THE TRAGIC GAP

We live in very broken times, times with lots of gaps between the difficult realities of life and what we know to be possible, humanly. One of the most important qualities a person can have in our time – a person who wants to make this a better world – is the capacity to ‘stand in the tragic gap’ between corrosive cynicism and irrelevant idealism, between what is and could be. We need the inner strength to hold both the reality and our hope at the same time.

Parker J Palmer couragerenewal.org.chapter-10-standing-in-the-tragic-gap

Rita

“I wish someone had asked us” - Rita’s family

South Gloucestershire Safeguarding Adults Board and Children’s Partnership

WHAT WILL WE COVER?

- How Rita's life has helped to bring out tensions in the system and show the need for better ways to support parents who have complex needs.
- How the system did not join together to support the whole family. In Rita's case, coordinated action occurred only weeks before her death.
- How Rita and her children managed to fall through the gap of services even though many professionals had contact with her and her children.
- Our Time Frame: Oct 2023-July 2024

What have we been asked to think about?

1

A parent has complex physical and mental health needs which may impact on the health and well being of the children leading to adult and children's services need to work together.

2

There are changes of tenancies due to arrears and housing conditions have deteriorated to be unsafe.

3

There are concerns for a parent with deteriorating mental health and physical health needs who sometimes self-discharges and does not give consent to referrals.

What human factors might have influenced what happened?

RITA'S STORY

- We are here to look at how the multiagency safeguarding system works through the circumstances and tragic death of Rita, specifically between April 2021 and July 2024. A key theme described by both Rita's family and Practitioners is that the system does not have clarity.

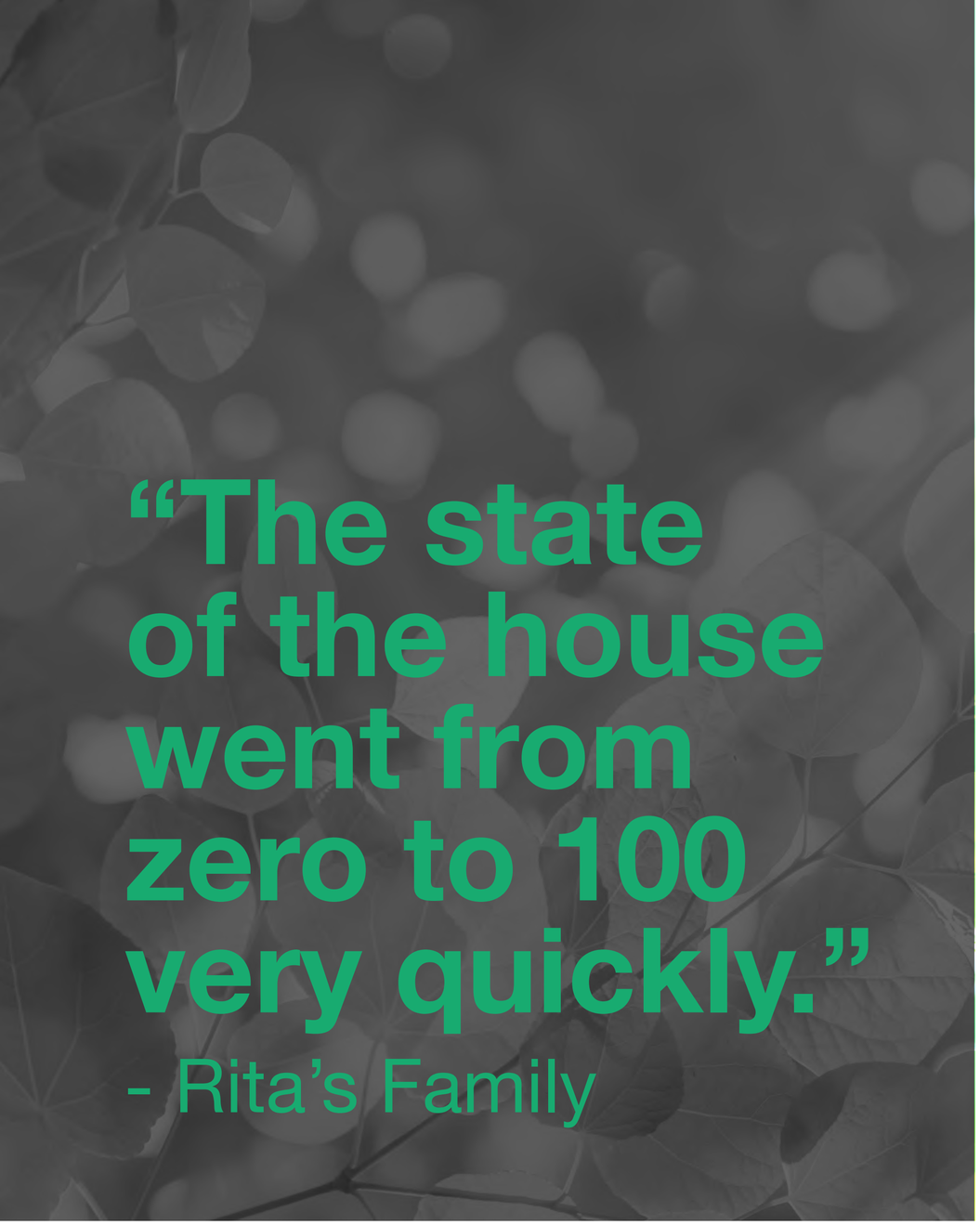
- Rita was a young woman with two young school age children. She had parents who supported her and who would sometimes collect the children from school, and tried to help her in the house. Rita kept them at 'arms' length' but they tried to keep in contact so that they could see the children. Rita did not want the children to see their father. He tried to maintain contact with them and with the school. Until the final safeguarding children's referral he was not contacted by any agency.

- Rita had physical and mental health issues which affected her daily life and there were many ambulance call outs, hospital and out patient appointments. These were mainly gastroenterology appointments. Rita had a history of vomiting blood, had severe pain and lost weight. She would often not wish to stay in hospital.

- Rita's story includes her children. Sadly there was missing information about their daily lives which is only coming to light after her death. The deterioration in living conditions was only seen following Rita's final admission to hospital. Every room was full of clutter and the kitchen had rotten food. Her youngest child could not sleep in his bedroom because of the clutter.

WHAT DO WE KNOW ABOUT RITA?

- There remain many things that we don't know about Rita. We know that Rita appeared to keep professionals at arm's length, as she did her parents. This raises questions about how we interpret terms like 'does not consent' and 'reluctant to engage' and how they may limit professional curiosity.
- She had a preoccupation with illness perhaps because of her own mental health and potential eating disorder.
- Professionals did try to help, Rita did not want to follow up appointments. The full extent of her circumstances was only known to her family.
- Rita told people that she had a diagnosis of of a rare illness called Behcets (an auto immune disease). In reality this had been ruled out following investigations. Professionals believed her.
- She had gastrointestinal difficulties and her GP was worried about the amount of ibuprofen she was taking which might have worsened her symptoms. It was not known that Rita also ordered large amounts of painkillers online.
- Rita's family told us that Rita would travel around to different Pharmacies to get pain killers. For many years Rita would take supplies of codeine and tramadol from family members. The family had tried at various points to raise their concerns with Professionals and no action was taken.
- Rita had a partner during the time period and little was known about him. He was mentioned by family after her death. Her family are concerned that Rita was giving money to him or was coerced. The children were also concerned that he took money from their Mum.

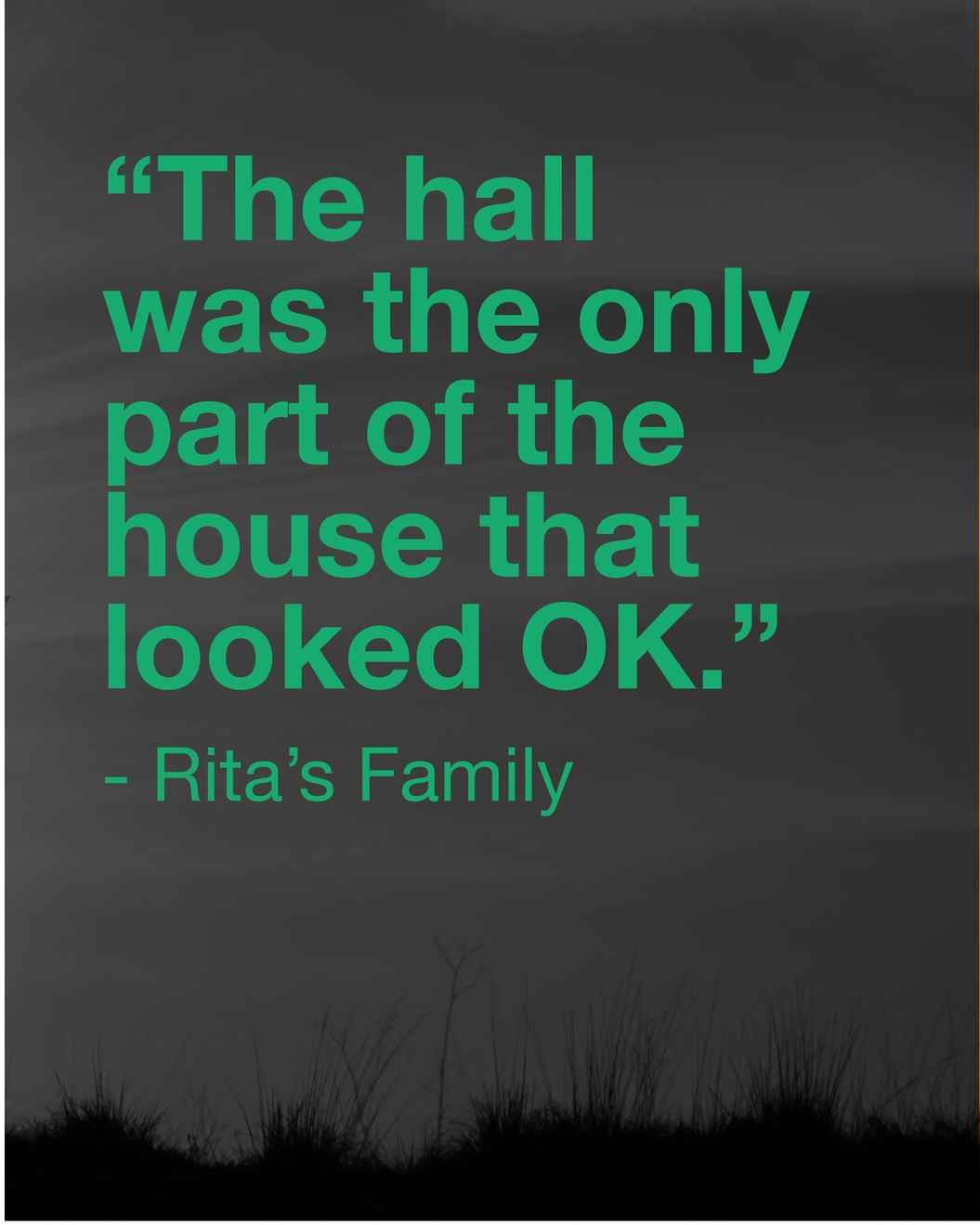


HOUSING & ARREARS

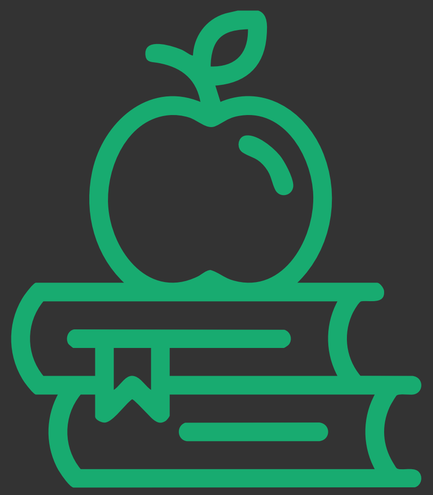
- Rita had a housing tenancy with a housing association from 2023.
- Home conditions seemed to deteriorate very quickly. What was not known by the housing association was that that this had happened in a previous tenancy.
- A court case was pending at the time of her death because of rent arrears and Rita was at risk of homelessness immediately prior to her death. This was also not known to other agencies, other than housing.
- Her family have expressed concern that they did not know the full extent of the arrears and could not understand how they became so big.
- Rita had a ‘housing coach’ who was in contact frequently and made safeguarding adult referrals and a request for a Care Act Assessment in 2023. The coach held a lot of information that was not always shared.
- Concerns about deteriorating home conditions and Rita’s mental health underpinned the referrals from the coach. Little information was shared about the children in these referrals which added to the lack of understanding.

JUNE 2024: FINAL VISITS AT HOME

- Home conditions continued to deteriorate quickly. When social workers, police and housing coach visited following the final children's safeguarding referral (and an adult safeguarding referral by paramedics, and the housing coach in June 2024) there was rubbish in every room and maggots. A fire referral was made because of risk.
- The children looked dirty and unkempt, and her son was seen lying on the floor. The children's father was able to look after the children at this point. Rita was sadly left overnight and was found the next day sitting on the bottom of the stairs hardly able to move as she was so weak. She agreed to go into hospital where she died a few weeks after.
- Rita said that she wanted a home and someone to care.



THE ROLE OF THE SCHOOL



The school staff knew Rita well and had concerns about Rita's mental health and felt in 2021 that there were indicators of Fabricated and induced illness/Perplexing Presentations(FII).

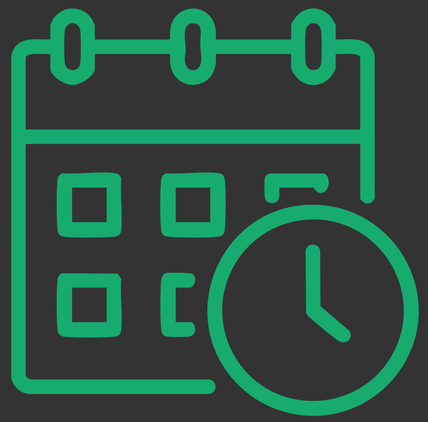
Although this was not the case the school were right to have concerns about what was happening in Rita's life and for her children.

Further enquiries might have shown the difficulties faced by the children and the complexities of Rita's life which we will discuss later.

RITA'S COMPLEX & PERPLEXING NEEDS

- Rita's ex-partner disclosed concerns about her mental health early in their relationship, including severe anxiety and delusional beliefs. This information was not known to professionals.
- Paramedics were greatly concerned about the home conditions and the impact on the children and submitted safeguarding children referrals.
- They were so concerned that they made a call to children's social care from Rita's home. They were told that an offer of early help had been made and Rita did not wish to engage. Further escalation was not made, which might have been helpful.
- Rita did not want support from social workers but she had a more trusting relationship with the housing officer/coach and the school.
- The school was not aware of safeguarding referrals made by other agencies.
- Rita asked for euthanasia at one hospital admission in May 2024 and spoke about not wanting to live. Thoughts of suicide ideation seemed quite frequent at this time and were recognised by the GP who made referrals for support to the community mental health team which was declined by Rita. The GP was not aware of home conditions.
- Rita wanted to 'end it all' when her children were collected by and cared for by their father in June 2024. She had previously said that she was the victim of domestic abuse.

SAFE-GUARDING TIMELINE SUMMARY



2021 – 2023:

- No Safeguarding Referrals. A concern raised by a food bank was passed from adult services to childrens'.

May – August 2023:

- Adult Safeguarding Referral initiated in May.
- Ended in August due to lack of consent from Rita.

Jan – March 2024:

- No safeguarding referrals or ambulance call-outs.
- Housing remained in contact over arrears.

April – June 2024:

- 2 Adult Safeguarding Referrals by Housing Coach (Care Act Assessment + photos).
- 2 Children's Safeguarding Referrals by Ambulance Teams.

June 2024 – Crisis Point:

- Strategy Meeting after Rita's hospital admission.
- First multi-agency collaboration (ASC + Children's Services). 'We worked well at the point of crisis '
- Full info about children still unknown.
- Family including the children's father unaware of strategy meetings.

COMPLETING THE JIGSAW:

The voice of the children following interviews with Family

- One child was unable to sleep or get in the bedroom because it was so full of rubbish. He slept downstairs. This had been happening for some time.
- The children struggle to sleep now as they are used to being alert for their Mum in the night and getting up to help her.
- They had to lift her into bed and care for her.
- They prepared their own meals and were not allowed to leave the house to play outside.
- Until the last few months they 'looked ok' when they went to school, as in, seemed to be dressed appropriately and did not appear neglected, but this was because of family help with clothes.
- One child aged 10 was given a dummy by his Mum. "He was the baby, the favoured child" (sibling).
- There was a partner occasionally in the house and the children were concerned about their Mum.
- They did not have much contact with their father for four years. As previously stated Rita did not want the children to see their father. He tried to keep in contact. Rita did not have anything in place to prevent access such as court processes. She had on a few occasions mentioned domestic abuse and this was not followed up. An assumption was made by agencies that the father was not part of the children's lives.

"The children were left far too long."

- Family

MIRROR MIRROR - WHAT DO WE SEE?

- No one had the full picture of deteriorating home conditions and risk of homelessness due to arrears.
- A partner was sometimes in the house and family worry now about financial abuse and his connection with rent arrears. What was known about him?
- The children's voice and presence is missing from the collective safeguarding response. We do not see a clear picture of the children and have no sense of their daily life and experience.
- 'Consent' became a reason to pullback and prohibited thinking about the children and risk.
- Rita was herself lost in plain sight with no exploration of her reasons for not wanting to engage.
- Many practitioners took at face value what Rita said about a number of matters such as the fact that she said that she had an auto immune disease and her relationship with the children's father.
- The impact of mental health and an eating disorder was missed and that Rita was ordering painkillers online.
- **"Should we see no consent as a red flag sometimes?"** - Practitioner
- **"What was missing from the system which stopped us from asking questions and challenging?"** - Learning Event Participants

WHAT HAVE WE SEEN AND HEARD THAT IMPACTS ON THE RELIABILITY OF SAFEGUARDING FOR SOUTH GLOUCESTERSHIRE?

Relationships matter – at every level. Protocols and processes matter but it is the activity of getting to know one another that makes the difference

→

Gathering information and intelligence is vital and should include family

→

The system does not have shared understanding of supporting parents who are reluctant to engage and have potential care and support needs

→

The children's and adult safeguarding processes did not converge at the point of risk but remained separate

"Its systemic" - Practitioners at the learning event

"It's who you know not the process" - Practitioner

TRAUMA INFORMED

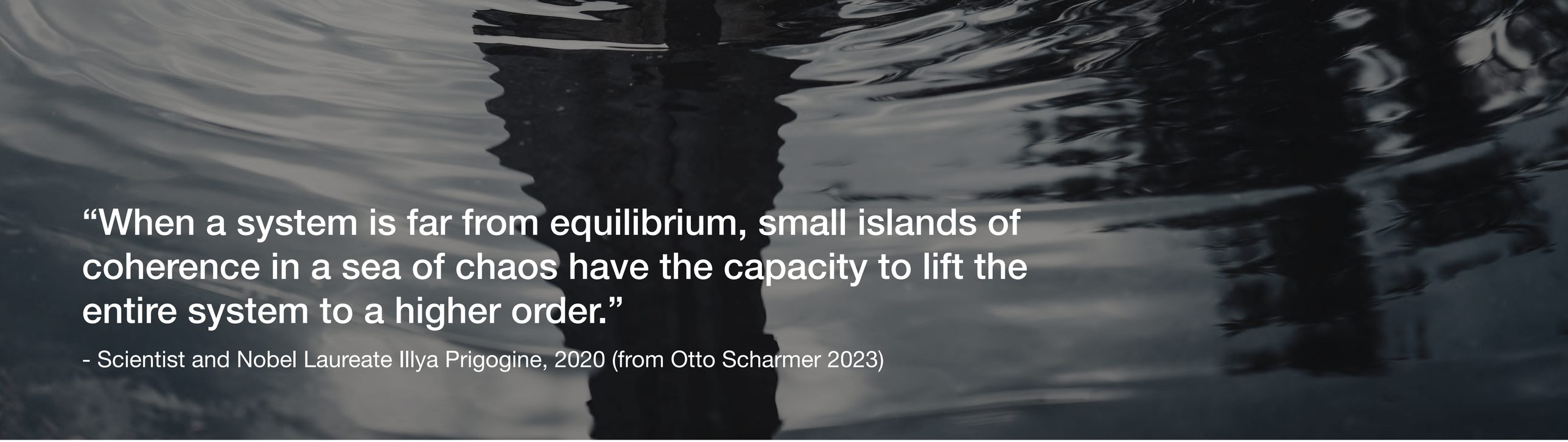
Where Are We?

- Trauma can lead to people having to function in various survival modes and can impact integration of various systems (e.g. time, arousal, executive function). Therefore, we want services to not reinforce or mirror this survival mode or disintegration and be able to reflect instead of react and to be more connected and integrated, rather than reinforce or mirror this survival mode or disintegration.
  Treisman_K_Report_2018_Final.pdf
- What was really happening with Rita?
- What did we know about who she really was?

SURFACING THE TENSION: NOTHING NEW?

- The impact in children is often seen as exclusively the domain of children's services- and the impact on adults as the role of Adult Social services and services such as adult mental health.
- The referral system does not enable a Think Family approach Build one referral system that covers both a parents needs and flags the risk to children.
- When parents do not consent / engage this is an opportunity to explore further and review risk.
- Time to be professionally curious and think is a systemic issue.
- Recognising and responding early means bringing together all we know about restorative processes and strength-based working.
- Critical thinking and challenge is central to safeguarding and ensures earlier intervention and a review of risk.
- Commissioning of services unconsciously creates silos and stifles creativity.
- The different legislative frameworks can lead to dissonance in understanding of consent and risk. A common understanding is needed when there are children who may be at risk of significant harm.
- Non statutory partners such as housing and education need to be part of conversations.
- Think Family is a term that in practice is not joined up, poorly understood and does not prevent silo working.

  An adults right to self determination is a core part of adult safeguarding and the Care act 2014 and yet this is affected when concerns extend to children.
- Clarity is needed on what multiagency pathways are available outside of statutory safeguarding.



“When a system is far from equilibrium, small islands of coherence in a sea of chaos have the capacity to lift the entire system to a higher order.”

- Scientist and Nobel Laureate Illya Prigogine, 2020 (from Otto Scharmer 2023)

- In other words - small islands of coherence and improvement can inspire clarity.
- Will you be a system shifter and help people to make sense of the messiness?
- What are the areas of interconnectedness that you could start with?
- Who do you need to involve? What is the role of commissioners and public health?
- There is no quick fix but there is a way forward.

A SYSTEM SAFEGUARDING THE MOST VULNERABLE

Insights from national practice and systems thinking combined with learning from the review identify a way forward.

Embedding the right behaviour and culture across all partners is central to successful change.

What if there was a simpler way and everyone worked together and listened to one another?

1

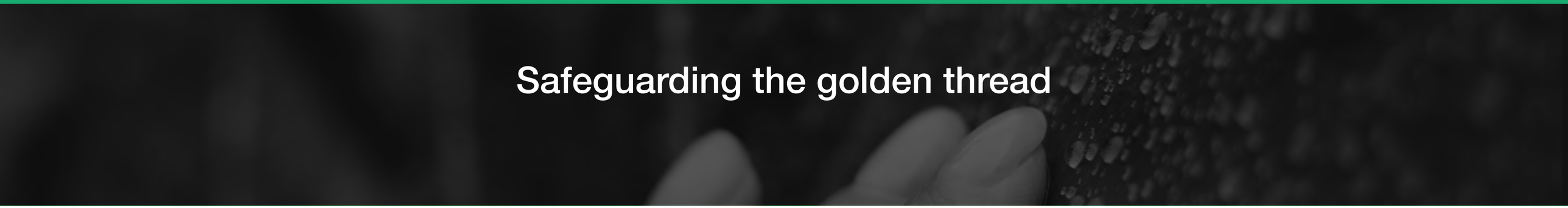
We learnt from reviews and could see the change in action

2

We stepped out from the boundaries of our own systems/ areas and there is organisational support to make this happen

3

There was a real collective commitment to build Think Family across the multiagency safeguarding system



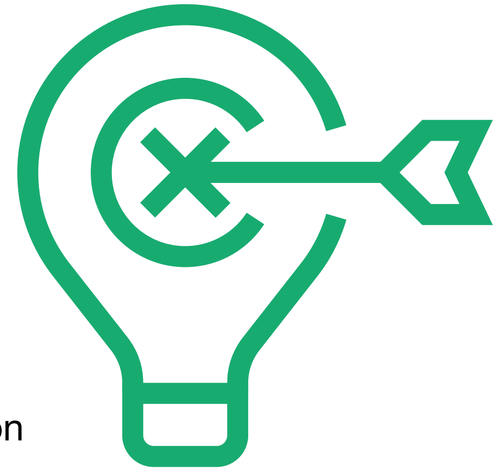
Safeguarding the golden thread

REMINDER

The Care Act states that:

“The intention of the whole family approach is for local authorities to take a holistic view of the person’s needs and to identify how the adult’s needs for care and support impact on family members or others in their support network.”

KEY MESSAGES REINFORCED



- **Consent should not be a barrier:**
  Non-engagement must trigger deeper exploration, not withdrawal.

- **Children's experiences must be visible:**
  Their voices were missing in real time and only surfaced after Rita's death.

- **Think Family must be embedded:**
  Not just a phrase, but a practice that bridges adult and children's services. An integral part of early help as well as universal cradle to grave services.

- **Information sharing is critical:**
  Especially across housing, education, health, and social care.

- **Trauma-informed systems are essential:**
  To avoid replicating the chaos and disconnection experienced by families.

- **Working with Fathers:**
  The voice of fathers is often not included in child protection work. We heard from family that vital information and context from earlier years was missed by not seeking out the children's father. South Gloucestershire Children's Partnership have developed a self assessment and planning tool to help practitioners to be more inclusive of fathers.

Working with Fathers | SafeguardingSouth Gloucestershire Safeguarding

THE BIG QUESTIONS

- What is the blind spot in the system?
- What is it that stops us from being curious and talking to one another?
- What assumptions might you be making about people you are working with that prevents you from understanding them and hearing their voice?
- What learning is there when families 'do not want to engage'?
- What will you do to ensure that there is earlier work in the process to think about risk when an adult has potential care and support needs and is a parent, or carer for another adult?
- What will you do to think about family and what they might want to say?
- What can you do to improve supervision and reflective processes that keep us critically focussed and balanced?
- **"What do we need to do to manage risk better?"**
  - Practitioners Learning Event

STEPS TO IMPROVEMENT

A key finding is that the challenges of working together are systemic, that is, they are deep rooted and part of the culture of how things are done.

The findings of this review reveal the disconnect that still exists across organisations. This makes safeguarding the most vulnerable in our society especially challenging in spite of the goodwill of people working in the systems.

Therefore, there are few recommendations but questions for the SAB to consider and action, including:

What needs to change so that we do not keep hearing the same recommendations?

RECOMMENDATION 1

“We make assumptions that we work well together”
-Learning Event Participants

The learning in this review about working together is replicated in other reviews. The SAB is asked to consider the following:

What conversations take place across the different Boards to share common areas of learning from reviews?

How do you work and share together as Boards?

If you knew that the system was working well together what would you be doing differently as leaders?

What is your role in promoting Think Family Work Family?

What is the system exploring to ensure that there is work towards a trauma informed way of working?

In order to do their work well practitioners’ need time for supervision and reflection how will you build this in? Staff identified this as major barrier.

RECOMMENDATION 2

Implementation of a Think Family Work Family (Leeds Model) Approach

It is essential to ensure that the needs of the entire household are considered. This requires a systemic, cross-cutting strategy that integrates Think Family principles into all relevant policies, procedures, workforce development, risk assessments and multi-agency frameworks.

The Safeguarding Adults Board (SAB) and partner agencies should conduct a comprehensive review of current Think Family practices. A briefing and protocol should be produced within six months, outlining strengths, gaps, and recommendations for improvement.

What practical steps can the SAB and partners take to ensure that there is whole family awareness?	What needs to change so that multiagency conversations take place earlier?	What common ground is there in the different legislative framework to help with consent and risk?	What learning is there from other areas?

“Do we need an early help family model?” - (Learning Event)

RECOMMENDATION 3

Referral Process: What is a good referral?

Review of the safeguarding referral forms for both children and adult services to ensure they reflect a working together approach:

- Consider an audit of referrals in the last 6 months of parents with care and support needs and outcomes of referrals.
- Review referral processes to include prompts/flags for engaging with and gathering information from the wider family and others working with a family at the earliest opportunity.

Encourage practitioners to explore family history and dynamics, especially when concerns are raised by family members.

“What can we do across the whole system to improve?”
-Learning Event Participants

RECOMMENDATION 4

Understanding complex and perplexing family situations

There were initial concerns raised by the education sector regarding the possibility of fabricated or induced illness. However, it appears that Rita appropriately brought the children to medical appointments. Despite this, Rita demonstrated a notable preoccupation with her own health, frequently discussing a range of physical conditions, including kidney disease and Behcets.

She was able to hold family and professionals ‘at arms length’.

While there is no confirmed evidence of fabrication, the complexity of this case warrants careful consideration. It is important for the safeguarding partnership to reflect on how best to respond to such perplexing and multifaceted presentations.

The Safeguarding Adults Board (SAB) should:

- Consider training on identifying and managing complex presentations in adults with potential fabrication
- The safeguarding children’s partnership and safeguarding adult board should request a review and audit of the Fabricated and Induced/Perplexing presentations-strategy. Consideration should be given to the needs of an adult who may fabricate illness/factitious disorder.
- All partners should consider how they work with people who have perplexing presentations and skilling up the workforce to think about unconscious bias.

Reflection Questions for Practitioners

1

What assumptions might you be making about the people and partners you work with?

2

How do you respond when someone declines support?

3

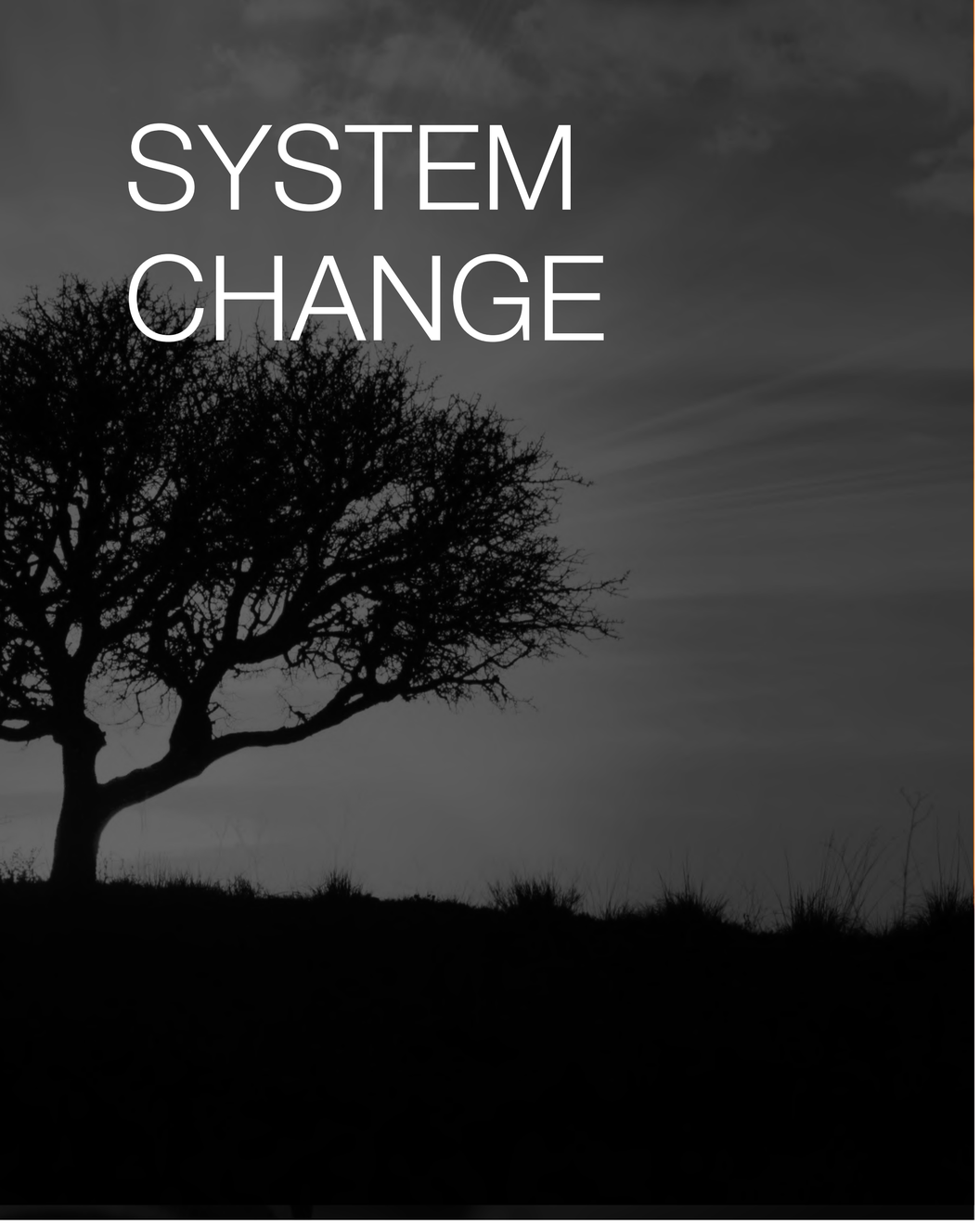
Are you truly hearing the voices of children and families?

4

What does “Think Family” look like in your daily practice?

SUMMARY: KEY TAKEAWAYS

- **Systemic Gaps:**
  Fragmented services and lack of shared information led to missed opportunities.
- **Children's Voices:**
  The lived experiences of children must be central to safeguarding assessments.
- **Trauma-Informed Practice:**
  Understanding complex trauma is essential for compassionate, effective support.
- **Multi-Agency Collaboration:**
  Effective safeguarding requires coordinated, early intervention across agencies.
- **Real professional curiosity:**
  Practitioners should explore beyond surface-level information and challenge assumptions.
- **Family:**
  Listening to the views and making contact with family members as well as the children is part of trying to build support. In Rita's case, family had significant history and insight that could have helped Rita and the children.
- **Final Thought:**
  'I wish someone had asked us' – a call to listen, connect, and act with empathy.



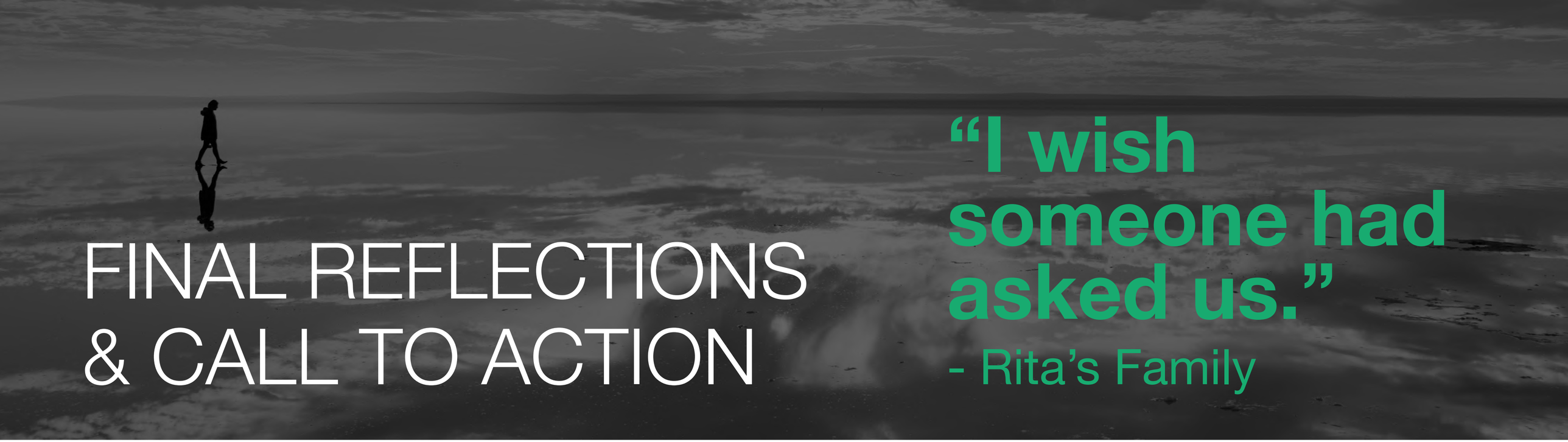
SYSTEM CHANGE

Heart of the Art

This means the real activity that encourages systems change is not analysis, or programme planning or project management. It is a relational activity that asks us to engage widely and openly, including with those who trouble us.

It asks us to enquire into their motive and means. It means we must be ready to listen more than to tell, to connect and not to direct, to propagate and not to control.

systems-leadership/encouraging-systems-change/



FINAL REFLECTIONS & CALL TO ACTION

“I wish someone had asked us.”

- Rita’s Family

- Rita’s life has shone a light on systemic blind spots in the multiagency system in South Gloucestershire.
- This review forces us to think about how systems work together across the whole life span and the importance of relational work.
- Rita was able to mask some of the challenges in her life and most importantly the experience of her children.
- We are left with hope that the children will experience life to the full and be able to process their trauma.

RESEARCH & LEARNING TO THINK ABOUT

Parental Non engagagement Understandings of Complex Trauma and Epistemic Trust 2020

MultiAgencyReform_Kantar_Report.pdf

Creative-Solutions-Forum-Plymouth.pdf

LeedsThinkFamilyWorkFamilyJan2025