Thematic Child Safeguarding Practice Review

NEGLECT

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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 two different cases.

1.2 Family 1 were considered at a Rapid Review meeting in November 2021 following the death of a four-week-old baby. There do not appear to be any suspicious circumstances regarding this child's death. An inquest has been held and the coroner has closed the file. Following the death, significant concerns were identified about the living conditions of the baby and their siblings, who were living in the family home with their mother as their sole carer. The mother of the children has accepted an adult caution for child neglect. The relevant older children range in age from two to seven years old. Some had previously been on a child protection plan (CPP) for neglect, alongside concerns about physical abuse, domestic abuse, and the impact of the mother's mental health on the children. This was followed by six months on a child in need plan. It is not clear who the father of the baby was. The children are mixed parentage, white British, and black Caribbean.

1.3 Family 2 were considered at a Rapid Review meeting in February 2022 after serious concerns emerged about the home conditions. The experienced police officers and EDT[1] social worker who attended the home described the conditions as the worst they had ever encountered where children were living. The family is made up of three children, one at primary school and two at secondary school. They lived with their mother and had regular contact with their father. The children had not been known to the police or children's social care (CSC) previously. Both parents had historic involvement with services, the mother due to serious abuse when she was a child, and the father due to his mental health and previous heroin use. The children are white British. The mother has been convicted for child neglect.

1.4 Police protection powers followed by care proceedings were used in both cases.

1.5 It was agreed that a thematic review should be undertaken, as the information shared about the similarities in both previously unidentified neglectful home conditions resonated with decision makers.

1.6 Learning has been identified from considering the professional involvement with the children considered in the following areas:

- The importance of knowing, seeking, and sharing case history, including parental vulnerabilities
- Family engagement challenges
- The cumulative impact of neglect

[1] Emergency Duty Team – provide out of hours social work responses in emergency situations.

- Understanding the child's lived experience
- Concealed pregnancy
- The impact of COVID-19

2 The Process

2.1 An independent lead reviewer was commissioned[2] 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 two case specific face to face group discussions with the lead reviewer that focused on practice in the cases and the wider system.

2.3 The lead reviewer had hoped to meet with both families, including the children in Family 2, to identify additional learning from their perspective. Despite attempts to do so, neither family agreed to discuss the review with the lead reviewer or a representative of the partnership.

3 The Learning

3.1 The learning identified for the safeguarding system and partnership is highlighted below, followed by detailed and case specific analysis.

Learning point 1: Sharing information about a child's history, a parent's vulnerabilities, and any on-going or current concerns is essential when considering if a child requires support, an assessment, and/or a safeguarding response.

3.2 The CSPR has identified several areas where knowledge about the family history was lacking, particularly in respect of the children in Family 1. The children attended schools where none of the education staff or the school nurse were aware, until just before the baby died, that the children had been on a child protection plan until November 2018 and a child in need plan until May 2019, and that their mother had impacting struggles with her mental health and a history of relationships where domestic abuse was a concern. This was even though the information was available to them in agency records. It is acknowledged that the child was no longer on a child protection or child in need plan and was just receiving universal services when they started school. Had the children been receiving an enhanced health visiting service at the time, they would have been identified to the school and the school nurse as vulnerable by the health visitor who knew the history. The 0-19 service however have records that are available across the service, and there was an opportunity for the school nurse to check the records and share information with the school at the time of their involvement, and single agency learning has been identified in respect of this.

3.3 If a school nurse is not involved however, there is still a need for school to be aware of concerns identified pre-school. This is a systemic problem as it is known that domestic abuse, parental mental health concerns and neglect of children are likely to reoccur, and those who work with the children need to be aware of this type of history to be alert for any such recurrence. It was just before the

[2] 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

completion of this review that it was identified that information about the previous child protection plans in Family 1 was available to the school. It was within the CPOMS[3] system and a member of staff from the school had uploaded this to the system. Single agency learning has been identified regarding the importance of checking information on the system when any concerns emerge about a child.

3.4 When children start school there is a reliance on the parent or carer to be transparent and inform the school of current or past involvement from CSC. A specific question is asked on the enrolment form. Mother 1 did not disclose any history of social work involvement, or the fact that she had two older children who were not in her care. These children had gone to live with their father in 2018 due to child protection concerns while they were living with their mother. Around the same time, Mother 1 was given a working diagnosis of borderline personality disorder and prescribed medication but was subsequently discharged from mental health services due to non-engagement. She had no active mental health support when the eldest relevant child started school, other than medication prescribed by her GP. The school/s the child attended, and the nursery attended by the next sibling down, reflected that it would have been helpful to know the safeguarding history and Mother 1's particular vulnerabilities; firstly, for planning how to communicate with the mother when there were concerns; and secondly to ensure that they were able to provide additional support as required. It would also have empowered the school when they referred one of the children to school health for an assessment and when they completed a Request for Service form to Family Connect[4] by including the family history alongside their current concerns.

3.5 The review has identified significant histories of abuse and neglect in the childhood of both mothers. They were both subject to child protection plans as children and spent time in care. There has been extensive research into the impact of 'adverse childhood experiences' that shows that when a person experiences abuse or neglect as a child, and the longer they experience it for, the worse their physical, mental, and social outcomes are likely to be. This includes the possibility that their children will be known to safeguarding services, and that they will require support in the future with their longer-term mental health. This appears to be relevant in both cases being considered by this review, as there is now evidence of both mothers struggling with their mental health. For professionals working with children where there are emerging concerns, as was the case in both Family 1 and Family 2, an awareness of parental childhood trauma and adult mental health concerns can ensure that they are able to recognise as early as possible that the children may need additional monitoring and family support.

3.6 In both cases there were historic or indicators of current parental mental health issues, which needed to be considered in the context of the impact on the care provided to the children. It is now known that Mother 2 had a very difficult childhood including time on a child protection plan and in care following serious and prolonged abuse and neglect. This information was available on her GP records, but there was no justification for making GP checks for her prior to the police protection orders. What it does reinforce however is the lifelong impact of abuse and neglect.

[3] Child Protection Online Management System,

[4] Family Connect in Telford and Wrekin is a one stop front door for advice, but also to make a referral to CSC.

3.7 Father 2 was receiving mental health support at the time that the primary school began to have concerns about the youngest of the three children. While his GP was aware that the father was experiencing reoccurring mental health issues and was considering suicide, and that there was a risk of relapse into heroin use, he was reassured by his patient stating that his children were the reason he would not act on his thoughts. While the children being a protective factor may be positive for the adult, this needs to be reframed to consider the negative impact this can have on the children who are likely to have concerns about their parents. However, as Father 2 did not live with his children and was not known to regularly have care of them, there is no evidence that the GP and IAPT[5] professional that spoke to him 'thought family' and considered the impact on the children. This is likely to be, in part, due to a presumption about gender roles.

Learning point 2: Professionals remain concerned about sharing or requesting information unless they are clear that there are child protection concerns.

3.8 There are few reviews where learning in respect of information sharing is not identified. To safeguard and promote the welfare of children, information sharing is vital. The 2022 Child Safeguarding Review Panel's report Child Protection in England – the national review into the murders of Arthur Labinjo-Hughes and Star Hobson states that 'there were three main information sharing issues: a lack of timely and appropriate information sharing; limited information seeking; and evidence not being pieced together and considered in the round.' They point out that to provide the right support and understand potential or actual risks, professionals need to have to have a full picture of what has happened and what is happening in a child's life.

3.9 It is important that professionals seek information, share information, and aim to have a full understanding of the vulnerabilities and risks. This means that there is a need to ensure that information is both requested **and** shared during any conversation held about a child. In the case of Family 1 there was an opportunity for Family Connect to ensure the school were aware of the historic child protection information when a request for services was made to then by the school in July 2021. During the meeting held with practitioners to discuss Family 1, a view was shared that professionals 'don't ask and don't tell' due to concerns about data protection and the need for consent. As the national CSPR panel says in their 2022 review, 'time and again we see that different agencies hold pieces of the same puzzle, but no one holds all of the pieces or is seeking to put them together.' To ensure that children are appropriately safeguarded, the aim should be to encourage and support professionals to seek all of the pieces, share the pieces known to them, and work together to see the whole picture without fear of reprisals or breaking data protection legislation. There must be consideration of the need for consent, but when there are or have been safeguarding issues in a family, the lack of consent should not impede information sharing. A discussion with Family Connect can help professionals who are unsure of what they can share or request, and safeguarding supervision can be helpful in supporting professionals in this difficult area of practice.

3.10 It is known that Family Connect did a thorough piece of work that was completed in November 2021 where all the family history was compiled and shared with health and education colleagues within

[5] Improving Access to Psychological Therapy is an NHS service designed to offer short-term psychological therapies to people suffering from low mood, anxiety etc.

Family Connect which was then shared with professionals working directly with the children, including their school. While this was good practice, this was some months after concerns emerged and just prior to the death of the baby and the identification of the appalling home conditions.

3.11 In the case of Family 2, there was significant delay in acting following an anonymous referral to Family Connect sharing concerns about the children on 13 December 2021, which included the potentially significant allegation that the children were living in a home without gas and electricity or adequate food. This was due to the perceived need at Family Connect to gain parental consent prior to speaking to other agencies and embarking on an assessment. The information shared implied that the children were suffering neglect from their mother who they lived with. What was shared was not thought at the time to meet the threshold for a strategy meeting and S47 response however, so parental consent was required for information sharing and assessment. This was a reasonable decision on the day, particularly because the family were not previously known to CSC, however, when the mother did not respond to numerous attempts to contact her by phone, text message, letter and two attempts to knock on the door, there was no reconsideration of the matter until 7 January 2022 when it was agreed that the youngest child's primary school should be contacted. The school shared that they had very little contact with the children's mother themselves, and that it was the father who they mostly saw and would contact if they needed to speak to a parent. There were some concerns, that had been shared with the father the previous November, including poor attendance and punctuality and the child appearing pale with thin and patchy hair. The father had given consent for a referral to the school nurse, who undertook an assessment, recommended a GP appointment due to possible anaemia and noted that her school uniform was dirty, but had no safeguarding concerns. While this was reassuring to school staff, it was also frustrating as they had hoped that the school nurse would assist them to gain evidence to build a case of neglect in respect of the child.

3.12 The secondary school attended by the two older children was contacted the following week. They also shared concerns about the children looking pale, and their belief that the children are often left home alone as their mother works long hours. Family Connect asked both schools to speak to the children and they reported back a happy home life with no concerns. It took another week before Family Connect requested that the police undertake a 'safe and well' check. This was refused by the police who suggested that a social worker undertake a home visit, as the children had been seen in school. A further referral was received from the same anonymous source (who identified herself to Family Connect but said she wished to remain anonymous) saying she remained extremely concerned. The same day the primary school contacted both Family Connect and the police in the early evening because they had sent the youngest child home unwell, and when they went round later to check she was alright, it became apparent that she was home alone. They had been unable to contact either parent and required assistance as they had taken the child back to the school. They had an extremely frustrating couple of hours where the police and EDT both said it was the responsibility of the other to assist. At 8.45 pm the children's father arrived at the school and EDT told the school that the child could go home with him. EDT then undertook a visit with the police and found the unsanitary and wholly unacceptable living conditions and a malnourished dog at the family home,

leading to police protection being taken on the three children. This was in part required due to their father not accepting the concerns and being extremely aggressive to professionals.

3.13 The review reflected on the impact of the referral being made anonymously and whether this had an impact on the lack of a timely safeguarding response. Learning from other reviews undertaken nationally cautions against making assumptions that the information may be malicious or less valid when an anonymous referral is made. If the concerns are regarding the safeguarding of a child and parental consent cannot be gained within short timescales, checks must be undertaken regardless.

Learning point 3: Professionals need to identify when there is an impact on children when they are having difficulties in meaningfully engaging with a parent.

3.14 The delay and chance involved in identifying the home conditions of both families has led to reflection on how difficult it is to work with families who avoid services and resist professional interventions. In both cases considered there were many occasions where concerns about the ability of professionals to meaningfully engage with the parents were evident. Both mothers were said to be aloof and hard to get to know. In the case of Mother 1, she was described as often angry and unreasonable. She often missed her own GP appointments and did not bring the children to theirs. As one of the children (aged 5) had health concerns, missing health appointments had a potentially significant impact on their health and wellbeing. It was not entirely clear at the time what the issues were, but when the child missed school, the mother would report it was due to sickness and diarrhoea, and that the GP was considering IBS, then later that they had diagnosed lactose intolerance and anaemia. Information provided by the GP to the review shows no evidence that this was the case, but this was not checked at the time as there was not thought to be justification for seeking confirmation.

3.15 Due to concerns about the eldest relevant child in Family 1's physical, emotional and communication issues, including her 'grey pallor', lack of appetite and thin hair, the school asked the school nurse to assess the child. The school nurse was able to get the mother's consent to see the child. They liaised with the mother before and after the assessment and informed the mother of the need for the child to attend the gait clinic for physical issues identified. They had no further concerns. This was potentially an opportunity for the historic information, including the child protection plan that this child had been subject to two years previously, to be identified, however. The school nurse involved told the review that it is not standard practice for them to consider other health records where this information would be stored, including the previous health visiting records. or to ask the GP for any background. They stated that in future their own practice will change to reflect this learning, and there is an agency recommendation that this will be expected practice going forward.

3.16 Another period of absence from school in June 2021 led to an unannounced home visit by the school which Mother 1 responded to negatively. She then began the process of changing the child's school. It is well known that professionals can be concerned about challenging parents too much as this can mean that they will no longer work with services, which will mean that the children do not receive the help and support they are providing. This leaves professionals in a difficult position if they wish to continue to have access to the child. The review reflected on how easy it is for a family to change a child's school, and there is concern from education staff that if they are too challenging to parents

there is a risk that the child will be withdrawn from the school completely. This will have a negative impact on the child, provide an inconsistent educational experience and mean that information can be lost. In the case of the eldest relevant child in Family 1, the mother did change her school. There is evidence of good practice between the previous school and the receiving school, as all the known information and concerns were shared verbally. However, neither school was aware, until just before the baby died, of the significant background information, including the existence of the older children not in mother's care, Mother 1's vulnerabilities, and the need for child protection plans in the past due to neglect and physical abuse. The first school had not identified the historic information available on CPOMS and therefore did not highlight this to the second school, who believed that they knew the history due to the handover conversation and they did not check CPOMS themselves.

3.17 There is a great deal of learning available about resistant parents in a safeguarding context, and safeguarding reviews regularly identify this as an issue in the most serious cases. The 2019 NSPCC learning from Case Reviews briefing on disguised compliance[6] (but possibly better termed as 'disguised non-compliance') identifies some of the issues that were evident in the cases considered here, where both mothers were resistant to the majority of professional interventions. Mother 1 would do just enough to keep professionals at bay, reassuring professionals that she was seeking support elsewhere (from the GP for example, or by stating that she had a private pregnancy scan). She would also avoid home visits unless there was no alternative. She would keep professionals in the one room in her house that was acceptable to the professionals but ensured they did not see the other rooms where we now know there were inadequate living conditions. Mother 2 however would avoid all contact with professionals, leaving them in a state of limbo or relying on the contact they could achieve with the children's father, although he was not living in the family home. The father appeared to the schools to be the main care giver so there was understandably not too much concern about the lack of contact with the mother. The secondary school were not aware that the father did not live with the children, but this is not unusual in a secondary setting. The schools were not aware of his mental health issues or his history of serious substance misuse, but there was no reason for them to be, as there were no known safeguarding concerns prior to December 2021,

3.18 Mother 1 did not have any antenatal care in her pregnancy with her baby that was due in October 2021 until she was 37 weeks gestation. Although her GP had confirmed the pregnancy at 7 weeks in March 2021, there was an incorrect record on midwifery records that she had a miscarriage, which appears to have been what the mother told them. There is rarely a need to challenge in these circumstances, however the pathway has now been amended to offer women a scan to encourage them to be seen and offer a bereavement service, and to confirm that the pregnancy has ended. When she was 20 weeks, the mother approached her GP for a termination, but due to the difficult logistics of having to go to Liverpool for the procedure, she did not take this course of action. When she was seen by a midwife at 37 weeks, a decision was made to refer to CSC due to the previous lack of engagement and the impact this may have on the unborn child. A professional working at Family Connect spoke to the mother who stated she had a private scan, and that while she had wanted a termination and had then considered placing the child for adoption, she did not wish to

[6] https://learning.nspcc.org.uk/media/1334/learning-from-case-reviews_disguised-compliance.pdf

engage with any support and wanted to care for her baby. This was not challenged, and this is explored further in Learning Point 5.

Learning Point 4: When it comes to recognising and identifying neglect, professionals need to explore and understand a child's lived experience and recognise the cumulative harm to children when they experience neglect over time.

3.19 In areas of high deprivation there is a need for professionals to be able to identify when a child is experiencing neglect rather than the impact of living in poverty. This is an issue in the areas of Telford and Wrekin where the children in both families live. The schools were able to reflect that while their expectations for the children are high, and that they always raise concerns about issues with attendance, school uniform, packed lunches, parental engagement with their child's education, and so on, they have to acknowledge that parents often do not accept or meet the school's expectations and standards. The schools have around 60% of the children who attend eligible for free school meals, which reflects the level of hardship and deprivation in the communities. The impact of poverty is likely to increase in the UK with high inflation and soaring energy costs, leading to what has been termed a 'cost of living crisis.' Like child neglect, poverty has a negative impact on a child's health and development and on their educational outcomes. They are more likely to experience a wide range of health and social problems including mental health problems.

3.20 This is a challenge for professionals as while poverty can be a factor when a child is neglected, poverty does not always lead to child neglect. Many poor families can bring up their children without abuse or neglect featuring. A recent study (2022) by the Joseph Rowntree Foundation shows however, that if all other things are equal, changes in income alone will have an impact on the number of children being subjected to abuse and neglect. What they also note is that professionals take insufficient account of the impact of poverty and can become 'desensitised' to its impact. In an area of high deprivation, it is possible for child neglect to be accepted as inevitable and due to poverty, rather than due to a complex set of factors which need assessing, challenging, and addressing in every case. There is evidence in serious case reviews and CSPRs of professionals effectively becoming immune and not seeing child neglect in areas of high deprivation, and Partnership need to ensure that this is challenged and that professionals are supported to avoid this.

3.21 The procedures and policies available can lead to a focus on individual episodes or issues of concern, with a failure to step back and look at patterns of parenting and the impact on children of care that dips just above and then below 'good enough' on a regular basis. The cumulative nature of neglect needs to be understood and always considered when working with children who have been affected by neglect. When working with a family where the care of the children is occasionally on the right side of 'good enough' this can lead to a view that the impact on the children will not be as serious as sustained neglect. However, each incident or episode of concern needs to be examined with an understanding of what the child has experienced before to assess whether a multitude of

factors, when considered together, constitutes significant cumulative harm[7]. This was particularly an issue for the children in family 1, who had previously experienced neglect while in their mother's care.

3.22 The national Safeguarding Practice Review Panel's annual report published in May 2021[8] stated that 'the recognition of cumulative neglect and its impact continue to be a key challenge for practitioners' nationally'. This a key issue for safeguarding partnerships and agencies nationally, as the life-time impact on children of long-term and recurring neglect cannot be underestimated, with outcomes for these children likely to be exceptionally poor.[9] The consultation with professionals involved in these cases showed that evidencing neglect is not straightforward. They agreed that they would welcome access to a specific neglect tool which can be completed with families and with other professionals involved with children, to explore whether neglect is an issue for the children. A recommendation has therefore been made.

3.23 As well as considering neglect in its own right, there is 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. In case reviews completed following the death of a child from physical abuse, neglect featured in the families reviewed more than previous physical harm. [10] Children who have experienced neglect are also more likely to be known to services due to the risk of child exploitation. This adds further justification to the need to identify indicators of child neglect and provide services.

3.24 While the children in Family 2 had not been known to children's social care before, and there had been no concerns in the children's earlier years, there were indicators even prior to the anonymous allegations that they may be experiencing neglect. It was not straightforward however, as there were no concerns about the children's academic achievements and only occasional concerns about their hygiene. The secondary school did have concerns about the older children's attendance. The eldest child had gone into the sixth form, so there was no statutory need for them to have good attendance, but the middle child often missed school and there was very little engagement with the parents about this. In the year prior to the children coming into police protection there had been over 10 attempts by the school to contact the parents about attendance, with the Attendance and Behaviour Improvement Officer visiting the home and leaving calling cards on numerous occasions, without getting any response. While this was of concern, this pattern was not unusual for children attending this particular school. The school staff found it very shocking when they saw police photographs of the home on the night in question. It was hard for them to understand how the children had not presented as far dirtier and unkempt than they were, considering the situation at home.

3.25 There were attempts to understand more about the children in Family 2's lived experience. The primary school provided space and an adult for the child to speak to, but she did not share anything

[7] Bromfield and Higgins in Australia first introduced the terms 'cumulative risk' and 'cumulative harm' in 2005 when they point out that 'the effects of patterns of circumstances and events in a child's life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.'
[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984767/The_Child_Safeguarding_Annual_Report_2020.pdf
[9] The terms 'cumulative neglect' and 'cumulative harm' were first identified in Australia in 2005 by Broomfield and Higgins.
[10] Brandon, M., Bailey, S., Belderson, P.and Larsson, B (2013) Neglect in Serious Case Reviews, NSPCC/UEA. https://www.nspcc.org.uk/Inform/resourcesforprofessionals/neglect/neglect-scrs-pdf_wdf94689.pdf

of concern. The older children did not raise any problems with their school and even when asked directly about how things were at home, they were positive and said all was well. It is well established that children can be torn about involving professionals in their family lives, and they may feel conflicted and/or concerned about sharing too much about their home or any concerns they have. The children would have been aware that their mother could get into trouble and were clearly keen to protect her. They may also have been coached to lie to professionals. The need to listen to the views of teenagers can provide a dilemma for professionals. The children often show loyalty to their parents and are likely to be fearful of what might await them if they are removed from the home. They can be insistent that they want to remain with their parent even if the conditions are poor. Any discussions with children need to recognise how difficult it will be for them.

Learning Point 5: When there is a 'concealed' pregnancy, information sharing, and a coordinated inter-agency approach is required.

3.26 This review was able to identify learning in respect of systems and practice in a case where professionals are unaware of a pregnancy, or where one professional is aware and assumes that those who need to be involved are. Concealing or denying a pregnancy is risky as it will limit the opportunities for effective antenatal care. The 'booking' appointment with the midwifery service should be around 10 weeks into a pregnancy[11] (NICE 2021). Mother 1 was aware of her pregnancy but did not access midwifery care. It is possible that she was in denial and unable to accept the existence of the pregnancy[12] however. She told the school that she had had a termination, and the midwifery service were under the impression from early in the pregnancy that there had been a miscarriage, and Mother did not inform them this was not the case. It was over 35 weeks into the pregnancy before the midwifery service identified that Mother 1 was expecting a child. They contacted her and made a referral to Family Connect at this point.

3.27 There are several areas in England with safeguarding procedures regarding concealed pregnancies. They state that it is important that the reasons for the concealment of the pregnancy are explored with the mother, alongside an understanding of any history held by other agencies such as adult mental health services and children's social care. The reasons for the concealment need to be taken into consideration when considering the needs of both the mother and the unborn child. Mother 1's GP was aware that she was pregnant as she had requested a termination. As she neared the upper time limit for the procedure she would have to travel to Liverpool, which she stated was not practically possible for her. There was information sharing between the GP and the midwifery service but not with the health visitor, despite the fact that a midwife is going to be involved with a family for a relatively short time compared to a health visitor.

3.28 When the Family Connect worker contacted Mother 1 to discuss the referral from the midwives, Mother reported she had wished to have a termination and that she had considered placing the baby for adoption. There was no further action taken from Family Connect, other than a suggestion that the midwifery service should support the mother. There was no information sharing with the health visitor,

[11] NICE 2021

[12] 'Intense psychological conflicts about a pregnancy may result in subconscious suppression where a person continues to think, feel and behave as though they were not pregnant'. Pan Sussex child protection procedures.

possibly due to an assumption that the midwives would do this. The need for professional curiosity is essential when there are issues in a case that may lead to additional needs or risks, and professionals should have an open mind to ensure they do not make assumptions about how a parent will cope with a new baby that was not planned. This was particularly important for Family 1 as there had been previous child protection plans for neglect and a history of maternal mental health concerns.

3.29 There are no specific procedures in Telford and Wrekin or within the West Midlands regional child protection procedures regarding the required response to a concealed or denied pregnancy. This is despite the evidence from many CSPRs and serious case reviews that shows a corelation between a concealed pregnancy and children being seriously harmed. Professionals working with a parent who has concealed or denied a pregnancy need to ensure that they consider 'the meaning of the child' and assess if there is any ambivalence to the child or concerns about the parent's willingness to prioritise the child. Professionals need to be aware that in these pregnancies there is an increased risk of emotional detachment and poor bonding, and a need for an increased level of monitoring of the parent and baby's well-being following the birth. This may involve an effective early help response or a referral to CSC if early help is refused or avoided.

3.30 There was a knowable history of neglect and maternal mental health for Family 1, which was considered at Family Connect following the community midwife making contact, but the current issues were not felt to be sufficient for a social work assessment. The midwives who visited Mother 1 at home for her booking appointment just a week before the baby was born had an awareness of the significant history. It is understood that at this appointment there was a lot of information to discuss with the mother and that a discussion about the 'meaning of the child' would have been difficult on a first visit, particularly as the three older children were present at the time. Following the birth there were no concerns about the care of the baby in hospital, although it was recorded by the hospital that the mother was agitated and very keen to be discharged due to her concerns about who could continue to care for her children at home while she remained in hospital. The new baby required a degree of monitoring due to Mother's mental health medications taken during the pregnancy. The hospital raised concerns with Family Connect about how much support Mother 1 would have at home, but as there were no safeguarding concerns Family Connect again decided there should be no further action.

3.31 Mother 1 and her baby were seen at home in the days following their discharge from hospital. The community midwives had made a detailed written referral to Family Connect prior to the birth and had shared that the mother had wanted a termination, information that had been shared by the GP. This referral was not copied to the health visitor however, despite this being a good way of optimising information sharing for a child that would soon become their responsibility. The community midwives' knowledge of the request for a termination and the information then shared by Family Connect that the mother had said she had also considered adoption, should have given them the opportunity to discuss with the mother her feelings about the child, particularly considering her lack of antenatal care. This opportunity was not taken. All the required information was discussed with the mother

regarding SIDS, sepsis, safe sleeping, and temperature control. The baby was gaining weight and Mother 1 was reported to be obstetrically and emotionally well. When the mother and baby were discharged from maternity led care, the midwives did not inform the health visitor of the mother's previous reluctance to have this baby, although they did share the lack of antenatal care. This means that no professional discussed 'the meaning of the child' with the mother or considered any potential risk to the baby due to this.

3.32 The midwives and the health visitor made attempts to identify who the father of the baby was. The mother was very positive about him but was unable to share his surname and stated that he lived in London and would not be actively involved in the care of the child. There was one occasion when he was said to be visiting and was apparently upstairs when the midwives visited. They did not meet him and said they could not be sure if he was there. The fact that they did not insist on seeing him was in large part due to the need to be aware of Covid risks at the time. He was, therefore, an unknown factor.

3.33 Neither the midwives nor the health visitor who undertook her post-natal visit around this time went into any other room than the family lounge. They all asked to see where the baby slept, and were told that it was in the crib, which was visible in the lounge, with the mother reporting that she slept on the sofa to ensure the other children were not disturbed in the night. This was accepted and the review was told that this type of set up is not unusual. The health visitor was not aware of the lack of antenatal care and the concealed pregnancy at the time of her post-natal visit. This was shared the day after the visit when there was a telephone call with the midwife. The request for a termination was not shared with the health visitor until the strategy meeting after the death of the baby. This means that the first visit was a missed opportunity for the health visitor, who knew the mother having been involved with the previous children including as part of the core group when there was a child protection plan, to speak to Mother about this and consider the meaning of the child and any potential concerns about bonding. In this case a joint visit between the midwives and the health visitor would have been good practice.

Learning Point 6: COVID-19 has had an impact on families and on the support provided.

3.34 The Child Safeguarding Practice Review Panel published a briefing paper last year that considered the initial COVID-19 outbreak (March – September 2020). Their analysis shows that COVID-19 exacerbated risk due to an increase in family stressors (including an increase in domestic abuse and mental health concerns alongside less wider family support), children not being seen as regularly, and difficulties with the requirement for ensuring safe professional practice.

3.35 The eldest relevant child in Family 1 started school in September 2020. It was established practice to undertake a home visit to every child about to enter the reception class. Due to the pandemic, this practice was suspended, and there was no visit to the family home prior to her starting school. The school were aware of the vulnerabilities and worked to ensure contact with Family 1, including undertaking doorstep visits with food and schoolwork for the children. The secondary school where two of the children in Family 2 attended reflected that they had not been able to undertake all of the positive transition events they usually provide when the middle child moved up to their school, due to

COVID, and that this had an impact on what they knew about her and her family. They did not realise she was related to the older child as they have different surnames. This type of information usually becomes apparent when the parents attend the transition events.

3.36 Schools remained open for the most vulnerable children and the children of key workers from day one of the first national lockdown. In both cases the children were invited to attend. In the case of Family 1 it was due to the perceived vulnerabilities, and in the case of Family 2, due to the children's mother working in a key worker role. None of the children attended. Despite the availability of school for most vulnerable children, COVID 19 enabled families who wished to avoid professional scrutiny to do so in a way that was hard for professionals to challenge at the time. A stated fear of catching the virus or a claim to be shielding had to be accepted and often left professionals feeling helpless to intervene. All the schools that took part in this review are in areas of high deprivation and offered many children the opportunity to attend during the lockdowns. The secondary school attended by the older children in Family 2 told the review that in the early stages of the first national lockdown, they asked parents of older students to consider if their child was safer at home rather than in school. This was due to the number of key worker children in the school, including the children of health workers.

3.37 There was reflection in both cases about the impact on professionals of having to wear masks, including the potential masking of smells. In both cases the homes were described as 'pungent', but the children were not noted to be smelly (other than on very isolated occasions where this was an issue) and the health visitor and midwives who sat in the lounge of Family 1 did not notice a bad odour. This may have been due to them wearing masks.

3.38 Another impact of professionals wearing masks was identified by the health visitor for Family 1. The mother was initially very hostile to the health visitor on her first visit. This was because she did not recognise that it was her former health visitor due to the mask she was wearing. When the health visitor reminded mother that she had been involved with the other children, the mother was much happier to cooperate with the visit and said that she appreciated seeing a professional known to her. There is evidence that parent's who may appear to be hard to engage, are often frustrated and anxious about meeting new people and there are benefits of consistency of engagement, as shown here.

4 Conclusion and recommendations

4.1 This CSPR has considered the learning from two neglect cases and identified learning that will be helpful for the wider system. The learning from serious case reviews and CSPRs generally shows that all professionals need to recognise neglect, understand the long term and cumulative impact of neglect, and take timely action to consider if children need safeguarding. This review has found the same. While there is some expertise locally in using the Graded Care Profile, it is seen as a specialist tool and can only be used by those specifically trained.

4.2 Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. There has been cooperation with this review from partner agencies, which was essential in establishing the learning from these

cases. The families chose not to meet with the lead reviewer, which limited the identification of additional learning from their perspective.

4.3 Having considered the learning not addressed in the single agency actions, the following additional recommendations are made to ensure improvement actions are taken:

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 3

That the Partnership shares the learning from this review with the West Midlands regional procedures group and requests that multiagency guidance on the management of concealed pregnancy be developed to improve practice in this area. When this guidance has been developed, there should be work undertaken to ensure it is implemented.

Recommendation 4

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.