Local Child Safeguarding Practice Review
Child B and siblings

Contents

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1: Introduction and summary of learning

1.1 This Local Child Safeguarding Practice Review (LCSPR) was commissioned by Stoke-on-Trent Safeguarding Children Partnership (SOTSCP) to consider the multi-agency safeguarding responses in respect of a young child involved in a near-fatal incident and his siblings. Child B was brought to hospital following a seizure. Concerns were raised that he had ingested some substances, and initial toxicology picked up citalopram (anti-depressant) and lamotrigine (anti-epileptic). Lamotrigine on repeat testing was felt to be a contaminant, but Citalopram continued to be present on repeat sampling. The scope for the review was widened regarding possible harm to Child B's younger siblings following additional toxicology evidence regarding substances also present for them. This meant the time frame included the period relating to this pregnancy covered a three-year period. At the time of the review, there was an ongoing police investigation to consider how the substances were administered/found within the child(ren).

1.2 At the time of the significant incident the children were closed to Children and Families Early Help services. The family was opened to Children's Services in the local authority for a very brief period when the family were thought to be moving to the area but then closed as this did not happen. When the family did subsequently move, they were supported via universal services[2] and two periods of Early help.

1.3 The Rapid Review[3] identified considerable family history that was knowable to agencies, but this was either not accessed or was not used to inform assessment of the family's safeguarding needs. Analysis of historical information is included where relevant and significant to the learning. The review will consider systems and practice within and between partner agencies to identify learning and strengthen and improve practice across the Partnership. Whilst the key learning reflects mainstream services at an early help and universal level,

there is transferable learning that applies to all services in respect of information sharing, understanding the history and neglect.

1.4 The timeframe includes the period of national lockdown between March 2020 and March 2021. The CSPR also bridges a period of transition for the local authority's early help offer with the launch of its Early Help and Prevention Strategy 2020-2024[4], setting out its ambition for providing early help support for children and families based on a continuum of need. One of its key priorities is providing support to parents to raise their children to be healthy and happy. Since 2021 one of the practice priorities for the Stoke on Trent Safeguarding Children's Partnership has been safeguarding 0-2-year-olds. The Partnership has worked with partners to promote Early Help for families emphasising the importance of supporting young families and has introduced the "thrive at five"[5] approach. The period also reflects Stoke-on-Trent's Children and Families Services improvement journey from inadequate when inspected by OFSTED in February 2019 to Requires Improvement in October 2022, demonstrating that services for vulnerable children and families in Stoke-on-Trent had improved substantially. This review does not intend to repeat learning actions already identified as part of this improvement journey but will highlight practice improvements and system changes relevant to this review now forming core practice across organisations that the Partnership can seek assurance on.

[2] These are services that are available to all children and young people such as health and education, they tend to have a focus on prevention
[3] A Rapid Review is undertaken to ascertain whether a LCSPR may be appropriate. Chapter 4 Working_together_to_safeguard_children_inter_agency_guidance.pdf (publishing.service.gov.uk)
[4] Early Help and Prevention Strategy 2020-2024 | Early Help and Prevention Strategy 2020-2024 | Stoke-on-Trent
[5] About Thrive At Five - Helping Children Achieve Their Full Potential

1.5 Summary learning.

The following learning points are detailed in the report and summarised here

- Knowing the history and understanding predisposing vulnerabilities and risks
- The impact of adult issues on parenting and assessment of support needs
- Consideration of the impact of adult medication on parenting
- Recognising and understanding neglect across universal and early help services
- Ensuring information-sharing and recording systems are clear and inform threshold decisions
- Patterns of attendance for health and education provision, the impact on the child(ren) and the systems in place to identify these
- Systems to support the coordination of services, support, and information across universal services for children with additional needs
- Holding the child at the centre of practice and systems and understanding their lived experience

2: Case overview

2.1 Child B is a male child aged 5 at the time of the significant incident. He was understood to have an Autistic Spectrum Disorder (his assessment was not concluded at the time). He was living with his parents and two younger siblings to be known in this report as Sibling 1 and Sibling 2, then aged 2 ½. All three children have a range of additional communication, developmental and health needs and were involved with targeted early help[6], universal, community, health, and hospital services to support their needs at different times.

2.2 Child B experienced a near-fatal incident following a seizure and he was taken to the hospital by ambulance, he was not breathing. This was the significant incident that led to this review. The children were closed to Children and Families Early Help Services. Early help has had two periods of involvement with the family although the first period was just outside the scoping period. (See timeline)

2.3 The family are White British and had previously lived in a neighbouring authority where Child B was subject to a Protection Plan for Neglect as an unborn baby. Mother had a further five elder children (now adults) who were not in her care. This is related to the mother's extensive history of heroin use (including intravenous use), criminal convictions involving burglary, deception and associations with violence and criminal damage. Mother was at that time reported to be free of heroin and had successfully completed a methadone programme and was drug-free. There remained long-standing worries about mental health including a self-report of bipolar[7]. Mother had a new partner, and he is the father to all three children in this review. Child B was father's first child. Father has a learning disability, and his cognitive ability and functioning are assessed as borderline/extremely low. A PAMS [8] assessment was successfully undertaken as part of the child protection episode to assess his capacity to parent and identify the skills he may need. At the review case conference, the multi-agency decision was that Child B was no longer seen to be at risk of significant harm and he was 'stepped down'[9] to Child in Need (CIN). There were ongoing worries and identified needs around parental mental health, financial issues including debts and registering with a GP. Child B had some emerging developmental difficulties.

2.4 The family then moved to the current local authority and a Child in Need referral was made and accepted. Within a few weeks and in the period of transfer, the family decided to return to the neighbouring authority where they continued to be supported as CIN. The family were closed to this authority as they did not stay. Within a year the family appeared to have moved again to the current local authority area where they have remained to date. There was no referral in respect of this.

2.5 A referral was received from a local charity asking for support related to financial and practical support, this was accepted for Targeted Early Help. Child B was reported to be very hungry and needed nappies, he was then nearly two years old. A further referral was made by an early years SEND practitioner to the Children's Advice and Duty Service (CHAD) and information was passed to the early support worker. The family were closed to early help after a brief period of intervention.

[6] Stoke-on-Trent Threshold Framework https://safeguardingchildren.stoke.gov.uk/homepage/52/threshold-framework

[7] Bipolar disorder is a mental health condition that affects mood and result in extreme mood swings, episodes of depression and mania (previously known as manic depression) Overview - Bipolar disorder - NHS (www.nhs.uk)

[8] Parenting Assessment Manual Software (PAMS) is an evidence-based parenting assessment tool developed by Dr Sue McGaw it supports an assessment of parents with learning difficulties or disabilities to evaluate their capacity to respond to children's needs

[9] Stepped down is a term routinely used to describe the decision by children's social care where the safeguarding worries have been addressed there are still ongoing needs requiring a social worker but as a child in need (CIN) and the period of child protection plan ends.

2.6 Within a month, Mother had a pregnancy confirmed as twins. Child B was by then under the care of a community paediatrician, portage, speech and language, physiotherapy, and targeted health visitor support. Parents did not bring Child B for key health appointments which is a pattern throughout the family's history. During the pregnancy mother experienced her own physical health issues.

2.7 Child B attended A&E just before the birth of his siblings where he was suspected of ingesting some of his mother's medication. No treatment was needed, and follow-up was to guide the safe storage of medication.

2.8. Siblings 1 and 2 were born and the babies were discharged home to the care of their parents. Within a few weeks, Sibling 2 was admitted to Hospital (one of three occasions) following difficulties in breathing, an episode of floppiness, unresponsiveness and then concerns over reflux. He subsequently had a feeding tube fitted. This was reported to be a stressful time for the family and medical investigations continued. In the same period Sibling 1 was seen at the hospital; following an incident where Child B accidentally head-butted him. A referral was later made by the hospital to CHAD regarding the family's situation and the stresses and complex needs within the family. The threshold was not agreed upon for CIN (Level 4 statutory specialist) and the outcome was a referral to Early Help Level 3 Targeted Support, this was the second period of early help intervention.

2.9 The health and developmental needs of the children were complicated, and practical help and support were provided to the family. There was further attendance at A& E where Child B was seen after licking an Airwick. Within six months a safeguarding referral was made following an incident at home involving father becoming verbally and physically aggressive to ambulance staff. Police were called when he refused access to Sibling 1 who had developed a rash after being given a dummy used by Sibling 2 who was taking antibiotics. The referral was passed to early help as there was current involvement.

2.10 Each parent was supported to self-refer to Improving Access to Psychological Therapies (IAPT)[10] for their mental health. Around this time mother was reported to have been verbally aggressive to a community children's nurse and her mental help was said to be deteriorating.

2.11 By the time the siblings were a year old, early help reported positive progress, all children were being assessed and/or overseen by community health and hospital services and the case was closed to early help.

2.12 In the period May 2021 to November 2022, a period of some 17 months the family were open to universal services (Level 1). There were patterns of was not bought (WNB) or cancelled appointments for health and educational services for all the children. Child B received an ECHP and was of statutory school age in the autumn term of 2022. He only attended on the day before the significant incident.

A high-level timeline was developed to support analysis of the multi-agency chronologies and information provided by the Partnership This has been used to support an understanding of the key periods of intervention and the multi-agency response to the family's needs

[10] NHS England » NHS Talking Therapies, for anxiety and depression

Timeline child B and siblings

1998 – 2011 Mother had 5 elder children (now adults) not in her care. Related to substance misuse (heroin) domestic abuse, criminality, burglary, deception, criminal damage, imprisonment, violence.

2017 – 2018 Period of Child Protection in neighbouring authority

2017

Child B born.
Unborn baby Child B subject to Child Protection Plan for Neglect. Mother was at that time reported to be free of heroin and had successfully completed a methadone programme. There were long-standing worries about mental health including a self-reported diagnosis of bi- polar.
Mother had a new partner this is his first child; he has a learning disability.
PAMS (Parenting Assessment Manual Software) assessment undertaken re father due to his learning ability, successful assessment.

Period of Child in Need – cross boundary working

2018

Child Protection Plan ended, and family stepped down after 7 months to Child in Need (CIN) Highlighted ongoing concerns re debts and finances, mental health, and registration with GP. Child B had some emerging developmental and communication needs.

Family moves to current authority CIN Referral made and accepted. Highlighted mother's mental health needs. History shared.

Case closed as family returned to neighbouring authority.

May 2019 – July 2019 Period of Early Help

May 2019

Child B aged 2
Family moved back to current authority Referral from charity referral was received from a local charity asking for early help support relating to financial and practical support.
Child B was reported to be very hungry.

2019

Further referral for family support from Early years SEND practitioner – relating to issues re housing, finances, benefits, medical appointments, and employment. Identified father had additional learning needs. Referral outcome - already open to Early Help.

July 2019

Case closed to Early Help. Family secured council house registered with GP.
Child B to be supported by Early Years Forum and Health visiting.

Case closed to Early Help.

Scoping period for the review **August 2019 – November 2022**	
Universal Services	
August 2019	Mother expecting twins. ***(Sibling 1 & 2)*** Midwifery made basic checks with CHAD. **Child B** was under the care of a community paediatrician, portage, speech and language, physiotherapy, and targeted health visitor support.
January 2020	**Child B** attended A & E rolling downstairs Mother reported physical health needs admitted to hospital Concerns shared by portage worker about Child B's behaviour, nursery attendance promoted. Parents did not always bring **Child B** for his health appointments; this became a significant pattern.
March 2020	**Child B** Attendance at A & E suspected ingestion of mother's blood thinning meds. No treatment needed, follow up re safe storage of medication.
Covid restrictions commence March 2020 – March 2021	
April 2020	**Twins born** Discharged to community services
April 2020	Mother expressing low mood **Sibling 2** identified additional health problems
May 2020	**Sibling 2** health needs increasing, admissions to hospital regarding feeding, vomiting, feeding tube fitted. Mother reported pressures with multiple demands and worries affecting her mental health.
June 2020	Extended periods in hospital for **Sibling 2** and mother reported to be struggling. **Sibling 1** was seen at hospital; following an incident where Child B accidentally head butted him. Hospital made a referral to Children's Social Care (CSC) following further admission for Sibling 2. Mother was experiencing low mood and struggling with additional needs of Twins . Threshold for CSC not agreed referral made for early help.
Second period of Early Help intervention.	
June 2020	Case allocated for Early Help assessment and intervention. Practical support provided. Health and learning needs for all children complex.
July 2020	**Child B** Seen in A & E after licking an air wick. Mother experiencing physical health issues.

October 2020	Ambulance crew called for police assistance after being unable to gain entry to the home. Mother reporting that **Sibling 1** was presenting with a rash and had been given a dummy (**of Sibling 2**) who was on antibiotics, by his father. Father was refusing entry to the home showing aggressive behaviour. Also present Mother's daughter and boyfriend. Indications that dad can be verbally and emotionally abusive. Safeguarding referral made. Referral was passed to early help, safety planning work undertaken with the family and domestic abuse explored.
October 2020	Both parents separately self-refer for support for their mental health. Father completed 9 counselling sessions. Mother referred for Cognitive behavioural therapy (CCBT) this was not taken up.
October 2020	Information that mother was verbally aggressive to community children's nurse when not able to respond as asked.
December 2020	SEN assessment of Child B commenced. Mum supported and confident to manage **Sibling 2's** nasogastric tube.
January 2021	Dip in mental health parental conflict observed Mental Health crisis team called. Depression review Mum denies recreational drug use. Medication increased.
	Early help case overview positive progress reported. **Sibling 2** discharged from community nursing team.
April 2021	Case closure. Twins now a year old – **Sibling 1** being assessed for developmental delay. **Sibling 2** still under community paediatrics. **Child B** nearly 4 years assessed for educational needs. Likely autistic spectrum disorder.
	All three children identified with developmental delay, health, and communication, needs.

Family closed to Early Help.

3: The review methodology

3.1 The Case Review Group agreed on the methodology and Terms of Reference for the review and has provided oversight and quality assurance. The review process was reflective and proportionate, and involved practitioners and managers in a face-to-face learning event and recall event[11] . It sought to avoid hindsight bias and individual blame. The rapid review identified initial learning and key lines of enquiry that focused on children not being brought to access

[11] The first version of the report is shared with the learning group to sense and fact-check.

services, the importance of considering family history, increased vulnerabilities, risks associated with adult issues, and understanding the daily lives of the children.

3.2 Family views are integral to LCSPRs and is best practice. There were ongoing legal proceedings during the period of the CSPR and it has not been possible to find a solution that would enable the lead reviewer to speak to family members.

3.3 The LCSPR has been undertaken in two phases, firstly an in-depth look at the multi-agency chronologies, key documents, and single-agency summary reports. The second phase involved engagement with front-line practitioners and key professionals in a learning event to consider what happened and reflect on practice and systems at the time.

3.4 The review has considered the systems and practice across the Partnership in relation to responding to and managing children's additional health and educational needs, appreciating parental history and adult needs and capacity from both a practice and Partnership (systems) perspective. They relate in particular to how vulnerability and neglect were understood and considerations of parental capacity to meet the children's combined needs.

3.5 The following practice themes were identified and formed a framework in which to analyse the findings, enquire and develop an understanding of what was happening and what it meant in the circumstances for Child B and his siblings. The learning events also used the system's framework, Pathways to Harm, Pathways to Protection (Brandon Sidebotham et al)[12] to support wider system understanding. Practitioners and managers attended the learning events and reflected on the key findings in relation to systems and practice and considered; W*hat was helpful. What got in the way? Highlight specifically the children's voices and experiences.* This was a positive and helpful session which has directly informed this report, supported wider learning and single agency learning and improvements.

Thematic learning
1. Understanding family histories, parental needs, and capacity
2. Understanding neglect
3. Multi-agency responses for managing the children's health and educational needs
4. Underpinned by understanding the children's lived experiences

[12] Figure 2 Pathways to harm, pathways to protection https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

4: Thematic analysis and learning

1 Understanding family history, parental needs, and capacity

How did agencies understand the family's history and the parenting capacity?

4.1.1 This theme explores the importance of why knowing the family's history and any predisposing vulnerabilities and risks is significant in the context of parental capacity and safety. Studies into practice with child neglect show that the family's history is not sufficiently taken into account, or adequately considered in relation to the impact of neglect on the child from adult behaviours[13] This is supported by a number of case reviews in recent years. In this review, it is clear that the family's history was known but did not inform or support assessment of the likely level of care needed for the children and therefore subsequent threshold decisions.

4.1.2 Child B as an unborn baby was subject to a Child Protection Plan for Neglect in a neighbouring authority whilst assessments were undertaken. He was his mother's sixth child born after a period of stability and change and with a new partner. Whilst out of the time frame for this review this is of importance because it details harm and vulnerabilities regarding mothers parenting historically and significantly how this information was considered and shared by the current local authority to ensure the right level of support was provided.[14]

4.1.3 During the pre-birth assessment, mother was seen to have made significant changes around her drug use and associated lifestyle; however, concerns were identified about ongoing mental ill health, debts, managing money and registering with GP for Child B. When the family were planning to move there was good cross-boundary working at a Child in Need (CIN) level between the two local authorities. The family subsequently returned to the neighbouring authority and Child B was appropriately closed to the current local authority.

4.1.4 At some point over the next year, the family moved again to the current local authority. There was a referral from a local charity asking for financial support and Child B was reported to be hungry. This was accepted for level 3 targeted early help[15] and it was not linked to the previous cross-boundary CIN referral. This was the first period of early help. The next day a further referral from early years SEND practitioner highlighted a range of issues for the family relating to housing, finances, benefits, missed medical appointments and employment. Father was identified as having additional learning needs. The referral was added to the existing referral as this had already progressed to early help meaning it did not trigger any further curiosity or re-assessment of the information already in the system. It is important to note here that the practice whereby further referrals were sent straight through to early help has since changed and formed part of improvement actions to systems and practice in the front door. Current practice is now that all new contacts/referrals go through the front door and have a further reflection on information already in the system and triangulation and discussion of the new information to evaluate needs, vulnerabilities, and risks. Discussions in the review process about these changes indicate there needs to be greater clarity about the systems for early help pathways.

4.1.5 Work was undertaken with the family to address the identified issues and within two months the case was closed after support work was concluded. Child B was identified as having developmental delay and his needs were to be

[13] Professional responses to neglect: in the child's time - GOV.UK (www.gov.uk)
[14] Threshold Framework (stoke.gov.uk)
[15] Stoke-on-Trent Threshold Framework https://safeguardingchildren.stoke.gov.uk/homepage/52/threshold-framework

managed via the Early Years Forum [16] Whilst this was helpful because it brought together a range of specialist services that could support Child B, the effectiveness of this will be discussed later (section 3)

4.1.6 The father of unborn Child B was not known historically to services but had identified learning difficulties, this was his first child. Good practice from the neighbouring authority was that a specialist parenting assessment (PAMS) was undertaken with father, this assesses the parents' capacity and provides educational work to help parents learn and develop skills to parent. This was key information that was known within the local authority referral history. Positively the referral from the SEND early years practitioner identified that father had additional learning needs, however apart from this reference there was no consideration of what support he may need and how this may impact his ability to parent. This should have been reviewed and specifically informed assessment around the pregnancy of the twins to understand what the family may need to help them parent twins. Fathers' learning needs do not inform any further parenting assessment or lead to specific interventions. Legislation and guidance[17] highlight the importance of services (including adult services) working together to ensure adults with disabilities are supported to fulfil their parenting role. This was an opportunity to provide whole family support, particularly with the increased vulnerabilities and pressures of the pregnancy of the twins. There were indications that father was struggling to cope with more than one child in October 2020 where he shared his worries about how he would cope with the care of two children if Sibling 1 was admitted to hospital.

4.1.7 Parents shared with maternity services at the initial booking appointment that Child B was previously subject to a Child Protection Plan, but CSC were no longer involved with the family. Good practice by maternity services was to follow this up with CHAD, who confirmed that the case was closed as detailed by the parents. There was differing information recorded and understood about this key point of information sharing and specifically understanding whether a referral had been made or not. CHAD did not have a record of a referral being made in respect of the unborn babies. It became apparent that midwifery had conducted "lateral checks" [18] as part of its safeguarding checks given what the parents had disclosed, this would have been a telephone conversation with the CHAD and was not recorded on the electronic systems in place as this was not routine practice. Recording practice has now changed and since 2020 all contacts[19] are now recorded providing a complete chronology for the family and an opportunity for reflection and curiosity. This was significant learning relating to both systems and practice firstly because it does not show the context of the CIN case referral which was never fully opened as the family did not stay in the area and it does not indicate consideration of the referral history, recent case closure to early help and the current family circumstances. The second area of significant learning here is in relation to understanding the risks and vulnerabilities for unborn babies and adherence to the safeguarding the unborn baby procedures discussed below.

4.1.8 The rapid review and learning event highlighted further findings in relation to information sharing regarding the accidental medicine ingestion by Child B (see timeline). Whilst information was shared across from the Hospital to the Health Visiting service there is a discrepancy regarding the information reaching the Health Visitor for action in the first incident and the learning event highlighted that within the hospital this was only known to the Emergency Department (ED) This was valuable information that did not inform the decision-making and safeguarding checks following mother's pregnancy booking. The second incident resulted in the Health Visitor discussing medicine safety with the parents.

[16] The Early years Forum is a 'multi-agency meeting that monitors whether the right services are involved to support pre-school children showing special educational needs and/or disabilities.' Stoke-on-Trent Early years forum - Staffordshire County Council

[17] Social Care Institute for Excellence (2007) Working together to support disabled parents.

[18] In this instance meant that checks were done with the front door to verify the family involvement with CSC. "Lateral check" is a term used by health professionals when a safeguarding concern has been identified and forms part of a process of information gathering and sharing.

[19] A contact is a term used to record information being received and forms part of information gathering processes

There have been changes to current systems that now mean the hospital provides immediate safety information to parents and also refers directly to the health visiting service as required. Health professionals shared that health visitors used to have a significant presence in the ED and would have picked up these types of cases on discharge. The consequence of this was seen as a vital loss in the health economy.

4.1.9 Importantly the actions did not follow local safeguarding procedures in Responding to Concerns about unborn children[20] as a referral was not formally made by maternity services. There were several co-existing risk factors; five previous children being removed, vulnerable parents expecting twins, parental learning disability and mental health concerns. In addition, there are evident increased vulnerabilities associated with Child B's developmental delay and parents not consistently taking him to appointments. An additional child and in this case two, to a vulnerable family needs careful consideration in the context of possible harm. As part of its improvement work Children and Families Services has undertaken work in relation to pre-birth assessments, the Safeguarding Partnership will need to seek assurance that practice improvements are across the Partnership, particularly with midwifery and health visiting services.

4.1.10 NICE[21] guidance on antenatal care specifies what pregnant women with complex social factors may need and provides advice about information sharing. Whilst this was followed the process of lateral checks did not lead to any consideration of a referral under SUB procedures by midwifery showing professional curiosity. A Social Work pre-birth assessment should have been undertaken here as the threshold was clearly met. There was no critical thinking to this from maternity services or other universal services involved with Child B actively working with the family throughout the pregnancy, indicating unfamiliarity with the procedure.

4.1.11 Following the Twins' birth a referral was made to CHAD from the hospital regarding increased stresses and needs relating to the health needs of one of the twins and mother's mental wellbeing this was supportive practice. This was not seen to meet the threshold for Level 4 statutory social work intervention but identified support and services would be helpful and the case was referred to Early help, this was the second period of early help intervention. This decision making does not appear to be informed by the known history and current vulnerabilities such as the parental difficulties and needs, and the additional social and developmental difficulties of Child B, caring for newborn twins one of whom was experiencing feeding difficulties and had experienced lengthy periods in hospital. All these would have contributed to significant additional pressure on the parents already vulnerable and potentially compromised through their own learning and coping abilities. This was a missed opportunity to analyse the information and provide a focus on the additional vulnerabilities and possible risks that shaped the children's lived experiences and to consider the threshold and critical challenge the level of intervention in line with procedures, the level appeared to be accepted. The key learning here is that past and current family history and context must inform threshold decision-making.

4.1.12 It is noteworthy that the period of the Twins' birth coincided with the start of national lockdown measures due to COVID-19. This resulted in many necessary changes to service delivery and normal protective services including face-to-face restrictions and hybrid working arrangements. This was a period for many vulnerable families where stresses increased vulnerability and therefore risk where "adequate support (was) not available, such tensions may lead to mental and emotional health issues and the use of negative coping strategies." (NSPCC Report Isolated and Struggling)[22] Thematic analysis of rapid reviews during COVID by the National Panel highlighted what it framed as 'situational risks'

[20] Safeguarding Practice Guidance - Stoke-on-Trent and Staffordshire Safeguarding Children Board (ssscb.org.uk)
[21] Overview | Antenatal care | Guidance | NICE
[22] NSPCC June 2020 Isolated and Struggling. Social isolation and the risk of child maltreatment in lockdown and beyond.

where ‘‘the potential to exacerbate pre-existing safeguarding risks and bring new ones” [23] was a factor in their findings. Early help practitioners continued to offer in-person visits to families in this period (with appropriate safe practice measures in place) to the family as part of their support offer which would have supported families in need of support at this time. Early help is not a statutory service, and this recognises the importance placed on preventative support for vulnerable families and is positive practice.

4.1.13 The corresponding period in the family’s life (see timeline) evidences the impact of increased stresses and issues for the family. These included Sibling 2’s health needs, increasing difficulties with Child B’s behaviours, deterioration in mothers’ mental and physical health, two separate incidents of aggressive behaviour with professionals, parental self-referrals for mental health support and Mental Health crisis team involvement for mother following observations of parental conflict.

4.1.14 Much of the conversation about care focussed on mother, and there is limited information about how the couple parented together. The learning event reflected that mother took the lead in all aspects of care and father ‘was told what to do.’ It is reasonable to understand that this placed increased responsibility for care upon mother. This is supported when Child B was an unborn baby and the lack of support by father was cited by mother as a contributory factor in later parental conflict.

4.1.15 Work was done with the parents including an exploration of domestic abuse and safety planning was completed with the family which was positive practice. However, this does not seem to have been linked to wider explorations about parenting capacity, particularly as father had indicated that underlying some of his behaviours related to his anxiety about managing the children on his own. Work around this could have been explored with both parents and identified what they needed to help them care well for their children. Whilst positive progress was reported leading up to case closure it does not appear that the underlying issues were fully understood. Early help support was provided by early help practitioners who worked hard to support the family with practical support (financial) and safety planning around two mental health crises for each parent and good relationships were developed. This was good practice however this work did not focus on the neglect (harm and protective factors), what the parents needed to be doing, what services were doing and then consider the impact of this on the children. There was significant complexity of need and vulnerability in the family that was not fully explored or challenged.

4.1.16 There are tools[24] that can support practitioners to make professional judgements, particularly about the likelihood of future harm. (Munro, E Asking the Right Questions) In the learning event, the possibility of disguised compliance was raised, and whilst being mindful of hindsight bias learning from this review explored this and opened up conversations about whether professionals could have possibly conceived that the children were being given medication as a means of parents managing the children’s behaviours and needs. This is a hypothesis that can only be realistically considered here with the benefit of hindsight and relates to the accidental ingestion of medication by Child B. There is learning from reviews involving parents who misuse substances and/or are on a methadone programme who have administered drugs to their children (i.e., methadone) to cope with parenting and the ‘normalisation’ of this as helping medicine and ‘*thinking the unthinkable’* that children can be abused by parents in this way though there was no evidence that mother had lapsed in her drug use. However, there should have been greater curiosity about the parent's prescribed drug use

[23] The Child Safeguarding Practice Review Panel Webinar January 2021 Thematic analysis of rapid reviews featuring Covid -19
[24] Graded Care Profile 2 NSPCC
Impact on the Child Chart. Strengthening Practice, Strengthening Assessment . https://www.strengtheningpractice.co.uk/

based on the history, needs, vulnerabilities, and parenting capacity of this family and how they were really coping. What would have helped here was some critical thinking from the multi-agency professionals around the family, Lord Laming calls this being 'respectfully sceptical' of the parents' and here this relates to greater exploration of their capacity to cope and meet the additional needs of their children and what they would need to do this well. Early help services involved with the family were very positive about the work undertaken with the family and indeed some of this work was appropriately targeted and demonstrated good engagement with the parents, however, the findings suggest a level of over-optimism and incomplete understanding of the complexity of the issues here by the services involved with the family.

Thinking about the learning here; what can professionals and services do differently when working with families to understand and appreciate through critical thinking what is going on for these children and their parents in the context of the children and parents' circumstances.

Learning points	
1	Decision-making in the Children's Advice and Duty Service (CHAD) should routinely take account of previous referrals and historical information to consider the right level of need in its threshold decision-making. Any subsequent information including 'open cases' at an early help level should receive the same level of rigour and triangulate with all services involved with the child(ren).
2	Knowing the family's history is critical to understanding predisposing vulnerabilities, risks, and safety and must be considered at critical stages such as in referral, assessment and intervention with children and families.
3	Practitioners and managers to be supported to strengthen their skills of professional curiosity and reflective practice. This can be realised in supervision and multi-agency discussions.
4	Practitioners and managers, including those in universal services, working with parents and children must consider the possible impact of adult issues on parenting capacity and children's needs. Any support needs must be identified and assessed to enable parents to help their children thrive. This includes • Understanding how the co-existence of adult issues such as learning disability and mental ill health increases the likelihood of harm. • Consideration of the child's age and developmental physical, learning, communication, and behavioural needs • Significant changes to family circumstances such as a further pregnancy.
5	An increased awareness and understanding of the Partnership s Safeguarding the Unborn Baby Procedures across all services to ensure risk, vulnerability and safety are considered and appropriately referred to the multi-agency Children's Advice and Duty Service (CHAD)

2 Understanding neglect

Why were Child B and his siblings not seen as neglected?

4.2.1 This theme explores how neglect is understood across the Partnership and the challenges for practice. The learning event demonstrated the different views about neglect for these children with some professionals not considering that neglect was an issue. This highlights the difficulties in identifying if the care children are receiving is neglectful. Whilst categories of neglect [25] can be helpful our understanding of neglect can often be affected by our perceptions of neglect. In this instance, assessment seemed to be related to the quality of the physical environment i.e., the home, which was described as clean and tidy, and because Child B was not of compulsory school age there was little to be challenged here. Education services made great efforts to try and engage and support Child B to access nursery and school provision, and this included home visits and practical solutions to barriers to attending i.e., transport. The family were supported on a number of occasions through early help support with financial assistance, advice about debts and encouraging take-up of services to meet the children's needs These are all important components of support however it must also include wider considerations about what these parents may need to help them parent and meet their children needs in the context of the parental and child difficulties.[26]

> *Children with complex needs are increasingly vulnerable to medical neglect as they can require frequent or intensive support from their parents or carer for a wide range of health needs (Sullivan and Knuts 2000)*

4.2.2 The number of cancelled and WNB to health appointments for all the children was clear in the chronology but there appeared to be no challenge or critical thinking about this. Research shows that not meeting a child's health needs is an indicator of neglect. The learning event reflected on the challenges for the family in taking or being available with three very young children with additional needs due to the number of health appointments. This is an understandable response however it should also consider that "*parenting a child with complex needs is, by definition, likely to be more complicated, more time-consuming, less familiar, more anxiety-provoking, and physically harder and/or emotionally more difficult."* [27] and this should not affect our expectations of what good parenting should look like. Studies of neglect in Serious Case Reviews[28] share important learning that needs to be considered in the context of understanding neglect for these children

- Inability to fully understand their child's medical condition.
- Parental learning disability means that they find it difficult to manage the demands of their child's complex health needs.

[25] Horwath, J (2013) Neglect Identification and assessment
[26] Sharley, V and Rees, A (2023) Working with children who have experienced neglect Coram BAAF
[27] Marchant, R (2019) Making Assessment work for Children with Complex needs. (Ed) Horwath & Platt The Child's World
[28] Brandon, et al (2014) Missed opportunities :indicators of neglect -what is ignored, why, and what can be done?

- Difficulties in continuing to attend appointments which could be attributed to an 'overwhelming' number of medical appointments; lack of transport, and work commitments; and

- Change in family circumstances such as a new family member – a new baby or partner resulting in the ill or disabled child's medical needs being neglected.

4.2.3 There were opportunities such as the Early Years Forum and the periods of early help where the children's needs could be discussed in a multi-agency space. It is important and best practice that information is triangulated and coordinated particularly where the children have complex needs and are seen by several professionals and specialist services. It is widely acknowledged that it can be "more difficult to judge when parenting is considered neglectful and a threshold for intervention has been reached" (Wilkinson & Brewer 2017 cited in Sharley et al ref 23) In the case of parents caring for children with additional needs there is likely to be additional strain, but it should not justify inadequate levels of parenting or neglect (ref 24). There needed to be a good appreciation of what the individual children needed and the skills and ability of the parents to meet those. Services were available across health, education, and social care (SEND[29] local offer) to help the children and their parents, therefore how these parents accessed these services is an important factor. What got in the way of accessing this support is a question that needed to be enquired of services, practitioners, and parents who form the support system for these children. There seemed to be a view that it was difficult for these parents, they were seen regularly, and parents appeared to be engaging. This provided practitioners with a limited understanding of what was happening in the family and dispelled any concerns. Disguised compliance was not considered during professional involvement with the family. This was further complicated because parents did engage with some services such as health visitors and early years workers' home visits.

> *Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions and allay concerns. Published case reviews highlight that professionals sometimes delay or avoid interventions due to parental disguised compliance."* *NSPCC Disguised compliance: Learning from Serious Case reviews 2016*

4.2.4 Child B was assessed as having SEN needs and had an EHCP (Education, Health, and Care Plan) plan to address these needs and an emerging diagnosis of Autistic Spectrum Disorder (ASD)[30] This meant for Child B he was nonverbal and had difficulties with communicating and interacting with others, he was described as having 'meltdowns' by his mother and she raised multiple concerns about his head banging. Good practice was that early indicators were identified and support to help with speech, language, play and communication through portage was put in place. However, because he did not attend preschool /nursery provision aimed at supporting assessment and communication skills he did not receive consistent support and intervention. Whilst it is accepted that his attendance could not be enforced as he was below compulsory education this needed to be challenged. The focus on compulsory school attendance seemed to be a barrier to practitioners fully considering neglect in the context of Child B's learning and communication needs. Cross-referenced with poor health appointment attendance this could have indicated neglect earlier on and enabled

[29] What is the SEND Local Offer? – SEND Local Offer (stoke.gov.uk)
[30] What is autism? - NHS (www.nhs.uk)

structured work around this. The Partnership has adopted Graded Care Profile 2[31] to support its understanding and approach to neglect, early help staff are not yet all trained in this, but this is being rolled out across the Partnership.

4.2.5 Significantly for practitioners here when evaluating whether neglect has occurred the following factors are relevant here to support understanding of the individual children's needs [32] (Good Practice Guide to working with Neglect 2023) and could have supported practice.

- The practitioner's understanding of children's basic needs.
- The age and developmental stage of the child.
- The parents' or caregivers' intention.
- Whether parents /carers have reasonable access to resources; to meet the child's basic needs satisfactorily (Horwath 2007)
- Whether neglect is a one-off incident or episodic and chronic.

4.2.6 Studies show that historic and current themes in cases of neglect are complex and often include "a multiplicity of factors – such as social and economic deprivation combined with parental difficulties"(18) The parent's adult issues, parenting histories and the children's additional needs associated with developmental delay, social and communication difficulties, health and feeding difficulties and some physical characteristics combined to create complexity. Debts and financial difficulties were a consistent feature in the family since Child B was an unborn baby, and whilst practical support and guidance were provided on numerous occasions it was not seen as an indicator of neglect. Studies show that poverty and inequality are key drivers of harm to children. (Bywaters, P)[33] For this family difficulties in budgeting increased their vulnerabilities but were not seen in the wider context of the family's needs and functioning.

Poverty affects every aspect of family life. Poverty is inextricably implicated in other factors which increase the risk of harm: including domestic violence, poor mental health, and substance use. Children's age and ethnicity interact with poverty in ways that increase inequalities.

4.2.7 There were significant patterns of non-engagement with services that had been put in place to assess, support, and intervene with the behavioural and communication difficulties Child B was displaying and reported by his parents. Children with complex needs are more vulnerable to abuse and neglect and patterns of failed or missed appointments to attend to their needs are significant and should be viewed in the context of the likely impact on them. There was huge inconsistency in the parents bringing their children to key appointments, in contrast to their availability to planned home visits by health visiting and early help staff, this appeared to have been viewed episodically by all services involved with the children and family and not sufficiently challenged.

Thinking about the learning here what can professionals and services do differently when identifying and working with children who may be experiencing neglect. It means here that there needs to be increased knowledge and skills in

[31] NSPCC The Graded Care Profile 2 (GCP2) is an assessment tool that helps practitioners take a strengths-based approach to measuring the quality of care a child is receiving and supports them to identify neglect.
[32] Sharley, V and Rees, A (2023) Working with children who have experienced neglect Coram BAAF
[33] Bywaters, P Skinner, G 2021 The relationship between poverty and child abuse and neglect. Nuffield

understanding the nature and context of neglect, how child vulnerability, adult issues and family history intersect, how to recognise patterns and think critically about what life is like for the individual children

Learning points	
6	Practitioners and managers appreciate that children's additional and complex needs can make them disproportionately more susceptible to abuse and harm. The use of evidence-based tools can support the assessment of neglect and work with families.
7	Increased knowledge and skills in recognising and understanding neglect across the Partnership. This will be supported by ensuring staff can demonstrate the use and impact of the Neglect Toolkit and the difference for children.
8	Patterns of 'was not brought' (WNB) and engagement with services put in place to support and improve children's well-being and development must be seen as an indicator of neglect. The use of multi-agency chronologies will support the analysis of this and highlight a timeframe for what needs to change from the child's perspective. This will support professionals to consider possible disguised compliance.
9	There should be respectful challenge with parents where children (under compulsory school age) with identified learning and communication needs who have educational provisions put in place and are not brought. The challenge needs to happen across all parts of the safeguarding system, in direct practice with parents, in supervision and in inter-professional challenge. (National Panel 2021 The importance of critical thinking and 'authoritative enquiry')

3 multi-agency responses for managing the children's health and educational needs

How effective was the multi-agency response to managing the children's needs?

4.3.1. This theme will explore the effectiveness of the multi-agency response to managing the children's additional needs. The review has highlighted the challenges around identifying neglect for services involved with these children and this has been made more complicated by the number of different information systems across adult, children, education, community, and hospital settings. The learning event reflected that some systems saw the children individually while others saw them as a family group showing inconsistency across the system. Exploring the effectiveness of the multi-agency repose was challenging for the learning group to consider and highlighted the different systems in place to manage services as part of a multi-disciplinary response

4.3.2 The Early Years Forum as discussed in the report is an example of good practice and a real opportunity for a multidisciplinary approach to consider the needs of children and services to support them and their families. Discussions about this show this may not have been as effective as it could have been at the time as key professionals were missing i.e., early help and there appeared to be a lack of clarity in the learning event about its role. Whilst early help is now represented on this Forum greater understanding is needed about the purpose, representation, pathways, and impact of this group. Given the significance and research about the importance of early identification of neglect, the interface

with special needs, and harm there needs to be a greater level of curiosity, critical reflection, and challenge within the group.

4.3.3 There did not seem to be any review of the WNB or means of tracking this across different health systems to think about what these missed health appointments meant for the children. For Child B he was only bought for 24% of his outpatient appointments, Sibling 1 only 62% and Sibling 2 only 50%. There was no challenge or reflection of the impact of this upon the children. This does not include other health and education appointments Specifically for Child B it is reasonable to conclude that the cumulative impact of not being brought to speech and language appointments and nursery school had a negative impact on his developmental needs and difficulties. Research into interventions for autism[34] and improving longer-term outcomes show how early intervention makes a significant difference to children experiencing autism to their development showing improved outcomes in social, communication and daily living skills. Positively there was early identification of Child B's needs and likely diagnosis of autism, however, the multi-disciplinary support put in place to support and improve outcomes for him was not consistently taken up by his parents meaning for Child B his needs were neglected.

4.3.4 There was a gap in involving adult services to support the father's learning disability and the mother's longstanding mental health problems. Cognitive ability does not change significantly over time, whilst there may be strategies and parenting skills to be learnt these need to be considered in the context of children's development needs over time and new and significant changes in the family's circumstances such as the twin's pregnancy. There were no specific services identified that supported father's needs or parenting capacity over time.

4.3.5 Mother had longstanding mental ill health and its impact was not given sufficient rigour and understanding although mother was fully open about her difficulties. Assessing the impact of adult mental health on parenting and family functioning is complex[35] and studies show it is the *family disruption* that the mental ill health causes that presents the greatest risk. Duncan and Reader[36] talk about availability and predictability when considering the impact of mental ill health on children. Mother whilst open about her mental ill health did not follow through with the recommendations of the IAPT assessment. She continued to access support from her GP, the learning event highlighted that assumptions were therefore made about mother being monitored via her GP. Both parents were registered with different GP practices, and this prevented the sharing of key parental information.

4.3.6 The co-existence of these parental and child factors combined to increase vulnerability and risk and are known risk factors associated with increased likelihood of neglect. The inclusion of adult services regarding parental needs could have supported assessment and support for the family holistically and helped professionals consider what these parents needed to be able to help their children thrive.

4.3.7 There is important learning about threshold decision-making (Sec 2) and consideration of family history, adult issues and children's needs leading to increased vulnerabilities for these children. It is important to note that many professionals and services had a high level of involvement with the family sometimes weekly and significant information was held across the Partnership about these children. It would seem there was insufficient focus on the impact of these factors on the needs and lived lives of these children. There were opportunities for all the professionals involved to consider neglect and look further than their singular involvement and consider the wider impact. There was a sense that

[34] Howlin et al 2014 Review Journal of Autism and Developmental Disorders
[35] Murphy M Rogers, M 2019) Working with Adult -orientated issues
[36] Duncan , Reder (2003)How do Mental health problems affect parenting

these parents were doing their best. This remained fixed throughout service involvement and relates to the consideration of disguised compliance.

4.3.8 Munro (2012) talks about the 'rounded practitioner' and the skills and knowledge to make sense of what is happening for children and families. Holding the child at the centre of work and understanding life from their perspective can help practitioners think and keep focussed on what might be happening for the child, by exploring the impact of the multiple complexities for each of the children.

Thinking about learning here there is some clear system learning about how information is shared across the Partnership, particularly at a universal level and considered in terms of risk and need. Neglect is a key priority for the Partnership and its objectives are detailed in Stoke-on-Trent 's Neglect Strategy (2022-2024)[37] Learning from this review needs to be considered in neglect strategy updates, measuring outcomes, and how it is applied to practice across Safeguarding Partnership.

Learning points	
10	The Early Years Forum is a key multi-disciplinary system that supports children with additional needs and disabilities. There is an opportunity to strengthen how this is working across the multiagency Partnership by building on findings from this review focussing on aspects of coordination, information sharing, critical thinking, whole family working, pathways, and outcomes for children.
11	Adult services who have the knowledge and skills about adult issues must be consulted to support the understanding of family functioning where child neglect is intrinsically linked to parental issues.
12	Understanding the lived experience of the child is particularly important when children have disabilities and are not able to communicate verbally what life is like for them. These are children who often have several different practitioners and services involved so there must be a shared understanding -from the child's perspective -about their experiences and circumstances.

6: Summary and Recommendations

6.1 This practice review has identified a number of key themes for the Partnership to consider and reflect upon regarding current systems and practices regarding neglect. There are some single-agency practice improvements that need attention highlighted within the review process and the review does not intend to repeat these or make recommendations that have not already been addressed as part of wider improvement plans.

6.2 There is no indication that the deliberate giving of medication to these children could have been known or prevented and universal services provided a range of support and interventions to respond to the identified practical needs of the

[37] Neglect (stoke.gov.uk)

family. Services were identified to support the additional needs of all of the children in both universal and targeted support and this was positive practice. However, there were key opportunities where the response could have been more professionally curious and identified neglect and it should have considered more widely the capacity and availability of these parents to meet the needs of their children given what was known about the history, the children's additional vulnerabilities and the family's circumstances.

6.3 The review also recognises the steady progress made as part of an improvement journey over the past few years for children's services and Partnership and of relevance here is the multi-agency reflective discussions within the front door. It has identified some areas of good practice in early help practice and systems for example the Early Years Forum that can be strengthened and developed. The learning from this review reflects national learning and challenges in identifying and understanding neglect The Safeguarding Children's Partnership has prioritised Neglect as a key theme and invested in training and Tools to support the implementation of its Neglect strategy across the workforce, of importance here is appreciating how it is being transferred into practice, particularly across universal and early help services.

Recommendations for the Partnership

Practice

1. The Partnership to evaluate the effectiveness of how learning about Neglect is being embedded in practice. This should include learning from this LSCPR and current research and good practice concerning neglect and the range of predisposing and coexisting factors that can create complexity, vulnerability, and harm for children. (Learning points 2,4,6,7,12)
2. The Partnership to consider how it can strengthen practitioner skills that enable critical thinking and respectful challenge about neglect. Using guidance from the Child Safeguarding Practice Review Panel (Annual Report 2021) through direct practice with parents, supervision and interprofessional challenges such as in multi-agency meetings, discussions in CHAD and spaces such as the Early Years Forum. (learning points 1,3,9,)
3. The learning from this CSPR is disseminated across the Partnership and partner agencies to provide evidence to the partnership of how the learning is making a difference in practice, to children and families they work with at a universal and early help level. (all learning points)

Systems

1. Children's Advice and Duty Service (CHAD) to assure the Partnership that previous referrals and historical information are used to triangulate information with all services involved with the family to consider the right level of need in its threshold decisions including cases open to early help. (Learning points 1, 2,)

2. The Partnership to ask partner agencies how they ensure all professionals have knowledge and awareness of Safeguarding the Unborn Baby Procedures and are aware of when a referral should be made. (learning point 5)
3. The Partnership to review how the multi-disciplinary Early Years Forum can be strengthened to improve the identification of possible neglect for children with additional needs and disabilities. It should build on findings from this review focussing on aspects of coordination, information sharing, critical thinking, whole family working, pathways, and outcomes for children. (Learning points 4, 8,9)
4. The Partnership to seek assurance from the Integrated Care Board (ICB) that there are robust systems in place to consider neglect by ensuring that children not brought (WNB) for health appointments are regularly reviewed and there is appropriate challenge and actions in place particularly for those children more vulnerable because of their additional needs. (Learning points 8, 10).
5. The Partnership to ensure services that support /come into contact with adults who are parents follow a 'whole family' approach. There should be clear pathways to services for consultation and support to consider family functioning and the impact of adult issues on children (Learning point 4, 11)