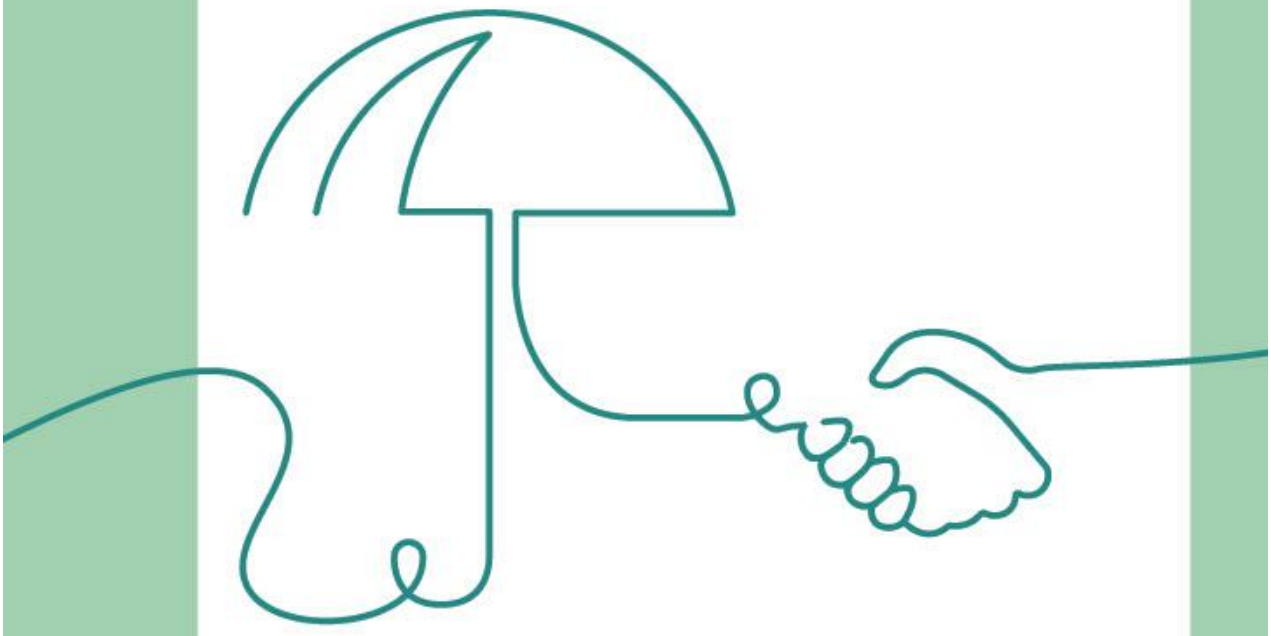
Maintain my continuing professional development.

As a social worker, I will:

4.1	Incorporate feedback from a range of sources, including from people with lived experience of my social work practice.
4.2	Use supervision and feedback to critically reflect on, and identify my learning needs, including how I use research and evidence to inform my practice.
4.3	Keep my practice up to date and record how I use research, theories and frameworks to inform my practice and my professional judgement.
4.4	Demonstrate good subject knowledge on key aspects of social work practice and develop knowledge of current issues in society and social policies impacting on social work.
4.5	Contribute to an open and creative learning culture in the workplace to discuss, reflect on and share best practice.
4.6	Reflect on my learning activities and evidence what impact continuing professional development has on the quality of my practice.
4.7	Record my learning and reflection on a regular basis and in accordance with Social Work England's guidance on continuing professional development.
4.8	Reflect on my own values and challenge the impact they have on my practice.

5 Professional standards

Act safely, respectfully and with professional integrity.



As a social worker, I will not:

5.1	Abuse, neglect, discriminate, exploit or harm anyone, or condone this by others.
5.2	Behave in a way that would bring into question my suitability to work as a social worker while at work, or outside of work.
5.3	Falsify records or condone this by others.
5.4	Ask for, or accept any money, gifts or hospitality which may affect or appear to affect my professional judgement.
5.5	Treat someone differently because they've raised a complaint.
5.6	Use technology, social media or other forms of electronic communication unlawfully, unethically, or in a way that brings the profession into disrepute.

6

Professional standards

Promote ethical practice and report concerns.

1a

As a social worker, I will:

6.1 Report allegations of harm and challenge and report exploitation and any dangerous, abusive or discriminatory behaviour or practice.

6.2 Reflect on my working environment and where necessary challenge practices, systems and processes to uphold Social Work England's professional standards.

6.3 Inform people of the right to complain and provide them with the support to do it, and record and act on concerns raised to me.

6.4 Take appropriate action when a professional's practice may be impaired.

6.5 Raise concerns about organisational wrongdoing and cultures of inappropriate and unsafe practice.

6.6 Declare to the appropriate authority and Social Work England anything that might affect my ability to do my job competently or may affect my fitness to practise, or if I am subject to criminal proceedings or a regulatory finding is made against me, anywhere in the world.

6.7 Cooperate with any investigations by my employer, Social Work England, or another agency, into my fitness to practise or the fitness to practise of others.

14 Appendix C

Safeguarding
Herefordshire Safeguarding Children Partnership

Meet the Panel

Karen Manners QPM BSc (Tech)Hons

Karen retired in August 2018 as Deputy Chief Constable (DCC) for Warwickshire Police after 32 years' service.

In May 2018, she was appointed as one of the inaugural members of the National Child Safeguarding Review Panel. This panel has oversight of the child safeguarding system, meeting regularly to oversee local reviews and to determine whether to commission national reviews of child safeguarding cases that are notified to them. The panel has its own statutory powers, independent of government. In March 2020, Karen was appointed interim chair.

Karen is an independent safeguarding consultant. She has recently concluded a piece of work for Chief Constable Simon Bailey, national police lead for child protection, updating the national vulnerability action plan (NVAP 2020-2022) for forces. In November 2020, Karen concluded a scoping piece of work on vulnerability to radicalisation as the 14th strand of public protection on behalf of Chief Constable Simon Bailey and Simon Cole (national Prevent lead) in response to a HMICFRS recommendation following their national thematic inspection in regard to Prevent.

In September 2020, Karen was appointed a subject matter advisor on behalf of the College of Policing to deliver input to training on Public Protection and Safeguarding Leadership course which has been supported by the Home Office. She is now a College of Policing Associate.

Karen has a wealth of experience and knowledge gained from her various leadership roles within the police service. As DCC for Warwickshire Police, Karen led the vulnerability strategy for the force and its alliance partner, West Mercia Police, leading the delivery of innovative frontline vulnerability training. She also led nationally for the NPCC on Child Neglect and Coronial matters and the creation of the National Vulnerability Action Plan. During her tenure as Assistant Chief Constable for the alliance of Warwickshire and West Mercia Police, she chaired two strategic boards for the Multi-Agency Public Protection Arrangements (MAPPA).

Prior to joining Warwickshire Police Karen also served within the Met and Hampshire Police.

Karen's national work on neglect and vulnerability was recognised in the Queen's Birthday Honours 2017, when she was awarded the Queen's Police Medal.

Sally Halls

Qualified as a social worker in 1980 and worked for many years for child and family services in the voluntary sector and local authorities, in a range of front-line, middle and senior management roles. Following three years working as an adviser for the (then) Department of Schools and Families, she worked for the Local Government Association, leading for the Children's Improvement Board on the social care sector response to policies in areas including adoption, care and family justice.

Since 2010, she has worked as a consultant specialising in supporting improvement in services to children and families, nationally and internationally, chaired a number of Local Safeguarding Children Boards, and both led and contributed to safeguarding audits in schools and the Anglican church. In these roles, she has always prioritised finding ways to engage with and listen to those who use services, to learn from their experiences and ensure they inform improvement.

Mairead MacNeil

Qualified as a Social Worker in 1983 and worked in both the voluntary sector and Local Authorities, as social worker and in management positions in three London authorities.

From 2002 she was senior manager for children's services in three separate authorities across the UK, and led and implemented each of the children's improvement plans where those authorities had been deemed to be failing through OFSTED inspection. All three authorities successfully came out of out of intervention to achieve Good and Outstanding ratings

She participated in various national children's services working groups with the DFE and OFSTED and contributed to policy development on a range of safeguarding children issues.

More recently, as a consultant, she has undertaken practice improvement roles with several Local Authorities, focussing on excellence and driving the improvement in the quality of Social Work and inter-agency planning to deliver better safe and sensitive services for children and their families.