Child Safeguarding Practice Review

Neglect Revisited

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1 Introduction

1.1 The Telford and Wrekin Safeguarding Partnership agreed to undertake a Child Safeguarding Practice Review (CSPR) to consider the local systems and practice where there are concerns that may indicate child neglect, using the learning identified from a case where a baby died[1] and there were concerns about neglect of the children in the household[2].

1.2 As a thematic CSPR (neglect) was completed just prior to this incident, it was agreed that the opportunity would be taken to consider the potential impact of the learning and proposed improvement actions on this latest case, and to agree any further recommendations that may be required. There were similarities between the two cases considered in the recent thematic review and the family being considered here, which warranted this approach.

2 The Process

2.1 An independent lead reviewer was commissioned[3] to work alongside local professionals to undertake the review. Information provided to the Rapid Review meetings was considered and additional information was requested from individual agencies via chronologies which included the identification of single agency learning and improvement actions that were required.

2.2 Professionals involved at the time were involved in a face-to-face group discussion with the lead reviewer that focused on practice in this case, the learning from the thematic review, and the wider system.

2.3 The lead reviewer met with both parents and then individually with the two older children to identify additional learning from their perspective. Their views are included in the report. The opportunity to meet with the children and ask them about their experience of services prior to the death of their sister was exceptionally helpful, and a separate piece of work is being completed to include their voices in training.

2.4 Learning was identified in the following areas[4] in the thematic CSPR undertaken earlier in 2022, which is also relevant to the case being considered by this review:

- The importance of knowing, seeking and sharing case history, including parental vulnerabilities
- Neglect (and the reasons for neglect) often reoccurs

[1] The cause of death has not yet been determined and criminal investigations regarding neglect are ongoing.
[2] The home conditions were reported to be unfit for the children. The referral for a Rapid Review stated that 'animal faeces was found throughout the home. Bedrooms were very dirty, with no toys or books, no bedding, black matters on mattress and faeces on the floor. No edible food was found in the fridge and rubbish was strewn all over the house. A strong odour permeated.'
[3] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and is entirely independent of the Telford and Wrekin Safeguarding Partnership
[4] Learning was also identified about concealed pregnancies which is not relevant to this review

- Family engagement challenges
- The cumulative impact of neglect
- Understanding the child's lived experience
- The effect of COVID-19 on services and families
- Impact of a new baby

2.5 Additional learning has been identified by considering this case in the following areas:

- Practice when a family move between local authority areas
- Cultural consideration, language barriers and gaps in a parent's history when they grew up outside the UK
- Considering, identifying and 'naming' neglect when a child has developmental delay
- Young carers

2.6 Recommendations were made in the thematic CSPR that are relevant to this review. They are:

Recommendation 1

That the Partnership recognises the need for, and implements, a neglect strategy and toolkit to improve the understanding of neglect and promote the early identification of children who may be at risk of neglect

Recommendation 2

That the Partnership Development Subgroup be asked to consider how it can build on recent work about barriers to engagement to ensure that it is addressed across all partner agencies

Recommendation 4[5]

The Partnership to ask for assurance that all schools are aware of the need to and are accessing information available to them about a child's history when they have any concerns about the child or their family

Recommendation 5

The Partnership to ask agencies how they are promoting and ensuring the expectation that professionals making a referral in respect of a child are checking their own systems to ensure they are aware of background, previous concerns and are including that information

2.7 Further consideration of any additional improvement actions that are required following consideration of this further neglect case is included below.

3 The case considered

3.1 This review has considered a family of four children. Detailed consideration was given to professional involvement with the family from June 2020 when they returned to Telford and Wrekin having spent around three years living in another Local Authority close to Telford and Wrekin[6]. The family were previously known to partner agencies in both Telford and Wrekin and the other Local Authority due to child safeguarding concerns.

3.2 The older children (referred to in this report as Child 1 and Child 2) had been the subject of child protection planning and spent time in care due to significant neglect, largely due to parental drug

[5] Recommendation 3 was in respect of concealed pregnancy, which is not relevant to this CSPR
[6] The name of the second Local Authority is not being disclosed to protect the identity of the family.

misuse, mental health, and criminality. They lived with their grandparents, who had Special Guardianship Orders, for eight years. The grandparents decided to return the children to their mother's care in 2018.

3.3 A third child (referred to as Child 3) had been born in 2017 to mother and her partner (referred to as Father in this review). This child was initially on a child protection plan and then a child in need plan in Telford and Wrekin when the family moved away in 2018. The child in need plan continued in the new Local Authority. Mother and the three children returned to Telford and Wrekin in June 2020 with the father of Child 3. Child 4 was born in April 2021.

3.4 At the time of the Child 4's death, Child 1 was living independently, and the three youngest children were allocated to the Strengthening Families[7] team in Telford and Wrekin, in part due to concerns about neglect of the children and the concerning home conditions.

3.5 The older two children were white British, and the younger two mixed white British/eastern European. Child 3 has significant development delay.

4 The Learning

4.1 The analysis below will consider the learning from this case, including a comparison with the thematic review and followed by areas for further consideration.

Seeking, knowing, and sharing the history for each child

4.2 When working with a family that is new to the area, or who have spent time living in another area, it can be more challenging to establish and access the family history. This case shows the importance of seeking detailed feedback from all involved agencies on what happened in the two years they did not live in Telford and Wrekin. The older two children's concerning earlier history was available to Telford and Wrekin agencies because they had lived here prior to their removal from their parent's care in 2010. It is clear however that the knowable history was not considered in detail by those involved from 2020. The pre-birth assessment on Child 3 was also undertaken in Telford and Wrekin and the child was on a child protection plan and then a child in need plan when the family moved to in 2018.

4.3 When the case was re-referred to Telford and Wrekin Family Connect[8] in 2020, the allocated social worker in the previous Local Authority forwarded the assessment that had been completed the year before and the most recent child in need review information with management oversight from June 2020, stating that a strategy meeting and section 47 enquiries should be undertaken, with a view to convening an initial child protection conference (ICPC) due to increasing neglect concerns and a lack of engagement with the child in need plan. This meeting was never convened as the family returned to Telford and Wrekin.

4.4 A new social work assessment was undertaken in Telford and Wrekin, but a strategy meeting was not held. With the extensive history, the change of circumstances and recent concerns, this would have been helpful, particularly if it had involved all of the professionals working with the family in both

[7] Strengthening Families provide local early help services for families with children aged 0-19 through children and family centres.
[8] The front door to children's social care, as well as the provision of advice, information, guidance and support on a full range of children's services.

areas. The assessment was undertaken promptly and involved direct home visits to the family during the Covid 19 pandemic. There is no evidence that the social worker spoke to the previous social worker or any of the other professionals who knew the family, including the children's previous schools or health visitor, however. There were no discussions with other professionals in Telford and Wrekin as the family were new to the area and had not yet engaged with schools or a GP. The two older children were spoken to, but the assessment was over reliant on self-reporting by the mother. At the conclusion of the social work assessment, it was decided that early help via Strengthening Families[9] was sufficient at the time. The social work manager who signed off the assessment was not informed of the decision made before the family moved that a strategy meeting was required.

4.5 There were several health visitors involved in decision making about the case following the families return to Telford and Wrekin. There was a gap of around a year however from when the family were last seen by a health visitor for the previous address and when they were seen, following the birth of Child 4, in Telford and Wrekin. While there is a record of a conversation between the health visiting service in Telford and Wrekin and the previously allocated health visitor, the child in need plans, records of meetings and so on were not forwarded to Telford and Wrekin or pursued by them. With a history of 'significant' developmental delay for the then three-year-old Child 3, and a history of non-engagement from the family, this was a missed opportunity to ensure, in a timely way, that her needs were assessed and being met.

4.6 The 0-19 service providing health visiting and school nursing assessed, at transfer in, that the family required a 'universal' level of intervention. There is no evidence of any challenge of this decision by any other professional, or of the decision by CSC that Strengthening Families should work with the family. Single agency learning was identified in respect of the delay of a year in the family being seen by a health visitor, bearing in mind the history from the other area and prior to that the older children's experience as young children in Telford and Wrekin. The fact that a social work assessment had been undertaken in Telford and Wrekin when the family first moved back to the area was reassuring for professionals, and no questions were asked about the quality of the assessment or the management sign off, and no consideration given to whether the family actually engaged with Strengthening Families, considering their history of sporadic engagement.

4.7 It is significant that the family did not go on to engage with Strengthening Families in July 2020, having told the social worker that they would. There was no re-referral to Family Connect by any agency at the time, and no request that the health visiting service visit Child 3, whose development had been the cause of some concern before the family returned to Telford and Wrekin. There is evidence that Strengthening Families informed the social worker who had undertaken the assessment directly about this lack of engagement, although they were no longer involved. No advice was given that a re-referral to Family Connect was required and there is no record of a discussion with a social work manager. This means that the on-going and escalating concerns about the children in the previous area after over a year of child in need planning were effectively 'lost' and the children were receiving less than universal services in Telford and Wrekin after a hasty move back to the area.

[9] Local early help services for families with children aged 0-19, provided through children and family centres

4.8 As well as the issues identified as part of the child in needing planning and shared with Telford and Wrekin following the families move, there were other concerns about the older children which were not explicitly shared. This included the potential exploitation and sexual abuse of Child 2 and concerns about the older children having caring responsibilities for the younger child. Child 2 was known to CAMHS when living at the old address but there was very limited engagement from the family to ensure that he attended. Mother told the review that Child 2 did not want to go, and that the social worker in the previous Local Authority was aware of this. The CAMHS worker had tried to transfer the case, but apparently the lack of the child being registered with a GP at the time meant this could not happen. What the information known to CAMHS indicated, was that Child 2 had an 'attachment issue', that he had been a victim of sexual abuse and exploitation, and that he had anger control issues and low-level criminal behaviour. At the time of the move back to Telford and Wrekin he remained vulnerable and in need of support and this was not provided in a timely way.

4.9 There had been ongoing concerns at Child 2's previous school about his poor physical presentation and incidents of him soiling himself in school, that were shared verbally with the new school in Telford and Wrekin after the move. The review noted that his written records had not been transferred however, and there were some delays in the receiving school escalating this. The expected timeframe for pupil records to be transferred to the receiving school is five days. For any child, the lack of records is concerning, but for a child with a history of safeguarding concerns and on-going challenges, robust practice is required. Both children told the review that they felt supported in the new school however and that there were members of staff that they liked and trusted. Child 1 said this gave her confidence to share her concerns about the care of the younger children.

Comparison with thematic review

The thematic review found that not all of those working with Family 1 knew the significant safeguarding history. This was due to records within agencies not being considered and the right questions not being asked of other agencies. To a certain extent this was also the case with the family being considered here. The decision to support the family without a child in need plan being in place when they arrived in Telford and Wrekin, after those working with the family previously had concerns that warranted considering a child protection conference, leads the review to conclude that the recent history and the ongoing vulnerabilities were not assessed thoroughly and that there was a lack of challenge from partner agencies about this.

Agencies shared in both reviews that they are reassured by CSC not having any concerns or when an assessment has been completed and resulted in no further action from CSC. There is a need to remain challenging of these decisions and consider if there remains a role for other agencies to assess and support families who have vulnerabilities, and for them to inform Family Connect of a lack of engagement. The parents told the review that they found the family support provided by Child 3's primary school very helpful, however.

Parental vulnerabilities

4.10 There was knowable information about the vulnerabilities of both parents. Mother and the father of the eldest children were known to have had significant issues when the older children were young,

leading to their removal from their care. The issues included substance misuse, what was recorded on systems as 'emotional domestic abuse' and poor mental health. At the time of the earlier concerns about the eldest children it was known that mother had experienced abuse and neglect in her own childhood, which had an impact on her parenting of the older children. This was not clear during the work undertaken when the family returned to Telford and Wrekin in 2020. A lot of information about Mother's history and more recent concerns was included at the time of the transfer. Mother told the review that she was felling overwhelmed with having to care for her older children when they returned to her care, and that she would have welcomes more help and support.

4.11 While the father of Child 3 and 4 was less well known, there was information held in Telford and Wrekin, as a local pre-birth assessment had been completed on Child 3, resulting in a child protection plan, and a 12-week parenting assessment was undertaken following her birth. It is not clear when Father moved to the UK, although he was thought to have been here for at least seven years. His UK GP information is unremarkable, but it is now known that he has a history of cannabis use and depression. He told the social worker after the death of Child 4 that he had spent his early years in a household where domestic abuse and physical abuse occurred, and that his father was an alcoholic. He was later cared for by both sets of his grandparents. This was not considered in the social work assessment completed in 2020.

4.12 When Mother presented with her pregnancy with Child 4 in October 2020, the midwife recorded Mother's history of depression and anxiety and previous use of cannabis (she said she had not used for a year). There was no record of any screening of the father's mental health[10]. Mother's midwife asked Family Connect about the family and was informed about the previous safeguarding history. There is no record that the midwife was aware of the recent concerns from the previous area or of the lack of engagement with Strengthening Families.

4.13 The health visitor who was involved following Child 4's birth met Father on occasion, and said he appeared to be confident in spoken English. She did not think that an interpreter was required. The review was told that during the parenting assessments completed after the death of Child 4, Father has been insistent that he did not require the support of an interpreter. When he was spoken to as part of the review, he stated that he did not feel he needed an interpreter and that he understood most of what was being shared. The reviewer reflected that while his English was certainly excellent, it was not always easy for her to understand exactly what he was saying. It was agreed with him that there is learning for professionals that they need to be very clear about whether they can understand and be understood when a service user has a different accent to the professional. It was agreed with him that understanding 80% is not sufficient when such serious issues are being discussed.

4.14 Like most of the professional interventions regarding the children prior to Child 4's death, the professional contact was predominantly with the children's mother. Professionals should always be aware of the need to consider available information on fathers/partners at all stages of intervention with families and meaningfully include fathers/partners in work with families. The agency responses to and in the rapid review meeting also made little reference to the father, and this appears to

[10] This would normally happen at the booking appointment, if the father was present. As there were still COVID precautions in place, most appointments only allowed the patient (i.e. the mother) to attend.

replicate the professional engagement at the time**.** Feedback has been given to the chair of the rapid review process regarding this finding.

4.15 The Strengthening Families worker who was allocated the case at the time of Child 4's death had noted in March 2021 that the couple had separated although they were living together. The potential stress of this arrangement on them and the children does not appear to have been pursued with them and there is no evidence this information was shared with other professionals.

4.16 This case shows the need to be robust in seeking information held within agency records and from other areas, and the need to challenge parents if their explanation of the history differs from what is reported. This does not appear to have happened at the beginning of the involvement of Telford and Wrekin agencies in June 2020, when the seemingly positive social work assessment, almost entirely written on the report of the mother, led all agencies to think that all was well.

4.17 There is also a need for the provision of challenging and reflective supervision when a professional is considering the case history and the impact of a parent's vulnerabilities on their child/ren to avoid over optimism, underestimation of the impact, parental avoidance and the need for effective challenge when there are concerns about the actions of other agencies and the effectiveness of a plan for a child.

Comparison with thematic review

The two cases considered in the thematic review showed the need for professionals to consistently consider and understand how a parent's vulnerabilities and experiences of trauma throughout their life pose a potential risk to their child/ren, and the ongoing impact of this. The case of Family 1 in the thematic review, where there had been child protection planning in the past due to concerns about the mother's parenting of the children, linked in part to her mental health problems, shows the importance of understanding the history. A full understanding of the parents own histories and impact on their parenting, along with a consideration of what has changed for the better was also required in this recent case when the family moved back to Telford and Wrekin.

As stated in the thematic review, partner agencies need to ensure that all relevant professionals have the resources and capacity to seek and consider the case history and any information about vulnerabilities of the adults in all cases where there are concerns. Those involved with this family reported that the main issue is that there is not always time to consider historic information, and that it can be time consuming and difficult to access historic information or detailed information from other areas. The review was told that actively seeking detailed information is rarely justified in cases unless there is a plan to go to court.

The thematic review made recommendations about the need for schools and professionals working with families, such as health visitors and school nurses, to access and consider information within their own agencies when they have concerns about a child. This was also found to be an issue in this CSPR.

There was little curiosity about the younger children's father's history. He was living with the family

for some time. He was present on occasion when professionals visited, and he attended some of the meetings held with the schools and Strengthening Families.

Engagement challenges

4.18 The previous CSC had informed Telford and Wrekin Family Connect that the parents had not engaged with their child in need plan and that there were ongoing concerns about the children at the time of the move. The previous health visitor also shared this with the health visiting service when the family moved. Following the end of the social work assessment in June 2020 until the birth of Child 4 (a period of around 10 months) there was very little contact from professionals with the family, as they had not engaged with Strengthening Families and had not responded to a phone message from the health visiting service. The older two children were enrolled in a secondary school in Telford and Wrekin from September 2020. While they had missed around a month of education prior to the school holidays starting, COVID 19 was still a concern in schools, and this was not thought to be overly significant for either child. There were some low-level concerns about Child 2 in the first year of his attendance at secondary school in Telford and Wrekin, but no significant issues emerged at the time.

4.19 There was a gap in the involvement of a health visitor, which was significant due to Child 3's emerging special needs. When the family had moved back to Telford and Wrekin, a health visitor in the Families First service was contacted by the previous social worker. Families First is the health visiting team that exclusively works with children with an allocated social worker due to them being on a child in need or child protection plan. This was relevant at the time as the children were on a child in need plan and a social work assessment was being undertaken in Telford and Wrekin. The background was shared by the previous health visitor, including the history and ongoing concerns about neglect. When the Families First health visitor checked the status of the case with Family Connect, they were told that the social work assessment was complete with no further action, so the health visiting responsibility was transferred to the community health visiting service as a universal case. There was no challenge of the conclusion of the social work assessment. The opportunity to consider the ongoing concerns about Child 3's developmental delay does not appear to have been taken on the families return to Telford and Wrekin. Child 3 was not seen by any professional for around a year, other than for her immunisations at the GP surgery.

4.20 A telephone message had been left on Mother's phone by the community health visiting service asking her to call to make an appointment for a home visit in August 2020. This was not responded to and was not pursued. It is not known if the number being used was correct, as Mother has had several different numbers. There was no further health visitor involvement until after the birth of Child 4, ten months later. Midwifery had been involved in the meantime, and they had gained Mother's consent for a referral to Family Connect due to concerns about her smoking. Family Connect advised the midwife to complete an Early Help Assessment. There is no evidence this happened. Post-natal home visits were completed by the midwifery service as expected when Child 4 was born, and no concerns were recorded about the home or the new baby. They understandably were not focused on Child 3.

4.21 When the newly allocated health visitor undertook a new birth visit to Child 4, they met Child 3 and were alerted to the child's developmental delay and the previous involvement of services like speech and language therapy before their return to Telford and Wrekin. This led to timely practice from the health visitor who undertook assessments, visited regularly, and made appropriate referrals in respect of Child 3's apparently significant vulnerabilities. She reflected, during this review, on the home conditions at the time, and said that while it was sparse and slightly cluttered upstairs, she had no concerns about hygiene at any time in the 6 months she was involved (until December 2021).

4.22 Mother told the social worker at the time of the return to Telford and Wrekin that she was returning because she had family support that was available to her locally. No professional involved at the time knew any more in respect of what help and support the wider family could or were providing, It would have been helpful to pursue this when it became apparent that the parent's were struggling to manage.

Comparison with thematic review

The two cases considered in the thematic review had clear issues with the lack of parental lack of engagement, and the children's homes not being seen by those working with the family, other than one room in the case of Family 1. In this case there were periods where there was little engagement, such as prior to the move back to Telford and Wrekin, with Strengthening Families in June 2020, the lack of GP registration for the older children in Telford and Wrekin, with the nursery nurse in 2022, and increasing avoidance of school staff at the start of 2022. There had been good engagement with the health visitor until December 2021 and other services in respect of Child 3's developmental delay prior to this however, which led to a degree of optimism about the family's willingness to engage with professionals in their children's best interests.

Research and learning about the impact on professionals of parental non-compliance, or where a parent does just enough to keep professionals at bay, was outlined in the thematic review when considering Family 1.

Neglect is an issue that tends to reoccur in families. In this case there had been years of neglect of the older children when they lived in Telford and Wrekin, resulting in their removal from their parent's care. Then there had been child protection planning in respect of Child 3 both pre and post birth. In the previous area there were increasing concerns about the children being neglected just prior to their return to Telford and Wrekin. It was optimistic to imagine that neglect would not be an issue again, particularly following the birth of Child 4. There were opportunities to 'think again' about the case at a number of points during the last year, and as recently as when the primary school made a referral to Family Connect and multi-agency checks were undertaken in January 2022 (see below.)

The same was the case for Family 1 in the thematic review, where there had been safeguarding concerns in the past about the children, including child protection planning. A full understanding of historical information must always inform decision making, along with consideration of what has changed, with an awareness that neglect tends to reoccur.

Exploring and considering the child's lived experience

4.23 In this case there were four children of differing ages with different needs that needed considering. When some children in a family have special needs, as it appears that Child 3 and to a lesser extent Child 2 did, this can lead to the eldest (and apparently self-sufficient) child and the youngest child, a baby with a limited 'voice', to be overlooked. Shortly after the family's lack of engagement with Strengthening Families following their return to Telford and Wrekin, the mother became pregnant again with Child 4. There was no consideration of the impact of a new baby on the older children and on the parent's ability to cope, or any consideration of the vulnerability of a new baby living in the household. Both children told the review of their anxiety at the time about the care of the younger children.

4.24 While there is evidence that the older children were met with and spoken to as part of the professional involvement with the family, there was less consideration of the unborn / Child 4. This may be because the older children were in school, because they had specific needs that were a focus for professionals, and because the early help assessment completed in December 2021, when Child 4 was eight months old, was undertaken by the primary school where Child 3 attended. This was a good assessment that included the impact on the family of having a young baby in the home, and the impact on the baby of the mother having to also meet the needs of two children with special needs. Information from Child 2's school was included, with details of the concerns they had about him. No earlier assessment, either early help or social work, had been completed during the pregnancy which means there was no focus on the impact this would have on the wider family or any specific needs and risks in respect of the new baby.

4.25 There were times where the children's 'voices' were evident and needed to be heard about their negative lived experience. There were the more obvious occasions, like the sharing of information by Child 1 about her concerns for her siblings shortly after she moved out to stay with a friend on her 16th birthday. Child 1 told her school in early April 2022 how worried she was that her mother was unable to maintain the home and care for the children, and implied that now she was no longer living at home, it was Child 2 who undertook most of the childcare of the younger siblings and that he wasn't equipped to do this. She painted a very bleak picture of the home life of the children. Child 1 told the review that it was not easy to speak about her concerns and that she knew it would have a negative impact on her relationship with her mother. She did not feel listened to other than by those supporting her at school. She reflected during the review that she felt her mother's voice and denial were taken more seriously than her disclosures.

4.26 At the time Child 2 was spoken to at school. Child 1 had said that her brother would not confirm the neglect, even if asked, as he was scared. The responsible Strengthening Families worker saw Child 2 at school, and indeed he was positive about his life and the home conditions, saying he 'wouldn't change a thing'. The thematic review includes analysis about children often being careful what they tell professionals and how they can be reluctant to show disloyalty to their parents or concerned about what will happen if they do say what is happening at home. The allegations about Child 2's inappropriate responsibility for his siblings was discussed with Mother at a virtually held Early Help

Support Planning meeting held the same week as Child 1's allegations, which she denied. When the Strengthening Families worker visited the home shortly afterwards, she recorded that the improved home conditions had been maintained, which also undermined what Child 1 had alleged about the deteriorating picture. Child 1 told the review that all the visits to the home were arranged in advance and that they would have to clean and tidy in preparation. Her view is that there needed to be unannounced visits to understand how the family were really living most of the time. While working with a family on a universal or early help basis, there are rarely unannounced visits by professionals. As part of the service provided by Strengthening Families however, this could have been agreed with the family as part of the support. If the family did not agree, this may have been a reason to step up the intervention to child in need.

4.27 There were other indicators that the eldest children were unhappy, including Child 1 voicing her feelings of abandonment by her grandparents and by her mother. The school reported that her general demeanour was of anxiety and unhappiness. Child 2 was excluded from school for physically assaulting another pupil shortly after he started school in Telford and Wrekin, he was noted to have drawn pictures of hangings, and the school recorded in October of 2021 that he was hungry, thin and dirty with damaged uniform. Both children told the review that when they were living at home they were often hungry. Child 2 said he now believes that he should have been taken into care sooner. Neglect in teenagers is not always clearly indentified and it is essential that professionals consider what they see and hear through a safeguarding lens if it is to be identified and appropriate support offered. This was also found in the thematic review.

4.28 Less obvious, but just as significant, was what Child 3's developmental was 'telling' professionals about her lived experience. The school made a request for service to children's social care in January 2022 where they shared their concerns about Child 3's neglect. It was not specifically considered by health professionals when assessing her delay prior to the death of her sibling however. This was despite the family history of neglect of the older children and the more recent concerns in the previous area, and information held by her school. It had been documented in the summer and autumn of 2021 that a possible cause for the significant developmental delay for Child 3 was 'poor socialisation', which was being seen more generally in children following the pandemic. When the Speech and Language Therapist assessed Child 3, she was found to have significant speech, language and communication needs. The fact that her father was eastern European was noted, with the impact of dual language heritage being considered. This was good practice, however there was no evidence that the family spoke anything but English at home, and this should have been known and considered during the assessment. A telephone assessment was completed by the Community Paediatrician in October 2021, and a further assessment was undertaken at Steppingstones in January 2022 and followed up at the Community Paediatric clinic in April 2022. Neglect was not specifically raised as causing, contributing to, or exacerbating the developmental delay by any of the health professionals involved with Child 3. The paediatricians confirmed to the review that they were not aware of the history of neglect and were focussed on identification (or elimination) of a medical cause for the developmental delay. The speech therapist was not aware of the history, although was aware that Strengthening Families were involved and thought it was because of Child 3's dental

caries and Mother's need for support in meeting her needs. If there had been communication between those assessing Child 3 and her school, their neglect concerns would have been shared.

4.29 As well as her delayed development, there were other indicators that Child 3 was experiencing neglect. Most significant were her reported 'black teeth', which the school listed as a sign of neglect in their referral in January 2022. In July 2021 Mother had told the health visitor that she had not been able to register with a local dentist. In the September the school spoke to Mother about their concerns for Child 3's teeth and referred her to the specialist dentist, supporting her with booking an appointment. Child 3 later saw the community dentist and a plan for dental treatment was made. It seems that Child 3's developmental delay and emerging learning difficulty were the focus of the health professionals concerns about dental hygiene, with Mother stating that Child 3 would not let her clean her teeth, rather than this being seen as a potential sign of neglect.

4.30 The health visitor told the review that she had been reassured by the mother's apparent willingness to engage with her and with the speech and language service. After the health visitor had an unplanned extended period of time off work from December 2021, a nursery nurse was assigned to the case and found Mother avoidant. The primary school that Child 3 had started in the September of 2021 had increasing concerns about Child 3's appearance as 2021 ended and in January 2022 concerns also begun to emerge about poor living conditions and the parents avoiding school staff. The primary school attended had undertaken a home visit on 13th January 2022 and had noted concerns from the doorstep, where they had spoken to Mother who did not let them enter the home. This included a smell of cannabis from the property.

4.31 The primary school made a referral to Family Connect. Multiagency checks were completed by and a decision was made that it was an early help intervention that was required, and a Strengthening Families practitioner was allocated to continue working with the family. The opportunity to consider a further social work assessment at this stage was not taken, probably because Mother agreed to work with Strengthening Families. This means that work was undertaken to address the poor home conditions without an understanding of why neglect was again an issue for the children, which a qualified social worker would have considered. Strengthening Families visited and provided direct work to the family to address the issues in respect of the state of the home. Over the course of the next week, a plan was made with the family to de-clutter and clean the home, including the provision of two skips. There is no evidence that the concerns about cannabis were addressed with the family, despite the known concerns in the past about the impact of cannabis on Mother's parenting. The review was told that work is now being undertaken with Strengthening Families and CSC staff regarding the need to understand family culture, vulnerabilities, and drivers, rather than providing simple short-term solutions like the provision of a skip.

4.32 There followed a largely positive view from the Strengthening Families worker of the improved conditions being maintained over the following months, although both the secondary and primary schools had ongoing concerns that the children were still coming to school dirty, and Child 1 was clear that the house was very dirty and that her mother would not clean it, as described above. There was no evidence that there was any meaningful consideration of where Child 1 was living and who

with at this time. She was just 16 years old and still of statutory school age. This concern has been shared with CSC who are seeking to engage with her regarding support.

4.33 At an early help meeting was held on 7th April 2022 where concerns about Child 2 and Child 3 were shared. There is no evidence that the use of cannabis was discussed. Mother told us she was using cannabis at this time, and that it was a crutch to her whenever she was stressed. The health visitor for the baby was not present so there was no consideration given to Child 4. (This appears to have been an oversight, and it was agreed at the meeting that the health visitor should be invited to the next meeting.) The same day 11-month-old Child 4 was seen by the primary school and was noted to have two small ('pea-sized') bruises to her forehead. Her mother stated that she was just starting to sit up and had fallen forward. This was reported to Strengthening Families as the case was allocated there, not to Family Connect. The school told the review that they would ensure that they also referred to Family Connect in future when there was a bruise noted on a baby. During the post-mortem undertaken on Child 4 around two weeks later a bruise was noted on the forehead, along with several bruises on the lower arm, a mark to her finger and some nappy rash.

4.34 The review is concerned that the focus at the time was on the school age children, and that Child 4 had not been specifically seen by any professional for a number of months. The concerns about Child 3's developmental delay had dominated the professional contact from the health visitor in the second half of 2021, and the family had not engaged with the nursery nurse who was supposed to be involved from January 2022. The Strengthening Families worker visited the home six times in 2022 and there is no reference in the records about Child 4's development and wellbeing. The fact that a key protective factor, Child 1, was no longer living with the family also required consideration. The review also questioned the explanation from Mother that 11-month-old Child 4 was just starting to sit up, which may have indicated some developmental delay as babies typically sit up with support at around 6 months old, and unaided at around 8 months old.

4.35 The next and last recorded contact with the family prior to Child 4's death was during the school Easter holidays in 2022, not long before Child 4's death. The Strengthening Families worker recorded that she had visited the family and that no bruising was evident on Child 4, as this had been reported by the school a few days earlier. Mother had shared that she had concerns about her own mental health to the Strengthening Families worker and was advised to see her GP. It appears that a referral to Improving Access to Psychological Therapies (IAPT) for Mother had been made by the Strengthening Families worker a few weeks before, but IAPT had not been able to contact mother due to a change of phone number.

4.36 It was specifically recorded that the home conditions were good on this visit and had been maintained, including the bedrooms (other than Child 2's bed where his bedding was 'balled up on the bed'[11].) It was just less than a week later that Child 4 died and serious concerns about the state of home were identified. The police officer and duty social worker stated that it was extremely difficult to imagine how such a deterioration was possible in just one week. Neither the review or the managers

[11] It is noted that on the night when Child 4 died, she had been sleeping with her 14 year old brother in this bed. However, the police told the review that co sleeping did not contribute to her death

at Strengthening Families have been able to discuss the visit of 11th April with the worker or their direct line manager, however further action is being taken outside of this review about this visit.

Comparison with thematic review

The thematic review found that a new baby in a family can lead to a decline in the care of the older children, and that the demands of the older children's needs can impact on the care of a baby. This was found in the thematic review with Family 1. In this case, within six months of the new baby arriving, the eldest child elected to leave the family and withdraw her help and support, which she told her school she felt very torn and guilty about.

When Child 2 was asked directly about how things were at home, they were positive and said all was well. He was also seen by the school nurse and painted a glowing picture of his home life and his own wellbeing. This was despite evidence that he had been soiling. This is similar to what was found in the case of Family 2 in the thematic review. It is well established that children can be torn about involving professionals in their family lives, and that they may feel conflicted and/or concerned about sharing too much about their home or any concerns they have, and that they may have been coached to lie to professionals. The need to listen to the views of teenagers can provide a dilemma for professionals, as it will be very difficult for them to be honest about their home life and for a child protection threshold to be reached. Any discussions with children need to recognise how difficult it will be for them.

The thematic review found learning about the need, when recognising and identifying neglect, for professionals to explore and understand a child's lived experience. Reflection was also identified about the following:

- Recognise the cumulative harm to children when they experience neglect over time, which is also an issue in this case.
- The impact of poverty on a child's lived experience and outcomes, but the need to understand that child neglect is not due to poverty and professionals must ensure they do not become immune to neglect in areas of high deprivation.
- Evidence that other forms of abuse co-exist with neglect, with children who experience neglect being more likely to experience other forms of abuse including physical harm and sexual abuse. This was potentially an issue for Child 2 in this case.
- The importance of professionals being actively curious and rigorous.

The analysis and research included in the thematic review in respect of the above will not be repeated here, but it is important that all professionals with responsibility for safeguarding are aware of the importance of considering these themes, which were also evident in this case.

Impact of COVID-19

4.37 The thematic review noted the general impact of the pandemic on both professional interventions and families. In both cases there was a direct impact, and this review has found the same. The family made the move at the end of the first national lockdown into privately rented accommodation. Services were said to be getting back to normal. However, there was an ongoing impact on services

of the COVID-19 disruptions to services, such as health visitors returning from being redeployed (in line with national guidance) which had an impact on contact with children who were not thought to be particularly vulnerable, like this family.

4.38 Even when there was no national lockdown, the ongoing cases of COVID had an impact on staffing and also on seeing families. There were no home visits from the Strengthening Families worker between 28th March and 7th April 2022 as the family had reportedly tested positive for Covid. This was around the time that the school had increased concerns. Antenatal home visits from health visitors were also changed to phone contact.

4.39 Both parents told the review that the pandemic had a negative impact on their mental health. Mother said this was acknowledged by professionals in respect of her, but not known in respect of Father, who was not asked. He was doing two key-worker delivery jobs during the pandemic and was struggling with the pressure of the long hours. The NSPCC published a statement in 2021[12] outlining the likely 'long-lasting impact on the future health, wellbeing and life chances of babies born during the pandemic, as parents face heightened stress, social isolation and mental health problems' with their helpline receiving a 44% increase in calls about this. A survey undertaken during the pandemic by Parent-Infant Foundation, Best Beginnings and Home Start found that 6 in 10 new parents shared significant concerns about their mental health because of the additional stress caused by COVID.

Comparison with thematic review
In the case of Family 1 in the thematic review it was noted that the primary school was not doing visits to the family home prior to a child starting in Reception, as had been their practice prior to the pandemic. This means they did not have the insight this can give into a child's home life. It was the same for Child 3 in this case, as she started school in September 2021. The two eldest children continued to attend school throughout the national lockdowns, in both areas. This was good practice in Telford and Wrekin, as this was facilitated despite the children not being subject to any plan. The children both told the review about their positive relationships with school staff, so their on-going attendance would have been most helpful to them at the time.

5 Conclusion and recommendations

5.1 This CSPR has considered the learning from a case where serious neglect was identified following the seemingly unrelated death of an 11-month-old child. As there had been a recent thematic review into neglect, this case was considered alongside the learning from the previous cases, and several similar issues were found.

5.2 The review aimed to consider if any further recommendations are required, as recommendations have already been made in the following areas:

- The need for a neglect strategy and toolkit to improve early identification
- Addressing barriers to engagement
- Seeking and considering historic information

[12] https://www.nspcc.org.uk/about-us/news-opinion/2021/pandemic-parent-mental-health/

5.3 It was agreed that the additional learning from considering this family were in respect of practice when a family move between local authority areas, the need to consider any cultural and language issues when working with a family with dual heritage and where one of the parents grew up outside of the UK, the need to identify and 'name' neglect when there is developmental delay, and the identification of young carers. When a child is on a child protection plan there are clear procedures to be followed when the family move. The procedures are less specific when a child is 'in need'. The West Midlands procedures[13] state that there is an expectation that the receiving authority, along with health services and education, are informed that the child/ren have moved. The receiving CSC should undertake an assessment within one month, which happened in this case. The issue the review has found was with the quality of this assessment and the impact this then had on the way that the family were seen and served by other agencies. There was also a lack of agency challenge regarding the decision to discontinue the child in need plan after the family moved into the area.

5.4 The following additional recommendations are therefore made:

Recommendation 1:

That this opportunity is taken by all partner agencies to remind professionals of the need to:

- Be culturally aware and competent in assessments and direct practice.
- Be sensitively honest about any difficulties in understanding a parent when English is not their first language.
- Identify and support young carers.
- The need to consider the needs and vulnerabilities of **all** members of the family.
- Include unannounced visits in plans when working with a family where neglect and household conditions are a concern.

Recommendation 2:

That the Partnership considers how it can ensure improved and good practice regarding safeguarding children who move across local authority borders, including those who are children in need.

[13] https://westmidlands.procedures.org.uk/assets/clients/6/Part%201/Protecting%20children%20who%20move%20across%20local%20authority%20borders.pdf