



Bedford Borough  
Safeguarding Children Board

## **Serious Case Review**

**Rosie**

## **OVERVIEW REPORT**

**BBSCB**

**10<sup>th</sup> October 2018**

**Lead Reviewer**

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## **Governance**

My credentials as an independent author and reviewer are that I am currently working as a freelance Child Safeguarding Consultant after a long career in the public sector, having specialised in child protection and safeguarding since 1994. I have prior experience as an independent author/lead reviewer for serious case and learning reviews and am actively supporting a number of individuals and organisations in learning and improvement in their safeguarding practice.

I declare that I have found no conflict of interest in leading this review and am independent to the Bedford Borough Safeguarding Children Board (BBSCB) and partner agencies. I am grateful to those individuals who have supported the review process, contributed to the learning, and been resolute in seeking to improve the services provided to children and their families. Attempts have been made to contact Rosie's parents, as their views on the services provided, would have enriched this report. Unfortunately, a meeting has not proved possible. It is hoped that the learning from this review will strengthen services to expectant and new parents, especially those who are additionally challenged by personal, social and economic difficulties.

The report has been commissioned by, and written for, the Board. In reflecting the importance of accountability to the wider public, the report will be published on the BBSCB website. As such, the details of the child and their family, and the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

Catherine Powell  
10<sup>th</sup> October 2018

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## **Abbreviations**

ACE – Adverse childhood experiences

ASQ – Ages and Stages Questionnaire

BBSCB – Bedford Borough Safeguarding Children Board

CAF – Common Assessment Framework

CIN – Child in need (plan)

CPP – Child protection plan

CSC – Children’s social care

DNA – Did not attend

EHA – Early help assessment

ELFT – East London NHS Foundation Trust

EPUT – Essex Partnership NHS Trust

GCP2 – Graded Care Profile 2

GP – General Practice/Practitioner

HV- Health Visitor

HCP – Healthy Child Programme

iHV – Institute of Health Visiting

KLOE – Key lines of enquiry

MASH – Multi-agency safeguarding hub

NICE - National Institute for Health and Care Excellence

NSPCC – National Society for the Prevention of Cruelty to Children

SCR – Serious Case Review

SIRG – Serious Incident Review Group

TAC/F – Team around the child/family

TWSCB – Telford and Wrekin Safeguarding Children Board

WNB – Was not brought

WTE – Whole time equivalent

## 1.0 Introduction

1.1 This overview report sets out the findings of an independently-led thematic serious case review (SCR) commissioned by the Chair of Bedford Borough Safeguarding Children Board (BBSCB). It concerns Rosie, a three-and-a-half-year-old White British child, living with both biological parents. Rosie was found to be suffering from life-threatening and life-changing neglect within her home environment. She required an emergency admission to a hospital children's ward and will need on-going specialist care to meet her health and developmental potential into the future. Child protection and legal proceedings have ensured her safety.

1.2 At the time of her admission, Rosie and her parents were known to universal health services and were receiving care from a GP-practice, health visiting and maternity services. The family had also had previous, but minimal, contact with adult mental health services, an emergency department, the children's assessment unit, the paediatric department, orthopaedic outpatients and children's social care services. Father had been known to the police service and substance misuse services.

1.3 Rosie's case was discussed at the BBSCB Serious Incident Review Group (SIRG) in November 2017. After due consideration of the circumstances, the case was deemed to have met the criteria for a SCR, as defined in the statutory guidance in place at this time<sup>1</sup> (HM Government, 2015). This is because Rosie had suffered serious neglect and there was a need to review the ways in which agencies had worked together to ensure her safety and welfare<sup>2</sup>.

1.4 The features and impact of neglect on Rosie's health and wellbeing can only be described as 'shocking'. She was found to be severely malnourished, unkempt, in poor physical health, socially isolated and developmentally delayed. These findings raised important questions about the quality and provision of local services to young children and their families, and the possibility that other children may be at risk.

1.5 Such concerns also reflected the emergent findings of another serious case review concerning neglect (*Family Q*)<sup>3</sup> in progress at the time. The Overview Report of that review has now been published (Telford and Wrekin Safeguarding Children Board (TWSCB), 2018).

1.6 The similarities in the two cases, together with a concurrent BBSCB-led strategy to improve the recognition and response to child neglect (reflecting learning and improvement activity following other recent SCRs where neglect was a feature), led to the inclusion of a requirement within the commissioning brief for this review to:

**'consider the quality of the current professional recognition and response to child neglect in the early years in Bedford Borough'**

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<sup>1</sup> HM Government (2015) *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children* London: DfE. This guidance was reissued in April 2018 and July 2018.

<sup>2</sup> Regulation 5 of the Local Safeguarding Children Board Regulations 2006 5(2)(b)(ii)

<sup>3</sup> This review was led by TWSCB, but refers to a period of time when the family lived in Bedford Borough.

1.7 The involvement of practitioners and managers has been fundamental to all stages of the review. A practitioner event, hosted early in the process, enabled those practitioners involved in Rosie's care to share her story and to begin to identify the areas for learning and improvement. Towards the end of the review a second practitioner event was held to test out the emergent learning and recommendations.

1.8 Whilst Rosie's case is central, we have also audited the pathways and experiences of six additional young children at risk of neglect who were receiving local services at the time of this review<sup>4</sup>. Practitioners who were known to the audit subjects were invited to take part in this process, along with their managers.

1.9 The overview report aims to provide a succinct summary of learning from the experiences of Rosie and her family, as well as from the cases we reviewed through audit. The report seeks to reflect an understanding of wider strategic and organisational issues, as well as individual practice. Where practice has been over and above what is expected, this good practice is recognised. Whilst the learning points that conclude the report are primarily for BBSCB to consider, the learning from this review may also have national relevance and application, particularly at a time when austerity and public health cuts are impacting on the provision of universal health services to children.

1.10 Rosie's case review has a degree of complexity that reflects the contextual nature of neglect, as well as the agreed timeline for the review. The timeline begins in the prenatal period and concludes with Rosie's admission to hospital; a period of more than four years. This timeline has been essential to highlight potential opportunities for learning and improvement in practice and provision in Bedford Borough.

1.11 Whilst being mindful of the core requirements for the conduct of reviews (see box below), and particularly the need to understand practice from the viewpoint of individuals and organisations involved at the time, the retrospective nature of the review has led to the identification of key episodes and points of contact where action *could*, and at times *should*, have been taken to safeguard Rosie's welfare. Understanding the reasons that prevented a timely response to this child's neglect forms the crux of this report.

**Core requirements of SCRs:**

- To understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- To understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- To be transparent about the way data is collected and analysed; and
- To make use of relevant research and case evidence to inform the findings.

HM Government (2015:74)

<sup>4</sup> The audit took place in June 2018.

1.12 The overview report opens with a brief description of the terms of reference and the methodology of the review. This is followed by a narrative chronology that describes the significant events in Rosie's life and the services provided to the family. The findings are then summarised, discussed, and synthesised with the findings of the audit. Reference is made to the literature, including other local reviews, and to recent developments in improving the response to neglect in the Borough. The final section of the report outlines the recommendations and learning points for consideration by Bedford Borough Safeguarding Children Board.

1.13 If there is one message to take forward from this SCR it is that Rosie was not, as was initially hypothesised, a child who was 'hidden'; until she was two years and four months of age, she was seen regularly by health professionals. Rather, she was a child who was 'hidden in plain sight', neglected by parents whose capacity to parent had almost certainly been limited by their own adverse childhood experiences and multiple known difficulties in their adult lives.

1.14 This critical history and background were not sufficiently incorporated into assessment and care-delivery. The findings support the need to ensure a holistic approach to assessment and to reflect the 'urgency' (Sidebotham *et al.*, 2016) of responding where there are emergent concerns about child neglect.

1.15 Addressing intergenerational patterns of adversity and disadvantage through the provision of early help and support is key, as is the need for service providers to ensure that practitioners remain focused on the health, development and daily lived experiences of children, particularly those who are impoverished by the circumstances of their very being.

## **2.0 Methodology**

2.1 The overview report is best considered to be a published summary of the key findings and learning points from a serious case review. The report is not an 'endpoint' in itself; the SCR is an iterative and collaborative process with learning and improvement commencing at the earliest opportunity and continuing to be embedded after the report is published. This section sets out the terms of reference and the methods employed to ensure that the review has been as robust and comprehensive as possible to inform a 'step-change' in practice.

### *Terms of reference*

2.2 In line with the statutory guidance (HM Government, 2015), BBSCB has developed a tradition of taking novel approaches to commissioning serious case reviews. This includes utilising a thematic approach where neglect (and disability) have featured. In scoping the current review, BBSCB identified the need for assurance that practitioners who work with children and young people recognise neglect at the earliest opportunity, and that they are enabled to provide a timely and helpful response. The Board also wanted to discover whether there were blocks in the safeguarding system and, if so, for reviewers to make suggestions as to how these may be addressed.

2.3 BBSCB have thus commissioned a short and concise thematic review that centres on Rosie's case, but also considers the learning from other local SCRs where neglect was a theme. The review was additionally to provide a window on the current child safeguarding

system and ensure that children, young people and their families are provided with the best possible support.

2.4 A SCR Thematic Review Panel was established to support the review process. This was chaired by the Lead Reviewer and membership determined by the SIRG, as follows:

- Dr Catherine Powell – Lead Reviewer/Author/Chair
- Manager for Safeguarding and Quality Assurance – Bedford Borough Council Children's Services
- Senior Officer for Public Health, Children and Young People – Bedford Borough Public Health
- Detective Chief Inspector – Bedfordshire Police
- Designated Nurse for Children and Young People – Bedfordshire Clinical Commissioning Group
- Named Nurse for Safeguarding Children – Bedford Hospital NHS Trust
- Head of Service Safeguarding Children – Essex Partnership University NHS Trust (EPUT), services now provided by Cambridgeshire Community Services NHS Trust
- Pathway to Recovery Worker - East London NHS Foundation Trust
- BBSCB Business Manager

2.5 The panel met face to face on three occasions to oversee the process and contribute to the learning. Members have additionally commented on an early draft of this overview report.

2.6 In scoping the terms of reference for the review, the SIRG, together with the Panel, developed and refined several key lines of enquiry (KLOE). These reflect a systematic approach to the review, drawing on the requirement to consider strategic and organisational learning and improvement, as well as learning from practice at the frontline. Appendix one provides more detail of the KLOEs.

#### *Integrated chronology*

2.7 At the outset of the review, involved agencies were asked to draw up a chronology of significant contacts and events in the life of the Rosie and her family. These covered the period from 6<sup>th</sup> July 2013 to 5<sup>th</sup> September 2017 (pregnancy booking until Rosie's admission to hospital) and were compiled by safeguarding leads from the following agencies:

- Bedford Borough Council Children's Services
- Bedfordshire Clinical Commissioning Group (on behalf of GPs)
- Bedford Hospital NHS Trust
- (Former) South Essex Partnership NHS Trust/Essex Partnership University NHS Trust
- East London NHS Foundation Trust
- Bedfordshire Police

2.8 The chronologies also listed key contacts with agencies prior to the agreed timeline for the review. This has provided important background. Once chronologies had been completed they were amalgamated to provide a detailed and helpful history of Rosie and her family's contacts with universal and specialist agencies.

2.9 The contributing leads utilised the 'comments' section to raise important questions and began to identify the issues for learning and improvement that have been central to this review. The quality of the chronology is largely commendable.

#### *Practitioner Learning Event*

2.10 A practitioner learning event, facilitated by the lead reviewer, was held on 27<sup>th</sup> April 2018. This was attended by six members of the thematic SCR panel and 11 practitioners who had been involved in the care of Rosie and her family, including those from universal and specialist health services, children's social care and the police.

2.11 Two health visitors, and a midwife, who were unable to be at the practitioner event, met separately on a one to one basis with the lead reviewer.

2.12 Practitioner involvement was fundamental to the review process. The main purpose of the event (and one to one meetings) was to build on the findings from the chronology and to discuss the delivery of services to Rosie and her family.

2.13 Attendees were also invited to contribute to the learning from the review, including identifying the points at which action could, or should, have been taken. Current practice was also discussed. Appendix two provides a summary of the learning generated by participants. Informal feedback from this event has been very positive.

2.14 A second practitioner event, held on 13<sup>th</sup> September 2018, enabled feedback, clarification and refinement of the emergent learning from this review. The event was attended by seven practitioners and managers from universal and specialist health services, children's social care and the police. Members of the SCR panel were also in attendance.

#### *Deep-dive audit*

2.15 BBSCB required that in addition to undertaking a retrospective review of Rosie's case, the reviewers also considered the quality of the *current* professional recognition and response to child neglect.

2.16 To achieve this, the Thematic SCR Panel led a 'deep dive' audit and case discussion. This aimed to gather evidence of the pathways and experiences of six additional young children at risk of neglect, who were known to local services at the time of the review.

2.17 The audit and case discussions took place over the course of one day, 8<sup>th</sup> June 2018. Three cases were subject to review in the morning, and three in the afternoon. Practitioners and managers associated with each of the cases were invited to attend.

2.18 The audit was guided by an adapted version of the Pan-Bedfordshire Safeguarding Children Boards Audit Tool (as agreed by the Thematic SCR Panel). The adaptations reflected the emergent learning from Rosie's case (for benchmarking purposes) and the creation of a 'box' for the Panel to make a judgement (see Appendix three).

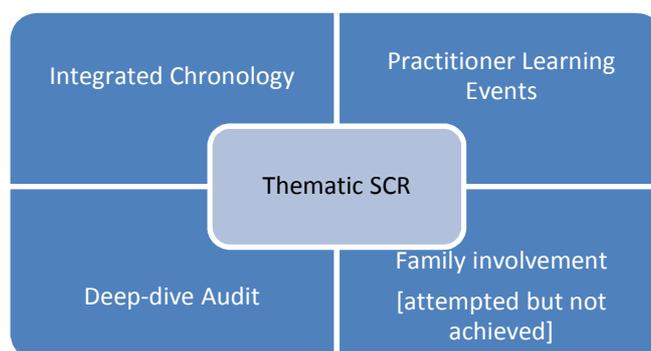
#### *Family involvement*

2.19 At the outset, on-going criminal proceedings meant that Rosie's parents were not able to be invited to make an early contribution to the SCR. Once permission was granted,

the parents were contacted by letter to inform them of the review and to be invited to engage with the process. However, despite further attempts to make contact, it appears that parents have disengaged from services, and thus have not been able to contribute their views.

### *Summary*

2.20 This section has set out the terms of reference and the methods employed to ensure that the review has been as robust and comprehensive as possible. The diagram below illustrates the methodological ‘building blocks’ that have enabled the learning and contributed to the conclusions and recommendations of this report.



## **3.0 Narrative chronology**

3.1 This section has been informed by the integrated tabulated chronology of key events and reports of agency contacts with Rosie and her family. These help to begin to build a picture of her life-story, to understand who was involved in her care, what they did, and why. The practitioner event enabled a deeper understanding of the family’s experiences of receiving care from universal and specialist services.

3.2 The narrative chronology is divided into four time periods. These reflect some background prior to the timeline for the review; the period leading up to Rosie’s birth and the key significant events from the time she was born until her admission to hospital aged three and a half years.

### ***Background prior to timeline***

3.3 Clinical records for Rosie’s father indicate that he was known to mental health and substance misuse services in 2008, with further contact in 2010. Alongside these difficulties, he also has a criminal record relating to serious offences, for which he was found guilty in 2009. There is a police report of domestic abuse against a previous partner in 2011. In the same year he was referred to mental health services by his GP who noted that he was ‘sleeping on the streets, using drugs and alcohol and feeling that life was not worth living.’

3.4 Similarly, in 2012, Rosie’s mother had an overnight admission to a mental health assessment unit, due to having suicidal thoughts. At her midwifery booking appointment in

2013, she also reported having had a history of misusing substances, including alcohol, cocaine and MDMA<sup>5</sup>, having stopped over a year before the pregnancy.

3.5 Following Rosie's admission to hospital, mother reported to police officers that her difficulties relate to her own experiences of child abuse and neglect, and subsequent entry into the care system. It has not been possible to verify this information.

3.6 There is some evidence to suggest that both parents have learning difficulties. This includes mother's report that she attended a special school. Seemingly, neither parent spent their childhood in Bedford, and this has impacted on agency information gathering. At the time of her pregnancy with Rosie, mother was in her mid-30's and father his late 30's.

### ***Pre-birth to one year of age (6<sup>th</sup> July 2013 to 7<sup>th</sup> February 2015)***

3.7 Rosie's mother was booked for ante-natal care when she was 10 weeks pregnant. This was noted to be her first pregnancy (father later shared that he had an older child, born in 2006). The midwife identified mother's history of mental health issues, homelessness, substance misuse history and lack of family support. She was referred for Consultant Obstetrician care and a single-agency information sharing document was completed outlining the safeguarding concerns.

3.8 Subsequently, the midwife completed a Common Assessment Framework (CAF), and made a referral to children's social care (CSC), citing concerns about mother's history as noted above. The referral also noted that parents had been together for two years and that father had reported support from his (large) extended family. Mother was attending all her ante-natal appointments and was said to be in good health. The CAF was undertaken at the GP practice.

3.9 CSC advised that because the concerns were 'historical', and mother was well supported, a Team Around the Child (TAC) should take place and that no further action would be taken by them at this time. Parents had also stated that they were 'reluctant to have anyone else involved'.

3.10 A TAC meeting was scheduled, but subsequently cancelled due to sickness.

3.11 The health visitor made two attempts to call mother to make an appointment for an ante-natal contact, as per the mandated visits protocol. Mother's phone had no message facility and the calls were unanswered. A planned visit was then cancelled by the HV administrator, due to staff sickness.

3.12 The TAC meeting was rearranged, but the midwife informed that a HV would be unable to attend due to sickness. The meeting went ahead, with both parents, the midwife and a children's centre worker in attendance. Mother was approximately 36 weeks pregnant at this point and attending all her ante-natal appointments. Parents agreed to be supported by the children's centre and reported that they had bought baby equipment.

3.13 A few days later, after several attempts to make contact, the HV spoke to the midwife to gain feedback from the TAC. She confirmed that there would be no input from CSC as

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<sup>5</sup> 3,4-Methylenedioxymethamphetamine, commonly known as 'ecstasy'.

'mother was attending all her appointments'. A further attempt was made to carry out the ante-natal HV contact; but mother did not return the HV call.

3.14 Rosie was born on 7<sup>th</sup> February 2014 by elective caesarean section, at 37 weeks gestation. There were concerns about her growth in utero and her breech presentation. Father was in attendance. Rosie's weight at birth was 2116 grams, just below the 9<sup>th</sup> centile, and she was admitted to the neonatal unit because of low Apgar<sup>6</sup> scores and, given a history of maternal substance misuse (albeit not during the pregnancy), the possibility of neonatal abstinence syndrome.

3.15 Maternity staff noted that both parents were of a 'neglected appearance'. They had arrived at the hospital without nappies or clothes for their daughter, reporting that they had no money and were awaiting a benefits payment. The parents also reported that they had been surprised by Rosie's early arrival. Staff were reluctant to discharge mother and baby without ensuring that support was in place and made an urgent referral to children's social care.

3.16 The following day a social worker visited parents on the ward and followed up this visit with a home visit with father to assess home conditions and preparations. The social worker observed that the bedsit was clean and tidy, with a Moses basket, steriliser and sufficient clothing for the baby. Father reported needing the benefits payment to buy nappies. Mother and baby were subsequently discharged from hospital to the care of community midwives four days after the birth. There was no further involvement of CSC at this time.

3.17 Community midwives visited the home on six occasions over the following three weeks. The health visitor (HV) also made contact and called to undertake a new birth visit, when Rosie was 17 days old.

3.18 Liaison took place between the midwife and HV, prior to the new birth visit, with reports that there was poor interaction between mother and baby. The HV has recorded that a referral was made to CSC by the midwife, but this appears to reference the referral detailed above, rather than a further referral relating to concerns about the relationship between mother and child.

3.19 At the new birth visit the HV noted that whilst mother was gentle with Rosie, she did not talk to her. The HV recorded the mother's depression and medication. When encouraged by the HV to smile and talk to Rosie, mother replied that 'she did this all the time.' Due to concerns about Rosie's failure to gain weight and feeding difficulties a paediatric referral was made and Rosie and her mother were admitted to the ward for two days for observation and support from the infant feeding team.

3.20 Follow-up and growth monitoring was provided by the nursery nurse and community staff nurse, who liaised with the named HV. Rosie was not taken to a follow-up appointment at the children's assessment unit one week post her discharge; albeit there appears to have been a mix up over the date of this appointment.

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<sup>6</sup> Apgar score is a simple assessment of a newly born infant. A low score suggests the possibility of medical assistance being required.

3.21 The day before this failed appointment she was, nevertheless, seen at the hospital by the orthopaedic service with a diagnosis of congenital hip dysplasia following her breech position in utero. This was treated conservatively with a hip harness until Rosie was four months of age.

3.22 The health visitor undertook a second home visit when Rosie was 26 days old. There had been some weight gain. Parents were assessed as being competent with basic baby care and were asked to attend local services for future input and support from HV service.

3.23 When Rosie was six weeks old there was a further overnight admission to hospital with concerns about feeding and weight gain. She was also seen by the GP for a routine six-week check, which noted the hip harness, but no other concerns. Over the next few weeks there are occasions where professionals had recorded difficulties in contacting each other to liaise about Rosie's weight or feeding regime. The chronology suggests that some recorded failures in attending appointments/baby clinic were due to clashes on the day (with hospital appointments).

3.24 When Rosie was eight weeks old she was seen in the Emergency Department following a house fire and smoke inhalation. Admission was unnecessary. The GP was informed of this event, and the HV became aware when she saw this on the shared health record.

3.25 At nine weeks old Rosie was taken to the practice nurse for a vaccination. Mother reported that she had accidentally banged Rosie's head on a door frame. A small graze was noted by the nurse.

3.26 Slow weight gain was recorded over the next few weeks, with weekly/two weekly attendance at the clinic. The HV contacted the paediatrician to query whether there was any underlying condition to explain this, e.g. foetal alcohol syndrome. It is unclear how this was followed up.

3.27 At four months of age Rosie was seen in paediatric outpatients. Her weight and height were below the 0.4 centile. A further referral was made to the dietician to offer support with weaning. No other developmental concerns were raised at this time.

3.28 At six months of age, Rosie's weight was noted to be static. She was reported to have been eating carrots and encouragement was given to mother to add other foods to her feeding regime.

3.29 At seven months of age Rosie was seen in the orthopaedic clinic, x-rays showed normal spine, hips and feet. She was re-appointed for further follow-up in six months.

3.30 At 11 months of age Rosie was not brought to a hospital paediatric appointment. Clinic staff attempted to call parents, but their mobile phone was 'turned off'. The GP practice was notified of this failure to attend and her subsequent discharge from the paediatric clinic. The practice followed up with a letter to the HV asking if the family had moved; this was responded to by a confirmation that the current address was correct.

***One year to three and half years of age (7<sup>th</sup> February 2015 to 21<sup>st</sup> August 2017)***

3.31 At 14 months of age Rosie was seen at the orthopaedic clinic; again, the finding was of normal spine, hips and feet.

3.32 Two invitations were sent for Rosie to attend a one-year review by the HV service; one for an appointment at home, the other for review in a group session. This review eventually took place at the family home, when Rosie was 15-months old. This noted a good emotional bond between Rosie and her mother, but also some developmental concerns, including the fact that she was not weight-bearing, that her (solid) food intake was poor and that her growth was still below the 0.4 centile. An 'ASQ' tool (ages and stages questionnaire) was not completed at this visit.

3.33 Also at 15 months of age Rosie was seen by the GP for a problem with her ears/teething. The GP also asked parents to make an appointment to discuss the missed hospital appointments. This was not attended.

3.34 When Rosie was 16 months old the GP contacted the HV with concerns that mother was struggling with depression, and that there was a past history of alcohol abuse and homelessness. This call also noted that she had a mild learning difficulty and no family support.

3.35 Mother rejected an offer of support from the nursery nurse and declined a visit. This was reported back to the GP, with the HV sharing a plan to encourage mother to attend the children's centre.

3.36 The HV also telephoned mother to monitor progress. Mother said that Rosie was now drinking less milk and eating more food. The HV shared her concerns about the non-weight bearing and offered to accompany them to the children's centre.

3.37 The HV attempted to call mother the day before the planned children's centre visit, but there was no answer and the message facility not enabled. On arrival at the home the following day, there was no one in. A letter was sent to mother to arrange a further home visit.

3.38 On arrival for the visit, the HV and nursery nurse found father at home, with a report that mother had left with Rosie 10 minutes previously. Father said that Rosie was standing alone. Subsequently, a telephone call was made to mother, who denied that she was deliberately avoiding HV contact. The HV was clear that she needed to assess Rosie, and that she would escalate her concerns regarding avoidance of health professionals to the GP and CSC.

3.39 The HV returned to the home the following day, accompanied by a HV colleague. Some developmental progress was noted, including the fact that Rosie could stand on tip toe and point to apps on a tablet. Advice was given about feeding; parents reported that she does not eat 'normal food' for her age and discards most of it. The ASQ was not recorded as being used as a tool for the assessment. Rosie's growth was noted to be below the 0.4 centile.

3.40 Mother reported that she was not keen to attend the children's centre as she was intimidated by groups but agreed to go with Rosie and Rosie's father. At this visit father

disclosed that he had an older child, born in 2006, who he had little contact with. Mother's mood was assessed, and no low mood reported. The findings, including that Rosie was meeting her developmental milestones, were reported back to the GP.

3.41 At 20 months of age Rosie was again seen at the orthopaedic clinic. She was noted to have started crawling, but not walking.

3.42 A two-year funding voucher to support nursery attendance was issued in January 2016 and the family invited to attend a Book-start Party at the Children's Centre. An attempt to contact parents was made as follow-up, but it is reported that the phone was not working. There is no evidence to suggest that Rosie attended any early years' childcare provision or groups.

3.43 At 22 months Rosie was seen by the GP for a fungal infection of her skin, the GP gave advice about scalp care. In February 2016, when Rosie was two years old, the family moved and registered with a new GP practice.

3.44 A health care assistant carried out a 'new patient check' the following month. This noted that Rosie was not yet walking. This was said to have been reported to the GP.

3.45 In April 2016, Rosie was not taken to an appointment with the consultant orthopaedic surgeon. The GP was not made aware of this failed appointment. A further appointment was sent.

3.46 Rosie was not taken to two subsequent orthopaedic appointments; the hospital safeguarding team, HV, and GP were made aware and clinic staff made 'numerous attempts' to contact mother.

3.47 When Rosie was two years and three months old, an appointment to assess her development at home<sup>7</sup> was sent by the health visiting (0-19) service, together with an ASQ (for parental completion). This review was to be undertaken by a nursery nurse. However, on her arrival, the family were not in. There is no evidence that this outcome was shared with the HV. A further appointment was sent; again, there was no access. This time the HV and GP were made aware.

3.48 Also aged two years and three months, Rosie was taken to the emergency department, and subsequently seen by the 'out of hours' GP service with a viral illness. It appears that this is the last time prior to her hospital admission in September 2017 that Rosie was seen by a health professional.

3.49 A week later the HV made an opportunistic visit to gain access and see Rosie but found no one at home. A card was left asking mother to make contact. Rosie was now just over two years and four months of age. The two-year developmental assessment did not take place.

3.50 When Rosie was three years old there was a further failed appointment at the orthopaedic outpatients' clinic. This time the decision was made to discharge her from the clinic, with a letter to the GP requesting that they make contact if Rosie was still under their care. No known contact was made.

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<sup>7</sup> This assessment can take place between two and two and half years of age.

3.51 The HV wrote a letter to mother regarding the failure to attend the orthopaedic appointments and asked her to contact them. This does not appear to have happened or been actively followed up.

***21<sup>st</sup> August 2017 to admission to hospital on 5<sup>th</sup> September 2017***

3.52 On 21<sup>st</sup> August 2017, a midwife made a home visit to undertake an ante-natal booking for mother's second pregnancy. The midwife had seen the mother just over a week previously at the GP practice, and had concerns regarding mother's unkempt appearance, poor dental hygiene and low-weight. Mother had reported that she ate well but had always been slim. She was said to be 13 weeks pregnant and had attended the practice alone.

3.53 The midwife contacted the multi-agency safeguarding hub (MASH) in advance of the home visit to ask if the mother was known to CSC; the response was that they were not.

3.54 The initial appointment offered five days after the midwife had seen mother at the practice had to be postponed due to staff shortages. The contact was made a few days later.

3.55 Mother, father and Rosie were at home when the midwife called. Rosie was seen to be very small, developmentally delayed, drinking milk from a bottle and dressed in a baby-grow (she was three and a half). On enquiring about whether she had had her two-year HV assessment, the midwife was informed by parents that she had, and that there were no concerns.

3.56 The midwife followed this up with further enquiries and escalated the need for a HV to see Rosie. This liaison took place on the 23<sup>rd</sup> August.

3.57 On 4<sup>th</sup> September two HVs called at the house to see Rosie. Parents appeared to be stressed at their visit and initially reluctant to allow entry. The HVs negotiated entry, completed an ASQ and found Rosie to be grossly delayed in all domains of her development. There were additional, multiple, physical and behavioural signs of neglect that have already been described in this report as 'shocking'. Father also reported that his sister had 'dropped' Rosie two months previously.

3.58 Growth monitoring at this visit showed that very little weight had been gained in the two years since Rosie's weight had last been recorded. The proximity to the 0.4 centile showed a markedly negative trend. The centile charts showing Rosie's growth monitoring have been shared as part of the review. They reflect stark evidence of malnutrition and failure to thrive.

3.59 Rosie was referred to the GP for medical assessment later that day; the GP made an immediate referral to the children's assessment unit at the hospital. This is on the same site. A referral was also made to the children's social care by the HV via the MASH team.

3.60 Parents did not take Rosie to the children's assessment unit that evening. This was followed up the next day by hospital staff who had been expecting her arrival. Parents were contacted by them, and Rosie brought. A full paediatric assessment, including a child protection medical, followed.

3.61 There were some constructive discussions at the practitioner event about the procedures, processes and events surrounding the referral and admission to hospital. These issues, which were evidenced in the tabulated chronology, include managing a disagreement between police, social care and health about the ‘grading’ of the urgency of the referral.

3.62 At the time of Rosie’s admission to hospital, there was also a query regarding the actions that could be taken if parents decided to remove her from the ward. A plan to escalate to police protection was put in place prior to the strategy discussion that took place on the 6<sup>th</sup> September. The strategy discussion resulted in a legal planning meeting and the granting of an Emergency Protection Order.<sup>8</sup>

## 4.0 Discussion of the key findings

4.1 The discussion of the key findings in the review have been largely structured around four over-arching, but inter-related, themes that aim to inform learning and improvement across the system. Reference is made to the literature, including other local reviews, and to recent developments in improving the response to child neglect in the Borough. Care has been taken not to overburden partners with a lengthy analysis that repeats information already being shared in other recent local reviews or as part of the wider neglect workstream. The findings from the audit help to shine a light on current practice.

4.2 The themes identified in this review relate to:

- Pre-birth planning and assessment
- Working with resistant parents/disguised compliance
- Assessment of child health, development and lived experience
- Workforce/organisational issues that impacted on practice

4.3 We begin by summarising Rosie’s story, highlighting the identified key episodes and points of contact where action *could*, and at times *should*, have been taken to safeguard her welfare. The summary also provides the basis for the identification of the four themes outlined above and the discussion that follows.

### ***Hidden in plain sight***

4.4 The chronology clearly identifies that both Rosie’s parents had a long history of adverse health behaviours and social problems; including substance misuse (alcohol and street drugs) and homelessness. In addition, there was evidence that mother had experienced abuse in her own childhood and had been ‘in care’ and that father had a history of violent offending and perpetrating domestic abuse.

4.5 Both parents had been known to mental health services and there was some evidence to suggest that parents, particularly mother, had a degree of learning difficulty. The fact that father had had a previous child who he had little contact with came to light when Rosie was 15 months old.

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<sup>8</sup> An Emergency Protection Order, widely referred to as an EPO, is granted under s.44 of the Children Act 1989. This would have prevented her removal from the hospital.

4.6 At the ante-natal booking, the midwife appropriately identified historical concerns, further noting that mother had a lack of family support. The midwife completed a CAF<sup>9</sup> and made a referral to children's social care (CSC). The father reported the support of his large extended family. CSC advised that because the concerns were 'historical', that mother was attending all her appointments, and that the family appeared to be supported, a 'team around the child' (TAC)<sup>10</sup> should take place. There would be no further action by them at this time.

4.7 Even with the benefit of hindsight, this decision may be seen to be questionable. As unanimously recognised by those attending the practitioner event, given the risks presented by the constellation of vulnerabilities in the parental background and history, the referral to CSC should have led to **pre-birth planning and assessment**, rather than a TAC, to safeguard Rosie's future welfare. This may in turn have led to statutory intervention (e.g. child in need plan under s.17 Children Act 1989), and importantly, would have enabled the expertise of social work assessment and oversight.

4.8 The TAC meeting did not take place until a week before Rosie's birth and attendance was limited to parents, a midwife, and a children's centre worker. The proximity to the birth meant that there was little, if any, opportunity to offer early help and support to the family. Father said that they would attend the children's centre and stated a reluctance to have 'anyone else' involved.

4.9 Whilst the early help assessment and TAC process require consent of parents (and older children), and parents co-operated in the meeting, the reluctance of parents to receive additional support should have been a potential red flag for their future engagement with services. Furthermore, there appears to have been no clear follow-up of the plan or identification of who would 'hold the ring' when the maternity services discharged mother and baby.

4.10 The health visitor (HV) was unable to attend the TAC, or to undertake an ante-natal visit, due in part to management and staffing issues, but also because of difficulties in contacting parents to make the necessary arrangements. Health visiting, as a universal service, was critical in this case, and the challenges facing the service, both at a local and national level are discussed later in this report. The difficulties in contacting parents were another possible indicator of concern. Later, there are more stark examples of **parental resistance and disguised compliance** and these form a second theme for learning and improvement.

4.11 The care around the time of Rosie's birth was good. This includes maternity staff's referral to CSC arising from concerns about the parents' neglectful presentation and the provisions being made for their new baby. The home visit by a social worker was good practice, albeit a joint visit with a health professional may have been helpful in reviewing background history and discussing the potential for additional support.

4.12 Rosie was a small baby, and her faltering growth was evident from the early days of her life. At the new birth visit the HV recorded poor weight gain and concerns regarding her

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<sup>9</sup> The CAF has now been replaced by the Early Help Assessment (EHA)

<sup>10</sup> The TAC is now usually referred to as a TAF (team around the family) to reflect a *Think Family* approach in the Borough.

observations about mother's interaction with her baby. Her encouragement for mother to smile and talk to her baby was met by the response that 'she did this all the time'.

4.13 The level of care provided through the *Healthy Child Programme* (HCP) (Department of Health, Department for Children, Schools and Families, 2009) was noted to be 'universal plus' in recognition of the additional input that would need to be provided to the family. More details of the HCP can be found in Appendix four.

4.14 The HVs concerns about Rosie's weight led to a referral to the hospital and admission to a children's ward, with follow-up provided by a dietician. Support for feeding continued through home visits by a nursery nurse and a requirement to attend the community baby clinic for weight monitoring. A second admission followed when she was six weeks old. Rosie was also seen on a regular basis at the hospital orthopaedic clinic for follow-up of unstable hips and by the practice nurse for immunisations.

4.15 During her first year, Rosie's attendance at health appointments appears to have been generally unproblematic, with occasional non-attendance followed-up and found to be due to confusion about dates/times or a clash of appointments. There was no evidence during this first year of any developmental delay, and although Rosie remained very small, there was evidence of a parallel growth trajectory.

4.16 The chronology records some apparent difficulties in professionals being able to contact each other, as well as confusion as to the role of community v. hospital in monitoring weight. A lack of shared records created further challenge (an improvement in recent times has been reported). Given Rosie's slow weight gain, and maternal history, the HV made enquiries as to whether there may be an underlying condition, for example foetal alcohol syndrome. As noted in the chronology, it is unclear how this enquiry was followed up.

4.17 After the immediate postnatal period, contact with health professionals usually took place at a clinical setting, rather than at home. These were scheduled or routine appointments, with two important exceptions; one being the attendance at the emergency department following a house fire when Rosie was eight weeks old, and the other the disclosure to the practice nurse at nine weeks that mother had accidentally banged Rosie's head on a door frame. The HV was not alerted to these concerning events in a timely manner.

4.18 What is striking about the health professional contacts is that although these were relatively frequent when compared with a 'similar child', they were very 'task focused'; for example, on weight, feeding, immunisation or examination of hips. There was scant evidence of a more holistic approach to assessment of Rosie's **health, development and lived experience**. This is important because it would have provided an earlier, clearer picture, of the inadequacy of parenting and the emergent indicators of child neglect. This theme is further explored below.

4.19 Just before her first birthday, Rosie was not taken to an appointment at the hospital paediatric clinic. Although this was followed up by a letter to the HV asking if the family had moved, she was discharged from the clinic without being seen. (Later, when Rosie was just over two years old, the family stopped attending the orthopaedic appointments; albeit her hips had been noted to be stable at this juncture).

4.20 Discussions at the serious case review panels have provided assurance that any failures in following the hospital 'was not brought' policy are being addressed.

4.21 The next contact with the 0-19 team was for the routine one-year review. After two failed appointments, this review was undertaken at home, when Rosie was 15 months of age. Whilst an ASQ was not completed, the review highlighted concerns about gross motor development (i.e. non-weight bearing) and diet. Rosie's growth was noted to be below the 0.4 centile; but this remained in line with her projected growth trajectory. There is sound evidence of the use of professional judgement at this visit.

4.22 Three key contacts took place with health services when Rosie was 20 months, 22 months and 23 months of age (see 3.41 to 3.44). These took place in clinical settings and include an orthopaedic review, a visit to the GP with a skin infection and a new patient assessment arising from a change of GP. There is no record of her being weighed or measured at these contacts.

4.23 However, the fact that Rosie was not yet walking was recorded, but no apparent follow-up of this striking gross motor developmental delay undertaken. Again, there was a focus on the 'task' in hand. These were missed opportunities to recognise and respond to the increasing evidence that Rosie's presentation and developmental delay may be associated with poor parenting capacity and the emergent picture of neglect.

4.24 When Rosie was two years and three months of age, appointments were sent by the HV team for her two-year review. This was to be undertaken at home. However, there were two 'no access visits' and a further attempt by the HV to visit opportunistically to undertake the review also failed to find the family at home.

4.25 Despite these attempts, the 0-19 service management has subsequently raised the question of a lack of persistence in securing the review. However, it also recognised that there may be a culture of accepting parental choice in this matter. It is pertinent to note that those responsible for delivering the HCP have no statutory right to ensure compliance or gain entry to the home.

4.26 A month later, Rosie was taken first to the emergency department, and then signposted to an out of hours GP, suffering from a viral illness. This should have provided a further window of opportunity for health professionals to assess her developmental needs, monitor her growth, and potentially to identify indicators of neglect that may have been present at that time, including parenting capacity.

4.27 When, just over a year later, the extent and seriousness of Rosie's neglect was identified by a midwife the response did not reflect the urgency of the need for rescue. Whilst a discussion with the HV team would have aided decision-making, the findings on this visit should have resulted in a referral to children's social care and the police, with a potential for immediate action to invoke removal under police protection powers.

4.28 It should, however, be acknowledged that practitioners retrospectively identified good practice in the midwife's 'think family approach' and in the persistence of the HVs in gaining access to the home and making an urgent referral to the GP. The challenges raised by the MASH HV in relation to the grading of the referral and the need for urgent access are

exemplary. It is pertinent to note that concerns about the grading of a MASH referral feature in another local SCR concerning neglect (*Child Patrick* BBSCB, 2016).

4.29 This summary has focused on the input from health professionals, however, it is also notable that Rosie did not attend any early years' provision, despite funding being available. Whilst there is no compulsion for young children to attend a nursery, it is unusual to find that by three and a half years of age, a child has not been given opportunities for socialisation and learning. A recommendation will be made for children's centre staff and other professionals to make enquiries and actively follow-up any child who is not attending such provision.

4.30 A further comment is made here on the role of neighbours and the wider community; not least because this review will be in the public domain. As in the tragic case of Kyra Ishaq, who was also severely neglected and malnourished, there may well have been family members or neighbours concerned about Rosie's welfare, and it is important to understand why no concerns were raised by members of the public (Birmingham Safeguarding Children Board, 2010).

4.31 Building social capital (i.e. social networks, neighbourliness) can help to create more cohesive and supportive communities that help to prevent child neglect and other forms of maltreatment (Turney and Taylor, 2014). This becomes especially important in times of austerity, both because of the increased risks to children who live in poverty and because of cuts to public services.

### ***Pre-birth planning and assessment***

4.32 Although it is recognised that pregnancy and childbirth can offer a unique window of opportunity for change, there is a wealth of evidence to show that parental difficulties may have a significant impact in pregnancy and on the longer-term health of the child (Lushey *et al.*, 2018). Furthermore, even where such concerns are historical, it is widely understood that there is likelihood of relapse and increased risk to children (see for example Reder and Duncan, 1999).

4.33 In Rosie's case, pre-birth assessment and planning to ensure her safety and well-being, was inadequate. Whilst the midwife appropriately identified the need for parenting assessment, and undertook a CAF, the ensuing referral to CSC led to no further action by them at that time. The convening of a TAC, which, due to apparent staffing issues, took place very late in the pregnancy, was further limited by the absence of key attendees, including the HV.

4.34 Despite several attempts to make contact, the HV was also unable to secure an antenatal visit. This would have provided a further opportunity for a health professional to identify the multiple vulnerabilities of the expectant parents and make a professional judgement on the need for pre-birth planning and assessment.

4.35 According to guidance for commissioners of the HCP, universal and targeted visits are crucial to securing improvements in child health and well-being, in particular it notes that:

'[the] universal reach of the HCP provides an invaluable opportunity from early in a child's life to identify families that are in need of additional support and children at risk of poor outcomes.'

(Public Health England, 2016:6)

4.36 In Bedford, multi-agency pre-birth planning and assessment guidance and tools have evolved over the past few years and are now incorporated into the Pan-Bedfordshire procedures (currently section 1.4.17). The guidance sets out some examples of their application;

- History of domestic violence
- Poor physical or mental health
- Substance misuse
- Social isolation
- Poor housing
- Poverty
- Parental history of care
- To assess learning difficulties and to provide support

4.37 It is self-evident to note that in Rosie's case, all the above applied. The last point, regarding assessment of parental learning difficulties, is particularly apposite. Provision to support parents, and parenting, may or may not have enabled adequate care, but it would almost certainly have provided opportunities for early intervention to protect Rosie from harm.

4.38 In referencing the literature, the pre-birth planning and assessment guidance raises two questions that are aimed to help practitioners and their managers decide whether the procedures might apply:

*'Will the new born baby be safe with these parents/carers?'*

*'Is there a realistic prospect of these parents/carers being able to provide adequate care throughout childhood?'*

4.39 Multi-agency pre-birth planning and assessment has been noted to be a significant omission in learning from serious case reviews concerning neglect nationally (NSPCC, 2015), and locally (*Baby Sama*, BBSCB, 2017a, *Thematic Review on Neglect and Disability* BBSCB, 2017b). However, their use is evidenced in a recent local SCR (*Faith*, BBSCB, 2017c).

4.40 As noted above, there was unanimous agreement at the practitioner event of the relevance of the pre-birth planning and assessment procedures in Rosie's case. The importance of their application will be reflected in the recommendations and learning from this review.

4.41 Furthermore, in the meetings with the HVs and the midwife it became apparent that there was a general reluctance amongst health professionals to challenge decisions made by CSC, for example regarding the outcomes of referrals, despite there being procedures for escalating concerns.

4.42 A perceived hierarchy between these professional groups was a finding of a previous local SCR (*Adam*, BBSCB, awaiting publication). Reflecting the literature, that review commented: 'professional disagreement is not uncommon in the complexity and emotion of child protection practice; escalation and management of concerns is a sign of a well-functioning system, not a failure in professional practice (Sidebotham *et al.*, 2016).'

4.43 It is therefore pleasing to see the current strategic developments in Bedfordshire in promoting formalised opportunities for work shadowing across early years, social care and health services. This should enable greater understanding, collaboration and collegiate relationships that can only be of benefit to children, young people and their families. The process, detailed in a 'brochure' for practitioners and their managers, could usefully be shared more widely and is an example of good practice.

#### ***Working with resistant parents/disguised compliance***

4.44 Working with parents who are resistant to services and who show partial or disguised compliance is a challenging aspect of child safeguarding and one that calls for authoritative practice. This is helpfully defined as an ability to demonstrate professional curiosity, respectful uncertainty, and being able to challenge both parents and other professionals (Tuck, 2013).

4.45 Disguised or partial compliance is characterised by features that may include deflecting or controlling conversations, telling workers what they want to hear, sporadic compliance (i.e. co-operating 'just enough' so as not to raise suspicions) and not attending, cancelling and/or rescheduling appointments. This includes active avoidance of home visits, such as 'being out' when workers call.

4.46 This behaviour is a frequent finding in serious case reviews and has been a feature of other reviews undertaken in Bedford, (e.g. *Baby Sama*, BBSCB, 2017a, *Adam*, BBSCB, awaiting publication, and *Family Q*, TWSCB, 2018).

4.47 It is apparent that in Rosie's case, parental resistance to professional input began to emerge during the ante-natal period, albeit this may be better acknowledged retrospectively. For example, at the TAC meeting, parents had expressed reluctance to allow anyone else to be involved and provided a smokescreen of assurance that father's family were supportive.

4.48 Later on, there were clearer signs that parents were less willing to engage with health services and this was recognised by professionals. For example, despite parental resistance and failed appointments, when Rosie was 15-months old the HV managed to negotiate entry to the home (with a colleague) having been clear about the need to follow-up her growth and developmental progress, and to put sanctions in place should parents not comply. This was a good example of authoritative practice that was replicated at the HV visit on 2<sup>nd</sup> September 2017.

4.49 Further examples of poor or disguised compliance include mother's rejection of nursery nurse support and failure to attend the children's centre, despite an assurance that she would do so, father's explanation of working at night rendering him too tired to take Rosie to nursery and various (false) assurances in telephone consultations with the HV about Rosie's diet and development.

4.50 Parental resistance to professional intervention and the increasing evidence of partial/disguised compliance with advice and support intended to promote Rosie's health and welfare during her third year is illustrated in the chronology that contributes to this review.

4.51 For example, there was a reluctance to accept visits to the home, particularly when they were unannounced. This may well be related to the fact that evidence found at the time of Rosie's admission to hospital suggests that substance misuse had once again become a feature of the parents' lives.

4.52 It is possible that parents found professional input in their lives problematic. In Rosie's early years they were having to manage appointments to see two different hospital specialists and attend the baby clinic, as well as coping with new parenthood and their own needs and vulnerabilities, without any apparent support from family.

4.53 NICE guidance for working with pregnant women who have complex social factors suggests, it is good practice to ask such clients about their satisfaction with the services that are provided (National Institute for Health and Care Excellence, 2010). This is also expected practice in undertaking serious case reviews, and it is regrettable that an opportunity to meet with both parents was not forthcoming.

4.54 In their review of the role of neglect in SCRs, Brandon *et al.*, (2014) remind us of the importance of being compassionate, but also of the need for practitioners themselves to be supported to make well-reasoned judgements. In a paper presented to the BBSCB in April 2018, the public health commissioning lead for the 0-19 *Healthy Child Programme* recognised the need for consistency, trust, honesty and understanding in building relationships with vulnerable mothers [sic] and their families and in securing improvements in child health and wellbeing.

4.55 The use of the NSPCC's Graded Care Profile 2 is currently being rolled out in Bedford and forms an important element of the BBSCB strategy to address neglect. A benefit of this tool is that it balances family strengths and weaknesses and provides a clear means to work with in partnership with parents on what needs to change.

4.56 There are four issues for practice learning and improvement that should be mentioned in the closing paragraph of this sub-section; the use of genograms, chronologies, supervision and being child focused. These are already being addressed in the learning and improvement from other recent SCRs in Bedford and their importance in working with resistant parents/disguised compliance is reiterated and summarised here.

4.57 Had a genogram (family tree) been drawn up with expectant parents it may have identified the fact that Rosie had an older half-sibling and enabled a discussion about circumstances around father's parenting and contact.

4.58 The use of a chronology should be routine; it can provide emergent evidence of deteriorating circumstances for a child and their family. This is starkly illustrated by the chronology that informs this review. The recent introduction of a chronology template onto *SystemOne* electronic clinical records in Bedford is good practice and will be a welcome improvement for those working in primary and community health services.

4.59 Embedding robust systems of supervision enables critical reflection, challenge and support. Compassion is a foundation for building resilience and delivering relationship-based interventions. It can also help to tackle issues of recruitment and retention in the workforce and prevention of ‘burn-out’ (Institute of Health Visiting, 2015a). There is some evidence of improved leadership and support in local health visiting services, but also of the impact of the national picture of shrinking numbers and cuts in service delivery.

4.60 The final, and arguably most important issue for practice, is to ensure that all contacts focus on the health, development and daily lived experience of the child. This can be difficult to achieve where there are high levels of needs and/or resistance to services.

4.61 To quote Laming (2003), these practice issues reflect ‘doing the basics well’ to safeguard and promote the welfare of children. Good practice will help to tackle the drift that can feature in neglect cases and ensure a timely response when there are emergent concerns about a child. A core principle of safeguarding policy, as highlighted in the statutory guidance in place at the time of commissioning this review, is that ‘for children who need additional help, every day matters’ (HM Government, 2015:7).

### ***Assessment of child health, development and lived experience***

4.62 Rosie and her family lived in an area of Bedford that is characterised by high levels of deprivation, poverty, worklessness (including zero hours contracts) and poor housing stock. It is some distance from the central amenities. Parental substance misuse in the town is higher than national averages, with recognition that it is both a cause and consequence of wider issues including poor physical and mental health, difficulty in securing and sustaining employment, homelessness and criminality (McGovern *et al.*, 2018; Public Health England, 2018).

4.63 Practitioners described the reality of the impact of working in this area with large caseloads of high need families and the adoption of practices and a mind-set that ‘normalises’ deprivation and expectations of parenting and poorer outcomes for children.

4.64 The issue of normalisation is extensively discussed in the *Family Q* review (TWSCB, 2018) and is well-recognised in the child protection literature. In coping with the delivery of services in challenging circumstances, Brandon *et al.* (2014) describe the mindsets adopted by practitioners that reflect fears about being considered judgemental when working with families who are vulnerable, poor, socially excluded and who have made particular life-style choices. This can result in undue professional optimism, an acceptance of sub-optimal parenting practice, a ‘down-grading’ of neglect, and a failure to appreciate the child’s lived experience.

4.65 The ASQ can help to address these failings through ensuring a comprehensive developmental assessment and early intervention for unmet need. The two to two-and-a-half-year review, for example, can utilise an ASQ that acts as an aide memoir for discussion of healthy eating, keeping active, managing behaviour, encouraging good sleeping habits, dental hygiene, safety and immunisations (Institute of Health Visiting, 2015b).

4.66 Whilst the use of tools should not replace professional judgement and critical thinking, they can assist in providing objectivity in benchmarking care, health and developmental progress. Both the ASQ, and the GCP2, can also help to engage parents in

understanding children's developmental needs and working to achieve the best outcomes for their child. Assurance has been received that improvements in the uptake and use of these tools is now in place in Bedford.

4.67 Another significant finding in common with the *Family Q* review (TWSCB, 2018), worthy of note here, is of a task-focused approach to the delivery of care. In Rosie's case this includes a reductionist approach to weighing, assessment of a viral illness and checking hips. The importance of a more holistic assessment that includes the opportunity to identify any safeguarding issues is an approach that is recognised in professional standards and guidance (see below). Feedback at the second practitioner event was that this can be difficult to achieve in tight timings for appointments and current workload pressures.

4.68 The Royal College of Paediatrics and Child Health (2018) recognise the need for staff working in urgent and unscheduled care to be trained in child health and development and aware of child safeguarding issues. This is particularly important as there is widespread evidence that vulnerable families make greater use of these settings to access their health care.

4.69 Equally, the Royal College of Nursing (2017), recognise that general practice offers valuable opportunities for early intervention, family support and recognition of children who may be at risk of harm. Acknowledging that the practice nursing team may include health care assistants, the guidance on expected competencies for working with children includes the ability to provide preliminary advice and support with feeding, weaning and speech development and to understand normal parameters for growth, together with the ability to recognise children who have faltering growth or failure to thrive.

4.70 Whilst the health visiting service and delivery of the HCP is critical in Rosie's case, this report will make a recommendation in respect of the need to ensure that opportunities are taken at *all* contacts with health professionals to take a wider approach to assessment of a child's health, development and lived experience. This may well be a training issue.

### ***Workforce/organisational issues that impacted on practice***

4.71 The input from the SCR panel's health safeguarding leads has led to a clearer understanding of the workforce and organisational issues that impacted on the services provided to Rosie and her family. Given the overlap in timescales, many of these factors are also reflected in the *Family Q* report (TWSCB, 2018).

4.72 The issues affecting the delivery of health visiting services include changes in management and leadership, relocation, high caseloads, increased travel time and the introduction of mobile working that led to a reduction in informal peer support (TWSCB, 2018). There were long term vacancies, staff absences and attendant high levels of stress and low morale in the teams. The contractual pressures to deliver the universal element of the HCP, meant that less time could be given to families with additional needs. A feeling of being overwhelmed and undervalued by other professionals was also mentioned.

4.73 There is evidence that welcome changes and improvements are being made in the Borough. These include reallocation of staff with reduction in caseloads (i.e. from 620 to 440

children<sup>11</sup>) and improved systems for support and supervision. The opportunity for health visitors to be part of the work-shadowing programme should help partners to better understand their expertise in child health and contribution in the wider safeguarding arena.

4.74 Whilst this improving picture in Bedford may be a reason for some optimism, nationally the profession is facing a crisis. Following a programme of growth, the numbers of qualified HV in England has dropped from 10,309 in October 2015, to 8,275 in January 2018<sup>12</sup>.

4.75 This reduction in the workforce nationally has been linked to the transfer of commissioning of the service from the NHS to local authorities (Institute of Health Visiting, 2017). The climate of austerity in public services is recognised to be challenging for families, as well as professionals (Brandon *et al.*, 2014).

4.76 Further concerns have been raised by the Institute of Health Visiting annual state of HV survey [n.1413] that practitioners are managing risk, rather than offering a universal service, feeling stretched (more than 21% of respondents had caseloads between 500 – 1000 children) and being concerned about the possibility of a child protection tragedy in their locality.

4.77 There are likely to be significant challenges nationally in managing the future delivery of the *Healthy Child Programme* given the austerity measures affecting the commissioning and delivery of public health services and the shortfall in health visitor numbers. The BBSCB will be mindful of the impact of this on partners, but also on the safety and well-being of the most vulnerable children, young people and families in the Borough.

4.78 Whilst there was minimal contact with CSC, organisational practice was recognised as needing improvement at that time (2013). This may have impacted on the ability to manage the initial referral from maternity services. Various improvements have since been put in place. This includes better systems for managing contacts and linking children and adults. The midwife's enquiry in August 2017 that resulted in a 'not known' regarding the mother would not be the case now. However, this would not have materially affected the outcome for Rosie.

4.79 Thus far, the discussion has centred on Rosie's case and the findings that emerge suggest learning and improvement in relation to pre-birth planning and assessment; working with resistant parents/disguised compliance; the assessment of children's health, development and lived experience; and the impact of workforce/organisational issues.

4.80 The discussion has referenced other local SCRs, as well as learning from other published SCRs concerning neglect. There are pointers towards an improving picture. The next section makes further reference to the BBSCB-led neglect workstream and the findings of the audit of current cases.

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<sup>11</sup> However, professional bodies for HV recommend caseloads of no more than 250 children per WTE.

<sup>12</sup> <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics---january-2018>

## **Current professional recognition and response to child neglect in the early years in Bedford Borough**

4.81 Concerns about the recognition and response to child neglect arising from previous local SCRs (as referenced in this report) have helped to inform a Pan-Bedfordshire Neglect Strategy that has been updated and refreshed (BBSCB *et al.*, 2017). This has raised the importance of the early recognition of neglect, the need to work with families in a positive and empowering way, and to offer a range of provision from early help services through to statutory intervention.

4.82 A neglect conference, attracting high profile speakers and held in March 2017, was well-evaluated, with learning and improvement followed up by a post-conference survey. The GCP2 tool for assessing neglect and monitoring improvements in parental care has been launched, and there is evidence of its use in practice.

4.83 There is also evidence that the BBSCB partnership are addressing the recommendations of a recent inspectorate review of child neglect nationally, albeit the focus of this review is of the older neglected child (Ofsted, 2017). This includes work being undertaken to promote an understanding of the potential seriousness of the impact of neglect on child health and wellbeing across agencies.

4.84 The need for a more widespread appreciation of the impact of neglect on child health and development has been reflected and discussed in other local reviews and is well-described in the literature (e.g. Brandon *et al.*, 2014). This factor, and the learning and improvement work already being undertaken, is acknowledged here, rather than raised as an additional learning point from this review.

4.85 In seeking to reflect the quality of current practice, the thematic SCR panel led a 'deep dive' audit and case discussion. This aimed to gather evidence of the pathways and experiences of six additional young children at risk of neglect, who were known to local services at the time of the review. The cases were selected by the panel member for Cambridgeshire Community Services NHS Trust, based on agreed criteria, as outlined in the box below:

1. Cases that may help to identify good practice; as well as areas for learning and improvement. A balanced approach will be taken.
2. The child was less than five years of age on 1/04/18 and lived with their family in Bedford Borough.
3. Concerns about neglect had been identified in the past year (Beginning April 2017 – end March 2018).
4. These concerns have led to assessment and/or the provision of additional services that includes one (or more) of the following:
  - Universal plus, or universal partnership plus health visiting (0-19) services
  - An early help assessment (EHA)
  - A referral to children's social care (s.17 or s.47)
  - The use of GCP 2.

4.86 The deep-dive audit took place on 8<sup>th</sup> June. Three cases were discussed in the morning and three in the afternoon. Practitioners and managers from health, early help services and CSC attended for each case and their involvement was invaluable. Whilst six

cases cannot be representative or inclusive of all children in need in Bedford, the process did shine a light on the quality of current practice in universal and specialist agencies.

4.87 The SCR panel members had taken responsibility for their agency's 'pre-completion' of the audit tool and this was added to during the audit by the BBSCB manager, who then ensured a combined tool was made available. The following paragraphs provide a summary of the audit findings.

4.88 The index children were aged between nine weeks and four years of age. With one exception, they all had siblings. Most of the children had been born into families with extremely complex problems and vulnerabilities; including parental physical and mental health issues, substance misuse, learning disability, domestic abuse and criminality. The children themselves had a variety of needs, such as those linked to prematurity, and often had frequent attendance at the GP practice.

4.89 There was extensive evidence of missed health care appointments, but also that these had been appropriately followed up. Several of the siblings had learning disabilities and/or poor physical health and problematic school attendance, sometimes linked to their neglected presentation.

4.90 All the children were known to CSC, although at the time of the audit some input had been 'stepped down' to early help services. The most common intervention was a 'child in need' (CIN) plan, but there had also been EHAs, TAC/family input and in some cases child protection plans. Pre-birth planning and assessment as per BBSCB guidance was not generally evident, although it should be acknowledged that this was not included as part of the BBSCB procedures during the pregnancies of the older children.

4.91 Referrals had followed a variety of concerns including; squalid home conditions, the impact of parental difficulties outlined above, neglect of children's health needs (not being taken to appointments) or because of services involvement primarily for siblings.

4.92 The Pan-Bedfordshire multi-agency audit tool, adapted slightly for the purpose of this review, encourages practitioners, managers and the audit panel to consider 'what's gone well' and 'what could have better'. It also allows for self, and multi-agency, evaluation using the Ofsted grading of Outstanding/Good/Requires Improvement and Inadequate in eight domains. The overall judgement reflects the lowest domain grading, meaning that even if 7:8 judgements are good or better, a lower judgement will be made overall (as was generally the case).

4.93 Despite the overall grading of 'requires improvement', the panel concluded that there was sound evidence of an improving picture, with most domains graded as 'good' by the practitioners/panel. Comments taken from completed audit tools demonstrate both critical thinking and reflection on practice:

*'Following social care intervention, the family did engage well with Early Help under a joint working arrangement and there was positive impact.'*

*'Good reflections of observations of [child] with family throughout assessments/ reviews. This along with 'voice' of older siblings was in case recording and plans to keep them safe-good outline of the voice of each child in CIN meetings in particular.'*

*'At the point of Dec 17 referral, there was comprehensive info sharing and discussion with mother whereby she said she wanted help and just felt overwhelmed. Rather than again recommending she engage in an EHA, the decision was to progress to SA [single assessment<sup>13</sup>] which considering the history of referrals was appropriate.'*

*'There appears to be a good relationship with the family from social care in that mother is able to be open and honest about her views of support/ professionals and engagement however, it makes me question whether this is disguised compliance or what impacted on this level of engagement with the TAF previously.'*

4.94 Where less good practice was seen, or room for improvement identified, this was also acknowledged. For example, there was some mention of difficulties contacting the universal health services (0-19) team and of limited engagement with them to gain their input in CSC-led single assessment. In two cases the question of parental voice being 'sought, heard and responded to' was judged as requiring improvement/inadequate because the father's voice was absent. However, overall the findings of the audit reflect positively on the current provision of services in Bedford and how these are providing benefits to vulnerable children, young people and their families.

## **5.0 Learning Points for consideration by Bedford Borough Safeguarding Children Board**

5.0 This overview report has set out the findings of an independently-led thematic SCR commissioned by the Chair of BBSCB. It concerns Rosie, who was found, aged three and a half years, to be suffering from life-threatening and life-changing neglect within her home environment. The review has not only sought to understand Rosie's story, but also to consider the quality of the current professional recognition and response to child neglect in the early years in Bedford Borough.

5.1 The involvement of practitioners and their managers has been fundamental from the outset of the review, as has the support of the local SCR panel. The learning points that are set out for consideration by the BBSCB reflect the collaboration and insight provided by their engagement and expertise.

### **Learning point one**

Children who are suffering from neglect (and other forms of child maltreatment) may be 'hidden in plain sight'. The BBSCB are spearheading an NSPCC poster campaign to raise awareness of neglect to a wider public audience, for example those using local leisure facilities, health services, libraries and children's centres. The findings of this review strongly support this initiative which will, we understand, be reflected in an update of the Pan-Bedfordshire Neglect Strategy.

### **Recommendation**

- The BBSCB and partner boards should consider how the refreshed Pan-Bedfordshire Neglect Strategy can impact local initiatives aimed at building social capital across communities.

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<sup>13</sup> Single assessment is led by CSC and requires contribution from other involved agencies.

### **Learning point two**

This review has highlighted the importance of pre-birth planning and assessment in offering early help and support to vulnerable parents and in ensuring the future safety and well-being of the unborn child.

#### ***Recommendation***

- The BBSCB should seek assurance regarding the utilisation of the Pan-Bedfordshire pre-birth planning and assessment guidance in practice. This may, for example, include joint-agency audit activity to ascertain the frequency and timeliness of use and the outcomes (i.e. early help/child in need/pre-birth child protection planning).

### **Learning point three**

This review has found that there remains evidence of a perceived 'professional hierarchy' and a reluctance to escalate disagreements with decisions made at the front door of CSC. More needs to be done to promote collegiate working, respect and mutual understanding of others' roles and responsibilities, including the limitations in practice.

#### ***Recommendations***

- BBSCB should seek assurance that partners are able and willing to engage in the Shadowing Project through monitoring activity.
- BBSCB should seek assurance via the scrutiny and assurance group that the findings in learning point three are not a wider systemic issue regarding referral pathways.
- BBSCB to raise awareness of the Escalation Procedures to frontline staff.

### **Learning point four**

This review has found limitations in the delivery of child health care that reflects both a focus on task, and a failure to appreciate wider aspects of health, development and the child's lived experience. All those delivering care to children, young people and their families must have the relevant competences to do so.

Professional guidance referenced in this report can greatly assist in the development of an upskilling programme (RCN, 2017), as can ensuring that practitioners can utilise the ASQ tools to support good practice in assessment.

#### ***Recommendation***

- That the Clinical Commissioning Group and Public Health Commissioners should seek assurance from providers that practitioners delivering care to children, young people and their families have achieved, as a minimum, the competences set out in the relevant professional guidance, including oversight from an appropriately qualified professional. A report should be made to the BBSCB accordingly.

### **Learning point five**

This review has highlighted the unusual finding of a three-and-a-half-year-old not attending any early years' provision or groups. Such provision helps children's developmental progress, socialisation and 'readiness for school.' It also provides an additional safety-net for vulnerable children and their families and a source of additional parental support.

### ***Recommendation***

- BBSCB to seek assurances that practitioners are asking parents/carers why young children are not accessing early year's provision. Early Years Services to report to the BBSCB on the processes currently in place and what could be done to assist and strengthen them. This should include outlining the resources available locally that can provide one to one support to those parents who do not want to attend group sessions.

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## Appendix One: Key Lines of Enquiry

### Strategic & organisational issues

- How does this thematic review resonate with the wider neglect work-stream? What have we learnt from previous national & local SCRs (neglect)?
- Local picture v. national picture (e.g. numbers of children subject to CPP for neglect; second and subsequent plans, length of time on plan; escalation to legal intervention)
- Thresholds/criteria for action/early help/statutory intervention/pathways, role of MASH/Single point of contact (SPOC)
- Are the multi-agency/BBSCB policy and procedures for recognition and response to neglect understood and applied? (include pre-birth protocols)
- Impact of commissioning changes in public health provision (health visiting or health visiting and school nursing); impact of policy on mandated visits; service specifications for the delivery of the healthy child programme; other universal provision (e.g. children's centres/nursery)
- What level of universal service was provided? How does this compare with any similar child?
- Workforce issues, to include caseload/workload, skill-mix, vacancies, sickness levels, learning and development opportunities, provision of clinical/child protection/case supervision, management oversight
- Are there any other system-based issues/additional factors that have affected the service provision, such as resources, management culture, team dynamics, supervision and support?

### Issues for practice

- What evidence is there of good practice?
- Was this a child/family who were 'unseen'?
- If so, how is it possible for a child to be so unseen in this day and age and what is the likelihood that there are other children living in such chronic neglect without any universal services involvement or knowledge?
- How do we demonstrate the impact of neglect on children and young people? How do professionals understand children's lived experiences and how do they ask, 'what must these children's lives be like living in this family?' Do professionals ask themselves, what does this child mean to the parent and what does the parent mean to the child?
- Do professionals accept the fact that neglect is not only harmful but can also be fatal should be part of their mind set as it would be with other kinds of maltreatment?
- What is the impact of poverty and deprivation on children, young people and families and how does this impact on practitioner response?
- Quality of assessment/use of 'tools' for assessing neglect (e.g. GCP2), children centred practice, understanding of developmental milestones; parenting capacity, including impact of substance-misuse & past history; assessment of 'wider family and environmental issues'; use of genograms; care planning & evaluation.

- How do we encourage both adult and children professionals to ask basic questions about family structures (who lives in the family home), language barriers, what and support networks are available to the family?
- What is the protocol for following up children who are 'not brought' (Did not Attend) their health care appointment?
- Professional optimism; professional expectations of parenting; drift and delay; understanding of non/partial/disguised compliance; use of professional curiosity; authoritative practice; are there low expectations by professionals of parents, based on experience of disguised or partial compliance and little or no evidence of positive change?
- How do we define what is 'parental support' and how and when should professionals challenge when parents/carers decline the support offered to support/improve their parenting/care? How do we get professionals to challenge parents self-reporting?

## **Appendix Two: Practitioner Learning Event**

### **Learning from the Case**

#### **What would you like to see in the review around good practice?**

- HV joint visit/working on the case – they challenged the parents and were persistent. They challenged the GP apt and assessed the situation as a CP concern.
- Midwife booking appt for the second baby – think family looking at [Rosie] and raised concerns.
- Early care offered at [Rosie's] birth – Dietician and Orthopaedic.
- Detailed HV assessment to the Police.
- Description of the home visit by the HVs.
- Detailed observation and thinking of the HVs at the home visit.
- Clear accurate communication about the risks they had assessed to [Rosie].
- HVs planning around the leave taken by staff.

#### **What can we learn from this case?**

- That a pre-birth assessment should have been carried out.
- ACE [adverse childhood experiences] impact on parenting
- EHA continuously updated
- Was not bought needed to have a more robust approach. DNA could also mean Do not accept!
- Follow up of referral.
- Information sharing between Health services. (Need to be clear about what how the systems are talking to each other now).
- HVs work via postcode and they felt the service worked better when they were aligned to GP surgeries
- What if conversations are now recorded by the MASH.

#### **Clear lessons to be learnt**

1. Golden thread – at several points there was a lack of follow up.
2. Pre-birth assessment – homeless and vulnerable multi-agency.
3. A lack of provision for adults who have learning difficulties – lack of pathways/procedures
4. Father's role/voice – parenting responsibilities of the father.
5. Need to look at the big picture – info sharing (Hospital paper records)
6. Joined up individual roles.

## Appendix Three: Additional Audit Questions

### SCR Panel:

**How did the care of this child and family benchmark/compare with that provided to ROSIE and her family?**

#### **Consider for e.g.**

Identification of neglect/impact of neglect on child/child's lived experience

Identification & response to parental vulnerabilities

Pre-birth assessment/other assessments

Risk/cumulative risk

Follow-through & follow-up

Response to Was Not Bought/no access visits/working with resistance/partial/non-compliance

Role of fathers/men in household

Evidence of authoritative practice/ 'respectful uncertainty'

Impact on worker/ 'normalisation'/lone-working/supervision & support

Caseload/workload issues

## Appendix Four: Overview of the Healthy Child Programme

The *Healthy Child Programme* (HCP), published in 2009, outlines the provision of universal health care and support for children from pre-birth to 19 years of age in England. Building on a tradition of child health surveillance and screening, it introduced a greater focus on ante-natal care, health promotion, social determinants of health and well-being and the need to include fathers. The programme supports the early identification of families who may require additional help and/or factors that may put their children at risk of harm, offering the opportunity for extra supportive measures on top of the universal approach at each stage.

The programme is delivered by midwifery and health visiting teams, children's centres, GPs and practice staff. It includes, as a minimum, contacts by the 12<sup>th</sup> week of pregnancy, a neonatal examination and screening, a new baby review (at around 14 days of age), a 6-8 weeks examination and reviews at one year and two to two and a half years of age. It links to the child health immunisation programme (normally delivered in general practice).

Five mandated contacts by health visiting staff have been detailed as part of the transfer of commissioning from health to local authority public health departments:

- A health-promoting visit at 28 weeks of pregnancy
- A new-baby review at 10-14 days after birth
- A six to eight weeks assessment
- A one-year assessment
- A two to two-and-half-year review

A model of health visiting services introduced as part of a drive to increase capacity, sets out how additional support can be offered from community-based services and targeted visits at a universal plus and universal partnership plus level of assessed need (Department of Health, 2011).

See:

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