A local child safeguarding practice review (LCSPR) commissioned under

The
Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

‘W’ siblings

Overview Report

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1 Context and circumstances of the review

1. This review is about seven siblings aged between sixteen and one year old born to different fathers. Two older siblings who are now young adults were previously removed from the mother's care.

2. The case is complex with a long history. The focus of the review is on events between December 2019 when a strategy meeting agreed on a joint s47 investigation leading to a child protection plan (CPP) and one of the older children became looked after and goes through until July 2021 when three other children sustained injuries as a result of suspected sunburn.

3. For clarity, the use of acronyms is kept to a minimum. To help preserve the privacy of the children in particular and of the adult stepsiblings none are referred to by gender. Schools are not identified by name. Birth family members are referred to by their relationship with the children. Professionals are referred to by their job titles or role such as family support worker (FSW) GP, health visitor, police officer, social worker or teacher. Some of those roles had multiple people such as police officers or social workers; there were for example three social workers between January 2020 and July 2021.

4. The circumstances of the siblings were discussed at a rapid review meeting in early September 2021 after the suspected sunburn injuries which were the subject of a police criminal investigation. All the siblings have suffered longer-term neglect and abuse over several years. One of the children was sexually abused by adult males and another child was at risk of child criminal exploitation. Evidence of neglect discussed at the rapid review included delayed and impaired development, poor attachment and severe dental decay resulting in extractions.

5. All of the school-age children suffered disruption to their education which compounded with parental neglect had contributed to significant developmental delays. The children have been presented to health services with an array of ailments at different times as well as with physical injuries many of which were not adequately explained. One of the children has cystic fibrosis and another has an autism spectrum disorder.

6. The children lived in an area that is amongst the nine per cent most deprived in England. The local authority as a whole is ranked among the 20 per cent most deprived in England. All of the siblings' fathers and the mother are white British and English-speaking. There is no record of any faith-based affiliation.

7. The mother is thought to have learning difficulties although this has not been formally assessed and diagnosed. Her childhood history was of poor parenting and sexual abuse by a close relative; there was extensive involvement by CSC; she has described it as being 'difficult'; she does not have a family or friendship network capable of giving consistent and positive

support. Domestic abuse has been a feature of her intimate relationships although little detail has been collated in assessments. Little information has been collated about the identity or background history of men who have been part of the household at different times although one was deemed a significant safeguarding risk and contact was prohibited without a court order. The identity of the fathers of some of the children is not known. Although convicted of assaulting a previous partner the mother is also described as a woman who has had little power in some of her relationships.

8. Statutory involvement with the children began in 2008 with a child in need (CIN) plan until 2010. This was followed by two further CIN plans as well as child protection plans and short periods for some of the children being looked after. The public law outline (PLO) was used on four occasions although no proceedings were issued until after the suspected sunburn injuries in July 2021. A legal gateway meeting had agreed that the PLO should be opened in January 2021; this involved further parenting work being done with the mother.

9. Multi-agency working was extensive with high levels of communication between different professionals and core groups and statutory meetings were generally well attended and continued through the Covid lockdowns. Although intensive work produced some improvement in school attendance it was not satisfactory and not sustained without a great deal of effort from different professionals. The children's circumstances and cumulative experiences changed little as a result of the multi-agency working or achieved sustained changes; the mother struggled to sustain changes and improvement in her care and parenting. The escalation of concerns about the children preceding the suspected sunburn injuries did not generate an appreciable change in how the local authority worked with the family.

10. The local authority relied on working with the consent of the mother. On more than one occasion children have needed to be looked after. These and other arrangements have been made on the reliance of the mother giving her consent although the children were subject to interim care orders and ongoing Family Court proceedings during the review and are being cared for in five different placements.

11. Some services struggled to recruit and retain appropriate staff, and all are working in an area that has some of the highest levels of child poverty and deprivation in the country. In particular children's social care appeared to have a succession of different social workers and managers involved with the case. Ten different social workers were involved with the family over three years; there were three social workers between January 2020 and July 2021.

12. The rapid review found that no individual or service had an effective chronological oversight. It was agreed that the serious harm criteria were met in that all seven children had experienced neglect and other abuse over several years. A recommendation was made to the NEL Safeguarding

Children Partnership's Executive by the NEL SCP Safeguarding Review Group on the 13th of September 2021 that a serious notification was submitted to the National Panel. The National Panel confirmed that there would not be a national review; that there was learning to be drawn from the case and agreed with the local decision to commission this LSCPR in early October 2021.

13. The rapid review acknowledged that there are examples of good individual practice to be found, and people had tried to work together. Professionals had tried to respond empathetically to a mother, who had multiple difficulties with a history of childhood abuse, social isolation and domestic abuse. Any changes that were made were only achieved with intensive agency support but were not sustained.

14. The rapid review was only able to give a limited picture of the lives of the children and the impact of their long-term neglect; agencies had limited information about why the history of the mother and the various males who were part of the household at different times does not appear to have been part of any enquiry or assessment. The review has to establish why despite some assessments and professionals being so negative about the safety and well-being of the children nothing substantially changed until three children were injured in July 2021.

15. The rapid review acknowledged that the case had highlighted that urgent improvements were needed in a series of recommendations being made to address significant learning. This LCSPR takes account of those recommendations and any outcomes.

16. The review identified key practice episodes (KPE) of professional practice and decision-making to be examined by the review. Details about the organisations that provided information and participated in the review are included in an appendix.

17. The siblings have not been asked to participate in any aspect of the review. This decision took into account the trauma and distress they had experienced before becoming looked after and the progress that the children are making and their differing levels of age and understanding.

2 Overview of information

18. Statutory involvement with the children began in 2008 with a child in need (CIN) plan that lasted until 2010. There was a second CIN plan from June 2016 until February 2017 when it was stepped down to early help.

19. A graded care profile (GCP) was completed in July 2017 and again in February 2018 which was “wholly negative on all domains”. These were not completed by CSC. Although the children presented with behaviour symptomatic of poor or disordered attachment no assessment of this was completed. Significantly one of the children who presented with anxiety and

did not speak at school started to talk after becoming looked after in 2020. Levels of aggression and other behaviour presented by one of the other children also improved after becoming looked after. Although there was a recommendation to complete a psychological assessment of the mother as part of a CPP this was reversed by a senior manager in the local authority and was not completed. There is no baseline of the mother's functioning and her ability to make sustainable changes.

20. A third CIN plan from July 2017 until January 2018 was stepped up to a child protection plan (CPP) for neglect until March 2019. The decision to end the CPP in March 2019 did not have an updated assessment; the health visiting service which was not represented at the CPC raised a formal objection to the decision afterwards; the health visitor had been on a training course which had prevented her attendance.

21. In December 2019 one of the children reported to their school not being fed regularly because mum had no money; the social worker was informed. Another school raised several concerns with the social worker by email in early December 2019. A child was regularly staying at an older sibling's home where there were concerns about the household and there was no bed for the child to sleep in and who was arriving late every day and their behaviour at school had deteriorated and was often "spaced out". The school reported seeing bruises on the child with unconvincing explanations. The mother was asking the school to let an 8-year-old child walk home from school; one of the siblings had been assaulted by another. Staff had found one of the children at school just after 08.00 having walked to school. Other concerns included seeing bruises on the child with unconvincing explanations, the mother asking the school to let an 8-year-old child walk home from school and a child being assaulted by a sibling. No action was recorded by CSC. The information was not considered at a strategy meeting almost a month later when the police had found the same child with bruising at the same older sibling's home.

22. In late December 2019, the police responded to a domestic abuse incident at the home of one of the adult siblings where the same child was present and found to have a bruised eye. The child told the responding officers that mum had assaulted the child. During the subsequent investigation, the child said that the injury had been caused by an older sibling rather than their mum. The police used their police powers of protection (PPOP) to make arrangements for the children to be cared for and the mother was arrested. Some of the children were in an unkempt condition with severe head lice infections. Several had bruises when examined. A younger child had a nappy rash. Some of the children had skin lesions. The children's history of being neglected was well known to all the agencies at this stage. The mother was 19 weeks pregnant with her seventh child, had been late making her booking appointment and had missed two other appointments. The NLaG concealed pregnancy guideline was followed at the time and social care was made aware of the pregnancy.

23. The children gave different accounts for the injury to the child none of which alleged that the mother had assaulted the child. The children had returned home before a strategy meeting in early January 2020. It discussed the information that included the history of missed health appointments for the children, poor school attendance, poor and neglected physical condition of the children and poor home conditions. The initial child protection conference (ICPC) agreed to the CPP for neglect that was still in place when the suspected sunburn injuries occurred in July 2021.

24. In early March 2020, an older sibling told a YMM practitioner that they had a secret but did not want to talk about it because the police would be told about it. The YMM were trying to complete one-to-one work with the child at the time although this was being disrupted by Covid restrictions.

25. The youngest child's birth at full-term in late March 2020 coincided with the first Covid 19 lockdown. Before the birth, the mother had intended to give up her child but now decided she wanted to keep the baby who was included in the CPP along with the six older siblings. In early April 2020, the midwife noted the baby's right eye was bloodshot; no further outcome was recorded. In late April 2020, the baby was admitted to the hospital via A&E; the baby had breathing problems and lost weight since birth. There was no contact with social workers or the MASH. On presentation the child protection information sharing system (CP-IS) was utilised appropriately by NLaG; however, a call should have been made to children's social care by A&E staff or the ward.

26. The day after the baby had been admitted to A&E the first review CPC agreed to continue with the CPP. Like all the other meetings it was a virtual meeting because of Covid restrictions; the mother did not log in to participate. The CPC was not aware of the presentation at A&E or the baby's bloodshot eye; the health visitor was concerned that the mother had not sought medical advice when the baby had been observed with blue feet.

27. In late July 2020, an older child reported that mum was assaulting the siblings and throwing objects in their home. The police and social workers visited. The house was observed to be chaotic; the baby was being prop fed and had a soiled nappy[1]; another child was running around naked and another was sitting in a chair ignored and neglected.

28. The second review CPC in late September 2020 coincided with the case transferring to a new social worker. Although limited progress was reported by the participants there was optimism that the mother might be engaging with the help and support being provided.

29. In mid-November 2020 a strategy meeting attended by 16 professionals discussed several concerns; the further deterioration of one of the children's

[1] Bottle propping exposes the baby to the risk of choking, ear infection, development of tooth decay and interrupts the bonding process.

behaviour; increasing aggression; a younger child's personality was changing adversely; another had a developmental delay and was not attending the nursery and was often naked as was another child; the baby was being left strapped in a pushchair; child immunisations were not up to date. There was discussion about seeking CSC management approval for an older sibling to be looked after and whether to go to the legal gateway panel; school 2 was becoming very concerned and escalated with the CSC team manager over three days; the school was very concerned about the deterioration in the older sibling and the impact on the other children; the school had to remove some of them from home temporarily because they were so concerned for their safety from the behaviour of siblings; nobody requested to reconvene the CPC and there was no consultation with the CPC chair.

30. A legal gateway meeting in late January 2021 agreed to the PLO process being started.

31. The day after the legal gateway meeting the baby was presented to the GP with an injury. There was no referral to CSC even though the CPP was still in place.

32. In late March 2021, the PLO was reviewed. The meeting was told that parenting work was 'nearing completion' and recommended that the mother needed time to have her parenting monitored with less dependence on professional support.

33. The third CPC review conference in late April 2021 discussed the CPP which had been in place for 15 months.

34. In June 2021 members of the core group escalated their concerns about the children with senior CSC management.

35. In late July 2021, three of the younger siblings were treated for severe suspected sunburn injuries. The children became looked after with the agreement of their mum and the legal gateway panel agreed that care proceedings should be opened in the Family Court. Interim care orders were made in September 2021.

3 Research and national learning relevant to the review

36. This summary includes the different types of neglect and the importance of understanding child and parent behaviour in that context, health care markers of neglect, adverse childhood experiences (ACE) and criminal child exploitation with a summary of contextual safeguarding when the risk to children comes from outside their immediate home environment (in this case it was in addition to the risk at home).

37. The neglect of children is the most prevalent form of abuse (and the largest category of risk for CPP nationally); it also presents the greatest challenge

for assessment, intervention and presenting evidence to courts. This is a contributory factor in the slow progress through legal pathways in this case. Children can experience neglect in very different ways and including the failure to:

a) Meet basic physical needs (in this case home conditions were often described as unsuitable although was an area of temporary improvement with sustained support from the FSW in particular).
b) Access to appropriate health care (poor starting in prenatal care).
c) Meet emotional needs (little detailed recording about the emotional care of the children whose feelings and lived experiences were not explored in assessments or CPC discussion; there was no structured work on issues such as the attachment of the respective children).
d) Ensure adequate supervision (evidence that it was largely absent in the home with a lax parental approach to allowing very young children to make journeys alone in the community).
e) Provide appropriate cognitive stimulation (little recorded evidence but all the children had delayed speech and some of the children had significant cognitive difficulties) [2].

38. Horwath[3] describes different types of neglect related to parental behaviour (that a parenting assessment should be exploring):

a) Disorganised neglect is when parents are driven predominantly by emotion and often experienced an unstable childhood; they have learnt to not depend on others but to focus on meeting their needs[4].
b) Emotional neglect is when parents may display a good standard of physical care and might be meeting the child's cognitive needs but are unable to provide a warm caregiving environment; it's a form of behaviour that can give a false positive where professionals are relying on physical standards and can be seen in this case.
c) Depressed, passive and physical neglect is when parents are unavailable to their children in terms of providing emotional warmth and meeting other developmental needs.

39. Children not being taken to health appointments is a tangible indicator of neglect relating to the behaviour of the parent and the impact and consequences for the child. Children are more likely to be from deprived backgrounds and to be the subject of child protection alerts in their patient records which are reflected in these siblings' circumstances[5]. For some

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[2] https://www.safernel.co.uk/wp-content/uploads/2021/10/WORKING-WITH-CHILD-NEGLECT-DURING-THE-COVID19-PANDEMIC.pdf

[3] Horwath, J., 2013. Child neglect: Planning and intervention. Macmillan International Higher Education.

[4] Howe, D., 2005. Child abuse and neglect: Attachment, development and intervention.

[5] French LRM, Turner KM, Morley H, et al. Characteristics of children who do not attend their hospital appointments, and GPs' response: a mixed methods study in primary and secondary care. Br J Gen Pract 2017; DOI: https://doi.org/10.3399/bjgp17X691373

time, the term did not attend (DNA) has been discouraged when describing a non-attendance at a health appointment although was evident in some of the recordings for these children. A parent/caregiver is responsible for taking children to appointments and it is, therefore, more appropriate to describe a child as not brought to the appointment. This was proposed in 2012[6] and evidence from serious case reviews and further research has reinforced the value of accurate coding of information in primary and other healthcare settings[7].

40. An abused child has been estimated as being up to eight times more likely to have untreated, decayed permanent teeth than a non-abused child[8]. Dental decay is a marker of a potentially wider neglect of children[9]. It is unlikely as an isolated issue to lead on its own to a child protection referral but is an example of being part of a cumulative experience for children that is harmful. It should be considered as part of a mosaic of issues associated with a neglected child.

41. It is generally recognised that there is no magic intervention that can address the different dimensions of neglect. Early help can assist in stopping difficulties from becoming entrenched and strengthening protective factors and resilience[10]. That did not apply to the circumstances of the W siblings. Research in the USA has shown that some long-term neglect cases can make progress but can take up to two years of sustained and intensive involvement and support[11]. Account has to be taken for what happens to children over such an extended timeline.

42. Adverse childhood experiences (ACE) cause harm during childhood and into adulthood. It encompasses abuse including neglect, domestic abuse in the household, mental illness and problematic substance misuse of a parent or carer. Experiencing ACEs along with hate crime, community violence or not having supportive adults exacerbate longer-lasting damage and is sometimes referred to as “toxic stress”[12].

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[6] Powell C, Appleton JV. Children and young people’s missed health care appointments: reconceptualising ‘Did Not Attend’ to ‘Was Not Brought’ — a review of the evidence for practice. J Res Nurs 2012; 17(2):181–192.

[7] Safeguarding Nottingham. Rethinking ‘Did Not Attend’. 2017. Rethinking ‘Did Not Attend’ - YouTube (accessed 22nd December 2021).

[8] Greene, P.E., Chisick, M.C. and Aaron, G.R., 1994. A comparison of oral health status and need for dental care between abused/neglected children and nonabused/non-neglected children. WALTER REED ARMY INST OF RESEARCH FORT GEORGE G MEADE MD.

[9] Bradbury-Jones, C., Innes, N., Evans, D. et al. Dental neglect as a marker of broader neglect: a qualitative investigation of public health nurses’ assessments of oral health in preschool children. BMC Public Health 13, 370 (2013). https://doi.org/10.1186/1471-2458-13-370

[10] Allen, G. (2011) Early Intervention: The Next Steps. London: HMSO.

[11] Turney, D., & Tanner, K. (2005). Research and Practice Briefing: Understanding and Working with Neglect. Research in Practice.

[12] https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

43. Parents who experience significant ACEs in their childhoods are more likely to present with a range of needs and difficulties such as poor learning and employment history, illness and substance abuse and will influence how they meet the needs of their children which can bring them into contact and conflict with people and services focussed on safeguarding children.

44. The co-existence of poor physical and mental health, poverty, learning difficulties and domestic abuse are factors that contribute to inconsistent parenting and disorganised lifestyles that are harmful to children such as these siblings. It can leave a parent with difficulty in controlling their emotions and providing adequate emotional care for their children and can be further complicated if there are cognitive or other issues to consider. It is why taking a good history is important as part of completing an assessment which is not evident in this case.

45. Interventions by health and social care services, in particular, have to develop responses that can help adults address the impact of an adverse childhood experience as part of strategies to prevent children from suffering harm. This has implications for how assessments of parents and children are completed and for encouraging greater curiosity and routine enquiry by people such as primary health care professionals and for providing access to appropriate help which can include trauma-informed care.

46. Poverty, as experienced by children such as the W siblings, alters the course of a child's life and sets in motion a disadvantaged path of social, economic and health outcomes (The Children's Society, 2017[13]; Ayer, 2016[14]). Adverse childhood experiences and becoming a looked-after child are considered factors of vulnerability to criminal exploitation (Children's Society, 2019[15]; Longfield, 2019[16]).

47. Children and vulnerable adults are often targeted by criminals because they are easy to manipulate and control, less likely to be detected and cheap to employ[17]. Children with special educational needs (SEND) have a generally

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[13] Children's Society (2017), Understanding childhoods: growing up in hard times [report], London, The Children's Society.
[14] Ayre, D. (2016), Poor Mental Health: The Links between Child Poverty and Mental Health Problems [Report], London, Children's Society
[15] Children's Society (2019), "Counting lives: responding to children who have been criminally exploited", available at: www.childrenssociety.org.uk/information/professionals/resources/counting-lives accessed on 20th December 2021
[16] Longfield, A. (2019), "Keeping kids safe: improving safeguarding responses to gang violence and criminal exploitation", London, Office of the Children's Commissioner for England, available at: www.childrenscommissioner.gov.uk/report/keeping-kids-safe accessed 21st December 2021
[17] Williams, A.G. and Finlay, F. (2018), "County lines: how gang crime is affecting our young people", Archives of Disease in Childhood, Vol. 104 No. 8, pp. 730-732, http://dx.doi.org/10.1136/archdischild-2018-315909

reduced capacity to process facts and other information to make 'informed decisions. They are most likely to be children with undiagnosed learning needs. There is well-documented evidence about the link between absence from school and safeguarding concerns; Covid has represented an unprecedented additional risk factor for these children.

48. The emergence of these 'cross over'[18] child protection involved children being especially vulnerable to criminal exploitation such as one of the older siblings is a major challenge for safeguarding partnerships across the country. Contextual safeguarding extends the locus of child protection thinking from the "home" to include the "environment". The effect of this strategy is to draw crime prevention and community safety approaches into safeguarding thinking and practice.

49. Public health is rooted in the philosophy of providing the maximum benefit for most people. A public health approach to reducing levels of criminal exploitation requires developing insights into the "causes of the causes" of criminality, offending and victimisation. This goes beyond situating the problem with the child and their family, to investigating the opportunities that allow for such criminality and identifying where organised abuse is occurring.

50. CCE, therefore, needs a comprehensive strategic safeguarding response rooted in a public health ethos of early intervention and prevention and is not just targeted at children such as the W siblings who have been subject to CPP and CIN over many years. The fact that their vulnerability was already known and caused the CPP and CIN, there should have been an additional element of assessment and intervention. Contextual safeguarding that does not just focus on the child's immediate home setting but also the wider setting has to be addressed. This applies in terms of strategic public health and policing prevention strategies as well as to child-specific decision-making. Barlow[19] describes 'the intersection of a motivated perpetrator, suitable target and absence of capable guardians (e.g., police, parents, neighbours, park wardens)' within a theoretical systemic framework of child criminal exploitation.

51. In addition to contextual safeguarding, other promising emerging approaches identified in the south-east England study include harm reduction approaches, trauma-informed practice and the value of relationship-based practice[20].

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[18] Baidawi S & Sheehan R 2019. 'Crossover kids': Offending by child protection-involved youth. Trends & issues in crime and criminal justice no. 582. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/tandi/tandi582 accessed 6th January 2022

[19] Barlow, C et al 2021 Circles of analysis: a systemic model of child criminal exploitation Journal of Children's Services p7

[20] Lefevre, M. et al 2020 [Report] Child Criminal Exploitation in the South East of England: family experiences and professional responses University of Sussex https://yjresourcehub.uk/images/Childexploitation1/Child%20criminal%20exploitation%20along%20the.pdf accessed on 20th December 2021

4 Summary of learning

52. The family had a good level of contact with different services with regular communication between the different professionals. Meetings such as core groups were well attended and there are examples of highly dedicated support to individual children by several people. The FSW developed a good supportive relationship with the mum who managed to improve some aspects of her care for the children using the graded care profile and Triple Plus Parenting programme and improved attendance at school although absences still occurred[21]. There were several occasions when people such as teaching staff and out of hour's workers visiting the home intervened to keep children safe from a sibling often going far beyond what would be expected. The school where the older siblings attended had for a long time been providing a great deal of support to the family which included intervening when the behaviour of one of the older children in particular, became dangerous, helping to clear up the house after episodes of damage and help to get the children to various appointments.

53. National studies describe the importance of good quality relationships with families as the primary requirement for effective safeguarding practice. The triennial review in 2016[22] outlined the importance of moving from episodic incident-based interventions to more extended models of support that are rooted in a cumulative perspective on safeguarding needs and are informed by a historical understanding of family patterns including how services are used.

54. This is a case where CSC struggled to provide the right level of leadership and coordination and did not appear to understand how to recognise and respond to neglect in a large sibling group. Some of the people who saw the children most often were not listened to carefully enough. CPC discussion was too focussed on action planning at the expense of developing a deeper understanding of the children's circumstances and independent chairs were not in a position to offer the level of reflection and challenge the case deserved. There was a palpable sense of drift including the use of legal measures to protect the children. Legal discussion involved people who generally knew least about the children or understood potential evidence to put before a court. Although professionals became very concerned about the children the concerns were raised outside of the statutory partnership's escalation process. It provided no significant impetus for senior managers to act differently or more effectively.

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[21] NSPCC had previously used the graded care profile when working with the mother and the older siblings although only two sessions were completed due to the home circumstances being impossible to complete any planned work

[22] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final Report 2016

55. The chaotic behaviour in families being mirrored in professional thinking and action and becoming overwhelmed by too many problems to deal with and with too much to achieve was described in 2009.[23] Practitioners who are overwhelmed not just by the volume of work that they are expected to do but also by the nature of the work are less likely to achieve good enough outcomes for children.

56. The family and its multiple difficulties were complex and overwhelming. The impact of being overwhelmed included:

    a) The inability to analyse or understand the family promoted a lack of confidence in the overall strategy and approach contributing to a reactive approach relying on the mother's cooperation and hesitancy in using the law better; the mother asserted several times that she saw nothing wrong with her parenting.
    b) Social workers and their supervisors, in particular, did not recognise indicators of neglect, the inability of the family to meet the diverse and complex needs of the children and complicated further by the family living in an area of generally high deprivation; social workers are less well equipped to understand the significance of data from education and health.
    c) Lack of a sustained professional challenge with a preoccupation with thresholds; the risk matrix against generalised danger statements or whether PLO was met for example.
    d) The temptation of starting again is exacerbated by an absence of consistency in key services such as CSC, an absence of good enough chronology and insufficient good quality assessment.

57. Some professionals such as health visitors and teachers were very worried about the children. The level of worry was less in CSC which had less direct contact and where there were problems of high workloads, high staff turnover and difficulties in recruiting and retaining social workers. This contributed to drift and less sense of urgency particularly when attempts were made to escalate concerns with more senior people. The reviewing service was also under pressure and could not provide the level of challenge and reflection the case needed.

58. Strong management support was not available to help social workers and conference chairs, in particular, manage, monitor and think more systematically about a case where long-term complex neglect had been an issue for many years. The focus was more on avoiding the children being on a CPP for too long rather than inverting the thinking into why these

[23] Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C., and Black, J., (2009) Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005-7, Department for Children Schools and Families, Research Report DCSF-RR129.

children had so many episodes of being on CIN and CPP and with such little improvement.

59. Although neglect is less likely to be fatal compared to other abuse it nonetheless has serious long-term adverse consequences for children of all ages and especially during infancy when critical development needs to happen. The level of risk facing the baby when the mother changed her mind about relinquishing was poorly understood particularly when it was known that face-to-face contact was going to become very problematic due to Covid.

60. The neglect of the children was manifest in multiple issues; none of the children had a good attendance record at school or nursery despite the efforts of the schools which included visiting the home physically helping to get children to school; several of the children presented with slower development in language and social skills compared to their peers; one of the children had multiple dental extractions; all of the children were exposed to violence from the behaviour of older siblings as well as from various adults who visited or spent time in the home. The children individually displayed behavioural and emotional symptoms of the persistent neglect they experienced in the care of their mother although were not reflected in risk statements such as the signs of safety (SoS) scaling.

61. Neglect is the result of a complex interplay between risk factors in children and the care they receive from their primary caregivers and is appropriate to their age and stage of development. Appropriately structured assessments that explore parental risk factors such as poor experiences in childhood, and mental and physical health and take account of other issues that can include domestic abuse and misuse of substances. Neglect is cumulative in terms of the child's lived experience and the impact on their development and well-being and was a factor for all the siblings. Assessment has to be from the perspective of the child. What is the child feeling? Are they feeling stressed? What makes them happy? Do they feel loved and valued? The quality and style of the respective children's attachment were not explored (despite behaviour and what some of the children were saying).

62. The baby needed regular changing and washing; a calm and nurturing environment with attention and stimulation to develop basic skills and to feel safe and secure. Records of visits to the home do not describe this level of care but rather the chaos and risk from the behaviour of siblings. The younger children needed stimulation and opportunities to experiment and interact with others through play; sensitive and supportive conditions to promote abilities and encouragement, praise and security. Attendance at the nursery was not prioritised by the mother. Neglectful care might result in a significant event such as an injury such as occurred in December 2019. Cumulative child neglect will be manifested in other evidence that includes

the behaviour of the children as can be seen in this case along with their impaired social, linguistic and educational development. Their intellectual and social functioning was below average and although linked to learning difficulties for some of the children was an issue for others who were not diagnosed with a learning difficulty. Language delay, difficulty in using expressive and receptive language, unable to articulate feelings was an issue for two of the children. All of the children had a poor vocabulary. Assessment has to be focused on what is happening to a child not what an adult says or expresses as their intention or wish.

63. The recording and consideration of the children's lived experiences, wishes and feelings were not given enough attention. Given the size and range of complexity of the sibling group and the absence of information being provided by CSC, an advocate could have been considered but was not. Children's behaviour is an important indicator of their lived experiences. Talking with children and encouraging them to speak about their day-to-day lives was given limited attention in CPC meetings. There was a reliance in the minutes of the CPC discussion that the social worker would be doing this work although is not included in reports or records of discussion. Another CPC met after the children became looked after and delegated the task to the LAC review process.

64. Except for the substance misuse service was in contact with two of the sibling's respective fathers no other service was working with the siblings and their mother had much-recorded information about the different men who were known to visit and sometimes stayed in the house.

65. The strategy meeting in December 2019 was the culmination of concerns about the children although the focus was on the allegation that the mother had assaulted the children which had been withdrawn and different accounts were given by different children for the injury to one of the children's eyes. The strategy meeting involved CSC, the midwifery service and the police as well as the schools that had daily contact with the children. The injury was not seen enough as a symptom of likely neglect when the responsibility was shifted from the mother to one of the children. Physical abuse rather than neglect was the preoccupation. The police highlighted during this review that the recording of decisions needed to be improved. None of the children was spoken to as part of enquiries.

66. The initial CPC in January 2020 was the second time a CPP was made and as before it was for neglect. The extent of concerns discussed included the specific needs of one child associated with autism and sensory overload of a chaotic household, the level of another child's aggression, emotional and behaviour difficulties, the sexual assault on another, their mother's pregnancy and her difficulty in meeting the needs of her children, the absence of a supportive family network as well as the general neglect of the children. The recent history of interventions through CIN and CPP should have provoked a discussion about whether the children were safe in the household without emergency measures being used or invoking the PLO

process. Such a large sibling group with complex needs represented a challenge in terms of possible placement options and may have been a further deterrent to a more assertive approach. Some of the ICPC attendees had concerns that it was mum and her needs that dominated the discussion rather than giving enough focus on the individual children.

67. The absence of a chronology being developed at this stage meant that until the rapid review and this LCSPR, none of the people who were trying to address the complexity of this family had the benefit of a complete picture of the cumulative harmful experiences to the children.

68. The signs of safety (SoS) framework is used in NEL (and many other local areas) to help professionals develop a shared understanding of the risk to children discussed at child protection conferences. The SoS draws heavily on elements of solution focussed brief therapy, working with the family's strengths and resources, goal setting and scaling. The SoS assessment or mapping is set out in a matrix of danger statements supported by separate columns detailing what is worried about, the reason, what is working well and what needs to happen.

69. The safety scale aims to judge the severity of risk by taking into account what mitigates risk alongside other factors that exacerbate it. It provides limited analysis and by its nature is a barometer of where people estimate the risk to be at a given moment. It is inherently flawed if there is not a robust enough assessment underpinning the discussions, particularly when working with cumulative harm from neglect. A short-term improvement in parental behaviour or physical standards can result in misjudging or becoming mistakenly optimistic. Disguised compliance may have been a factor in this case given the mother's repeated assertion that she saw little wrong with her parenting and access to the home became especially problematic during the Covid lockdowns when the mother reported more than once having symptoms and therefore preventing scheduled visits from taking place. Some of the professionals who participated in a consultation event as part of the review described their repeated efforts to make contact with the children at home and how this was not sufficiently flagged as a concern. This included the SAL practitioner who was not included in the core group or invited to child protection conferences.

70. A difficulty facing the SoS process was not having danger statements that reflected need and risk as they related to each of the children. For example, a danger statement that reads "that conference is worried that all children have suffered neglect" is not as compelling as making statements about how neglect had harmed each particular child; one child was sexually abused by an adult allowed into the home; another child's multiple and complex problems were not a condition of a learning difficulty or disability; a third child's constant state of distress to the physical and sensory chaos around the home. These are harms that had been happening to the children for a long while and continued. The complexity of actions that resulted along with how progress was then managed resulted in professionals becoming persuaded that progress was being made when for example there was an

improvement in some aspect of physical care. There was a disconnect between harm and what was then being assessed as an improved outcome for the children.

71. The long and complicated actions that flowed from the SoS process constrained and encouraged the CPC to be a discussion and activity planning session rather than a forum able to address the quality or effectiveness of various actions in improving the circumstances of individual children.

72. One of the children's levels of aggression was a dominating concern and after becoming looked after in 2020 a review CPC queried whether PLO proceedings were still required suggesting that there was not clear enough attention on the harm to other children irrespective of one of the sibling's particularly violent behaviour in the home. The Young Minds Matter (YMM) service worked with the child. It was this service that recognised that the child had multiple risks in terms of themself and others. The child was being careless with personal hygiene as well as displaying increasingly risky behaviour towards other people and had access to large amounts of money. This was reported to the initial CPC in January 2020. The YMM were focussing on therapeutic work to help the child self-regulate their anger and emotions. The Covid lockdown brought an end to the involvement of YMM.

73. The ICPC agreed that the children needed a "safe and happy place to live for their basic needs to be met by their mother who was expected to ensure there were no unsafe adults in the family home". The midwifery service was not a party to the ICPC and there was no discussion with the midwifery service about the impact on the baby from the already chaotic and risky home environment. The ICPC resulted in 25 tasks being agreed upon. The mother was pregnant with the baby and throughout the pregnancy was planning to relinquish the child at birth.

74. The quality of assessments overall was not good enough and the absence of a chronology and changes to social workers contributed to the cycle of starting again which frustrated other professionals. No psychological or cognitive assessment was completed with mum to establish a baseline about mum's understanding of her individual children's needs; it was not supported by managers in CSC. Mum disputed that there was anything wrong with how she was parenting her children. The absence of a positive and supportive family or friends was given little attention. A parenting assessment could have created the opportunity for a clearer understanding of how some very complicated history and need was interacting and influencing the parenting of the children as well as where and from whom mum would get support other than professionals.

75. The minutes of the first review CPC provided an update against actions agreed at the previous CPC as well as describing new or refreshed actions. The CPC was not aware that the baby had been presented at the A&E the

day before the CPC. However, the CP-IS that notifies children's social care of their attendance at A&E was utilised.

76. The baby's birth was full term and occurred before the first review CPC. There was no strategy for responding to mum's change of plan to take the baby home just as the Covid 19 lockdown was being implemented. In a core group discussion just after the birth was told this was a last-minute decision. The health visitor expressed concern that no preparations had been made. There was no consultation by the social worker or any other core group member with the chair of the CPC or request to convene an early CPC and no discussion about the potential use of emergency legal measures. It is an example of where there was little confidence and challenge. Following the birth, the midwifery team informed the social worker of the delivery and that mother did not wish for the baby to go into foster care. A social worker contacted midwifery and confirmed that the mother and the baby could go home when fit for discharge and CSC would visit the family home. There was not a discharge planning meeting due to Covid -19.

77. The lockdown prevented the routine birth home visit by the health visitor who tried unsuccessfully to call mum on the phone. When the health visitor managed to speak to mum in early April 2020 the health visitor was concerned about the slow weight gain. The baby was not taken for the new-born hearing test and was presented at the A&E the day before the first review CPC which was not made aware of the contact. The attendance was routinely notified to the GP who would have known about the CPP but did not follow up on the information either with the health visitor or the social worker. Also due to restrictions of the Covid-19 pandemic, the new-born hearing test was not able to be completed on the ward at birth and not at home either due to shielding with another sibling with complex health problems and Covid restrictions. This was later picked up and health professionals were aware this was required at a later date.

78. The social worker's email to the core group confirming that mum had decided to keep the baby informed the core group that a legal meeting had been held. There is no reference to an outcome and there is no record of a legal meeting taking place since the birth. The social worker reported waiting for senior management advice on how to proceed and confirmed that core groups would meet virtually. The email stated that CSC was "reviewing how best to support the family" and acknowledged that there would be a reduction in the visits to the home. It also acknowledged that there were "significant concerns for all the children" and the need for "oversight" and would do its "best to have the support in place for the family". It was effectively hoping for the best. The email is indicative of a significant systemic weakness in critical oversight and decision-making for children. The social worker had no mandate or clear direction and did not appear to have the necessary support and direction from a manager.

79. There was little knowledge and discussion about the legal pathway outside of CSC which meant that evidence about neglect held by most of the

services was not included. The safeguarding nurse for Children's Health Provision (CHP) is now part of the gateway panel.

80. The schools continued to have almost daily contact. Some of this was to help with practical arrangements for organising remote learning but it was an opportunity to talk with mum about what was happening and how she was coping. It was evident she was struggling physically and part of that was letting the older siblings do their own thing such as sleeping in to avoid arguments. It was the schools that had the most regular contact and escalated concerns later in the year. The schools were not made aware of other significant contacts such as the joint visit by CSC and the police in late July 2020 or the contacts with the GP.

81. The GP had little involvement or knowledge about the significant events that occurred during the scope of the timeline. The record of the mother's adverse childhood and abuse was contained in the GP records. The GP was also aware of a pattern of the children not being brought to health appointments and there were also presentations at the A&E service. These were all potential alerts. The GP practice did not receive invitations to CPCs or receive minutes or the CPP. The GP had no information recorded about the baby's presentation at the A&E in April 2020 because the baby was not registered until mid-May 2020. The consultation in January 2021 when the baby had sustained a bruise does not refer to the CPP; the recording is only focused on physical symptoms and giving reassurance. There is no discussion at an MDT safeguarding meeting.

82. NAVIGO mental health services were not invited to any multi-agency meetings although were working with two of the sibling fathers who had regular home visits from substance misuse practitioners.

83. The school's escalation of concerns in mid-November 2020 followed several email exchanges within the core group and with CSC which included the school, social worker and out-of-hours service as well as the police having to intervene in a series of incidents where the mother was struggling to manage very challenging and destructive behaviour from some of the children. Significant damage was caused to the fabric of the house and various possessions on different occasions. The school like other services did not contribute information directly to the legal gateway discussions. Members of the core group had wanted the siblings' circumstances to be discussed at a legal gateway meeting during 2020 although this was not supported by senior managers in CSC. It was at that point that the core group escalated their concerns although this was not done through the safeguarding partnership's procedure.

84. The criminal exploitation of children is a threat to the safety of children who are already likely to be experiencing an adverse childhood that includes multifaceted abuse within their homes. The older child's needs were already complex and made them vulnerable to criminal exploitation. This was a significant additional and different threat to the child's safety from outside

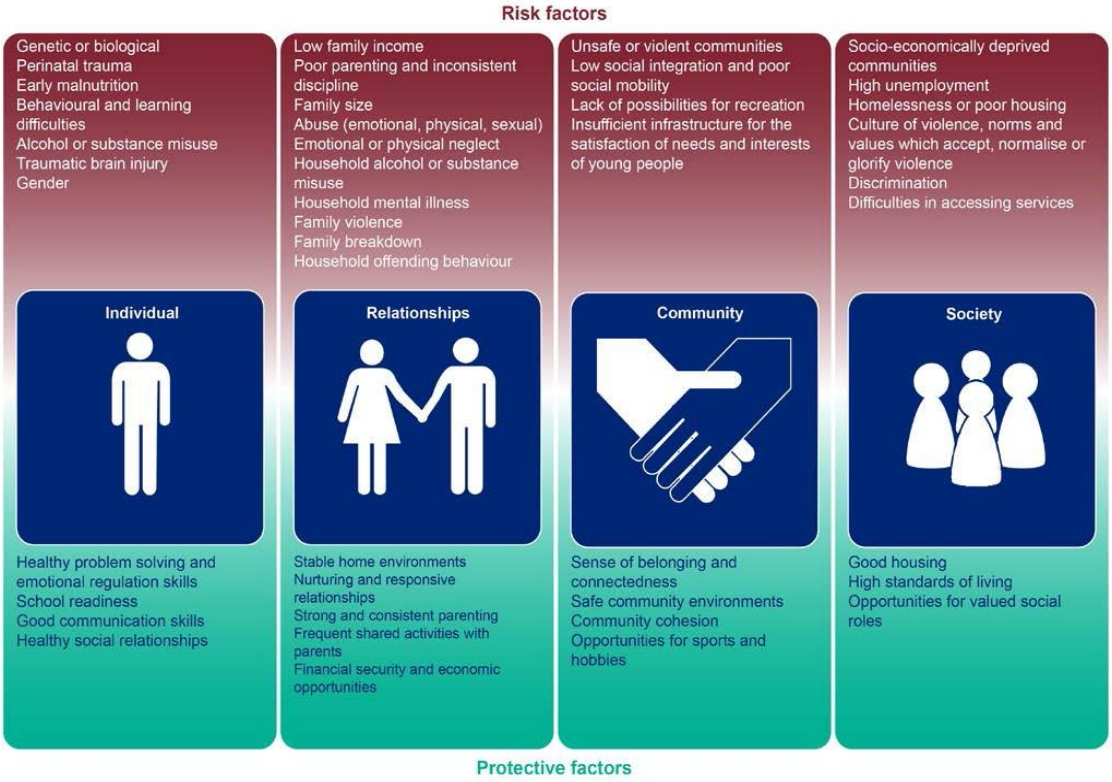
the family. It required an assessment and analysis of the community risk factors alongside family functioning and coordinated professional intervention that included criminal justice as well as other services.

85. Contextual safeguarding is a model that recognises children and young people are influenced by a wide range of people and environments outside their immediate family. Children such as the W siblings are confronted with multiple risks associated with their family as well as from outside through criminal exploitation for example. This means that at an individual level for a child, the risk assessment needs to take into account where the risk is coming from and identify strategies for addressing it.

86. It also requires individual risk assessment and safety planning to be part of a broader public health strategy that targets the context and conditions in which criminal exploitation is taking place and develop effective partnerships focused on systems-based interventions such as those advocated by Public Health England[24] and the contextual safeguarding network[25]. The PHE report includes the following infographic summarising the risk factors for offending behaviour for children and young people.

[24] Public Health England (2019) Collaborative approaches to preventing offending and re-offending in children (CAPRICORN) A resource for local health & justice system leaders to support collaborative working for children and young people with complex needs PHE Available from https://www.gov.uk/government/publications/preventing-offending-and-re-offending-by-children [accessed 31st December 2021]

[25] https://contextualsafeguarding.org.uk/wp-content/uploads/2020/10/CS-Legal-Briefing-2020-FINAL-1-1.pdf



87. The W sibling had few sources of resilience the risk of becoming criminally exploited was always high.

5 Assessment of systemic or underlying influences

88. This part of the report includes information and reflections from the consultation event with people who worked with the children or for example chaired child protection conferences.

89. Significant influences and learning from the review include:

a) Keeping a focus on individual children within larger sibling groups in collating direct testimony about their lived experiences, feelings and wishes as well as measuring their development, health, safety and wellbeing has workload implications; having a baseline from which to make reliable judgments about the evidence and impact of neglect; the value of a child's advocate in complex and longstanding cases to ensure children's voices and lived experiences are sought, considered and given status in assessment and plans despite the information being reported by schools in particular; this includes giving clearer attention to behaviour as indicators of emotional distress; Insufficient direct work with children included within reports and CPC discussions; reliance on the social worker representing the children's view despite having less contact and knowledge than other professionals such

as schools; during the consultation event the social worker currently working with the children since the summer of 2021 described how each of the children's needs were now being assessed.

b) Lived experience of children and understanding communication; several people at the consultation event talked about how the way the children behaved was not understood well enough by non-specialist staff including social workers; some talked in detail about how a non-verbal child's behaviour had profound implications for understanding the importance of their care environment and routine that was absent at home and the acute distress displayed by the child at home compared to other places; another health professional talked about the evidence of head flattening (Positional Plagiocephaly) for the baby not being picked up as evidence of a child being left unattended.

c) The importance of chronology and holistic assessments; no single assessment model is a substitute for thorough assessments that provide sophisticated analysis that takes account of the development needs of individual children, family and environmental factors; sufficiently comprehensive assessments that consider the history and are informed by an analytical understanding of cognitive, developmental and psychological factors; at the consultation event there was a consensus that there had not been enough knowledge about the history and that frequent changes of social workers had diluted knowledge.

d) People with the most contact with children and who are best informed about their needs and their daily lived experience are vital sources of information and professional partners; school and health professionals are clearer about evidence of developmental harm; people who have the least day-to-day contact with children can have a superficial understanding.

e) Good participation in meetings and regular communication is not a substitute for well-co-ordinated and purposeful work and analytical reflection; respecting the validity and specialist insight that people like education and health professionals can provide in understanding signs and consequences of neglect; the SALT was not invited to the child protection conferences or involved in the core group.

f) GP practices need to be involved in enquiries, assessments and shared information about children subject to CPC and CPP; the role of other health services such as dentistry as potentially important partners in identifying concerns about children.

g) People working with children subject to CPP need access to effective systems of consultation that are linked to

procedures for escalating concerns about children through internal systems and these are linked with local statutory partnership escalation pathways.

h) The importance of having a clear strategy for responding to neglect that is owned and understood by all the respective organisations; this also needs to be supported by having assessments that can meaningfully explore the nature and impact of neglect.

i) Having enough social workers with the appropriate knowledge and experience to work with complex families and have the time and support appropriate to the task; means having the right people with the time and aptitude who are well supervised and supported being able to develop effective relationships with parents whose lives are complicated and complex; many factors combined as cumulative harm such as ill-health, substance misuse, poverty, criminality, and domestic abuse create the latent conditions for inconsistent and ineffective parenting.

j) Relationship-based practice and working with parents who have experienced trauma or instability or abuse in their childhood are likely to display difficulties in how they can respond to and understand the needs of their children; this can manifest itself in many ways including disorganised parenting, putting their own needs before that of their children, emotional unavailability; providing timely trauma-informed early intensive help.

k) The chairs of the CPC have the remit and capacity to ensure effective risk assessment and good quality reviewing is more than discussion and activity planning sessions and can challenge including the use of legal measures; distinguishing between the CPC overseeing the effectiveness of intervention and the core group being responsible for detailed activity and planning; the importance of professionals bringing clear information and concerns to a CPC and recognising that the CPC is an integral part of escalating action to protect children; the chair of some of the CPCs described how the SoS scaling did not reflect the level of concerns that had become evident through the review; several people who attended the CPC and core groups described it as an exhausting and very frustrating process.

l) Quality assurance and supervisory oversight of social work practice including oversight of information being provided by CSC to the CPC; in this case reports were unsigned; no use of child advocates despite a large sibling group where children have distinct and individual needs and some have become voiceless; poor understanding about the importance of observing recording and understanding behaviour within developmental frameworks.

m) Escalation processes that are effective and that all professionals understand and confidently know how to use to raise concerns and deliver outcomes for children; although concerns about the slow response of CSC, in particular, were raised, this was done outside of the escalation framework and protocol; a contributory factor was agencies not having a designated lead to ensure the process is used and there is no oversight or auditing; three separate occasions were described at the consultation event when different professionals tried to raise concerns that did not lead to change happening; on one of those occasions the core group wrote to the Director of Children's Services (DCS) who acknowledged it was an escalation of concerns but did not result in different outcomes; some people were surprised that they had not been aware of all the times an escalation had been attempted; the escalations had been with line management in children's services rather than to the safeguarding board (now a partnership) and there was discussion about how the process is now routed to the chair of the safeguarding partnership; more than one person at the consultation event reported that the challenge of identifying suitable placements as well as cost was a factor in not removing the children more promptly.
n) Managers in children's services did not take timely action which led to the informed advice and judgment of professionals working with the children being disregarded; they contributed to the episodic start-again cycle and retained undue influence as key decision-makers such as the legal gateway panel meetings.
o) Legal and child-based risk discussions being aligned and delegation of decision making; agendas for strategy meetings and child protection conferences considering whether legal advice including emergency action is likely and have access to legal advice; several participants at the consultation event described their frustration when there were repeated requests for new or additional evidence and their exclusion from conversations about legal action; one person referred to "changing the goalposts".
p) Understanding of contextual safeguarding concerns and the axis of family and individual factors with the environment; children at risk of harms from outside of their family; different approaches and interventions are required for children at risk from criminal exploitation; it requires a focus on crime prevention and community safety strategies that are part of child protection, child welfare and safeguarding and built on partnerships.

6 Recommendations to safeguard and promote the welfare of children

1. A copy of the report should be given to the commissioner appointed by the Secretary of State for Education to inform the improvement plan and development of professional practice in response to neglect.
2. The Director of Children's Services (DCS) should provide information and evidence about how issues of social worker and manager recruitment and the capacity of the service to respond to complex child protection highlighted by this case will be addressed. This includes management oversight/supervision to prevent drift and to improve social work practice and IRO capacity and effectiveness.
3. The Director of Children's Services (DCS) should satisfy themselves with the effectiveness of Signs of Safety (SoS) as implemented in NEL in supporting effective assessment and management of risk for children.
4. The Director of Children's Services (DCS) should ensure that a review of arrangements for the chairing of child protection conferences and reviewing of child protection plans is completed and action is taken to ensure the CPC provides appropriate reflection and challenge and is linked to the processes for escalating concerns about children.
5. The Director of Children's Services (DCS) should ensure that the IRO service has an effective system of escalating concerns about individual children that are also linked to the safeguarding partnership's escalation procedures for local services.
6. The Director of Children's Services (DCS) should ensure that advocates for children can be appointed and are routinely considered in complex and/or longstanding cases involving neglect.
7. The Director of Children's Services (DCS) and Director of Legal Services should ensure that appropriate arrangements are in place for social workers to seek emergency protection for children when necessary and that strategy meetings, child protection conferences and core groups have access to appropriate legal advice when necessary.
8. The Director of Children's Services (DCS) and Director of Legal Services should review the constitution, membership and functioning of the legal gateway to ensure appropriate evidence from professional core groups and child protection conference participants is considered.
9. The Director of Public Health should consider what further work is necessary to raise awareness among public health professionals including dental services about their role in identifying and responding to potential child neglect.
10. The CCG should consider what further advice and support should be given to primary health care services about having effective policies and protocols in place for responding to child

neglect. This includes the use of relevant codes to flag patient records and the value of multi-disciplinary team meetings.

11. The NEL safeguarding children partnership should ensure that a strategy for understanding and responding to neglect in NEL is agreed upon and is supported by multi-agency and assessment frameworks.
12. The NEL safeguarding children partnership should review and if necessary, change the escalation procedures to ensure that all relevant organisations and their workforce can raise concerns about a child. This includes making sure that the chair of the partnership has a clear role and oversight of the arrangements, and that organisations have appropriate arrangements to promote awareness and use of escalation when necessary.
13. The NEL safeguarding children partnership should review existing policy and practice guidance for responding to children not brought to appointments and for this to encompass SALT along with other health care professionals.
14. The NEL safeguarding children partnership should consider what further developments may be indicated in respect of early help and intervention with younger children at risk of community-based harm and the use of local contextual safeguarding arrangements.
15. The quality assurance sub-group of the NEL safeguarding children partnership should ensure that arrangements for inviting primary care health professionals including GPs to child protection conferences and sharing minutes and child protection plans are effective.

The methodology and terms of reference

Agencies who provided information to the serious case review

90. The following services provided information although for some such as Cafcass[26] and the local contact service this was not until the children became looked after as a result of the Family Court proceedings:

a) Humberside Police have responded to multiple incidents which included domestic abuse and child behaviour.
b) Lincolnshire Partnership Foundation NHS Trust provided the Young Minds Matter service (YMM) working with one of the older children from October 2019 until May 2020.
c) NAVIGO substance misuse services had regular contact with two of the siblings' fathers.

[26] Children and family court advisory and support service

d) North East Lincolnshire Children's Health Provision is responsible for health visiting, school nursing and a team of specialist safeguarding nurses.
e) North East Lincolnshire Residential Care Services; one of the children was provided with respite care from December 2019 beginning with an emergency placement.
f) North East Lincolnshire Council Children's Safeguarding and Review Service; independently chaired the child protection conferences and statutory looked after child (LAC) reviews after the children became looked after by the local authority.
g) North East Lincolnshire Council Inclusion Service; service was involved with one of the children for behaviour support to prevent permanent exclusion from mainstream education; their reintroduction to the mainstream was delayed by several incidents of Covid related shielding and isolation; the service advised that a PAMS assessment might be helpful but mum declined.
h) Northern Lincolnshire and Goole NHS Foundation Trust hospital-based outpatient emergency care centre (ECC) had contact with six of the children, four at ECC and two on an outpatient basis
i) NSPCC knew the family that predates the scope of the review and concerned the mother's two eldest children; during their contact, they attempted to complete a graded care profile although only two sessions were completed despite the efforts of social workers who were concerned about the level of neglect both children suffered. NSPCC did not have involvement with the family during the scoped timeline for the review but participated in the review and contributed to learning. The service has introduced a case management and supervision planning tool to better capture case progress and actions when significant personnel such as social workers or managers move to different roles.
j) School 1 was attended by one of the children from 2018.
k) School 2 was attended by four children until they became looked after in 2021.

Action from the rapid review

The rapid review identified the following action to be taken:

i. A Performance Report of children who have been open/closed for neglect for significant periods across CIN/CP/EH is to be built and run within two weeks. Cases are to be reviewed and reported to SCP within six weeks. This will identify any children in the system who may have similar characteristics in terms of length of involvement across thresholds.
ii. Children on CIN / CP plan for neglect for more than 15 months to be audited by auditors skilled in neglect to eliminate drift any drift and delay.

iii. The SCP Executive to consider how a greater understanding of the reasons why the local escalation process over time has not been effective.
iv. An inter-agency task and finish group is to be established to develop Standards for multi-agency meetings, (Early Help CIN/Core groups) to include children not seen by any member of a core group within a time frame, child development and key milestones) the lived experience of the child and using Signs of Safety scaling to demonstrate progress.
v. Where a child who is open to Children's Services has an identified therapeutic service provision i.e., SALT, Occupational Therapy and discharge are being considered due to the child not being seen, this should be reviewed in supervision with the safeguarding lead for the agency and decision recorded.
vi. Children receiving short breaks are to be subject to children's social care performance reporting meetings monthly to ensure compliance with legislation in that no short break should exceed 17 days of continuous care and total provision should not exceed 75 days. If accommodation is needed which exceeds this, then it should be provided under the specific duty of S.20 (CA 1989) and is not classed as a short break.
vii. Work to be undertaken with local dentists to raise awareness, highlight safeguarding issues related to safeguarding issues and local referral pathways.
viii. Strategy discussion to be held within 24 hours of Police Protection being issued and a decision regarding whether any other legal order is required to be made.
ix. The SCP to make a decision/ recommendation in respect of the use of multi-agency chronologies on neglect cases at key decision points
x. Multi-agency chronology technological solution to be explored.
xi. Any children subject to initiation of 2 Public Law Outline episodes for the same concerns are to be reviewed at the Head of Service level and consider whether all appropriate assessments have been completed.
xii. Multi-agency family history to be considered as an indicator of risk within single assessments and reassessments.
xiii. Clear practice guidance on when reassessments or specific assessments should be undertaken (for example but not exhaustive) new pregnancy, concern re neglect (GCP2), parenting assessment, PAMS, psychological, AIMS, mental capacity, video interaction guidance VIG).
xiv. The SCP Executive facilitates partners to produce, and agree on the local approach and /or response to neglect, to ensure consistency of application of thresholds.
xv. Children's Social Care to review the scheme of delegations and determine management decision points including but not exhaustive: escalation, and children subject to more than one period of Public Law Outline.
xvi. The effective use application and impact of the local Escalation process to be added to the SCP audit programme

xvii. NLaG is developing Guidance for the Management of Bloodshot Eyes in babies.
xviii. A&E to ensure that a pathway is followed for Children and young people who attend without a GP and who would be notified. This is followed up by the safeguarding liaison nurse and children's health providers are notified.

Details of the independent author

Peter Maddocks was the independent reviewer. He has not worked for any of the organisations that have contributed to this review and has not held any elected position in North East Lincolnshire (NEL). He is not related to any individual who either works or holds an elected office in NEL.