



Serious Case Review

Family Q

OVERVIEW REPORT

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Version 3.4 FINAL

Signed off by Telford & Wrekin Safeguarding Children Board on 2nd May 2018

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1 Introduction

- 1.1. This Serious Case Review (SCR) is in respect of five children made subject to Police Protection¹ and taken into the care of the Local Authority due to neglect by their Parents. The children were aged between six weeks and nine years old at the time of their removal from the family home.
- 1.2. Telford & Wrekin Safeguarding Children Board (TWSCB) considered the circumstances of the children and agreed that the criteria for carrying out a Serious Case Review as defined by Working Together to Safeguard Children 2015² had been met.
- 1.3. TWSCB recognised the potential to learn lessons from this review regarding the way that agencies work together in Telford & Wrekin (LA2) and Bedford Borough (LA1) to safeguard children. The purpose of a Review as outlined by Working Together is *'to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organizations should translate the findings from reviews into programs of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'* (p73). Good practice and learning identified by this review are outlined within this report.
- 1.4. This review established that observations recorded by professionals were not identified as potential indicators of neglect and that information and evidence available to agencies was not assessed or shared.

A summary of the key findings from this review are:

- There was limited information sharing about indicators of neglect when the children moved within and between local authorities
- There was a lack of holistic assessment of the family. Each child was seen as an individual and there was very limited information about Father
- Home visits by different professionals were task focussed and undertaken in isolation
- Information provided by Mother was accepted without further enquiry and there was an absence of professional curiosity
- There was limited understanding and appreciation of the lived experience of the children
- Indicators of neglect were normalised by professionals who spoke about their work in areas of high deprivation
- Available tools to support the early identification, assessment and analysis of neglect were not routinely used by professionals

¹ Section 46 of the [Children Act 1989](#). Under this law, the police have the power to remove children to a safe location for up to 72 hours to protect them from significant harm.

² A guide to inter-agency working to safeguard and promote the welfare of children, HM Government

- Engagement of parents that may have indicated disguised compliance was not explored or assessed throughout the timeline for this review
- There was little evidence that practitioners had the confidence to exercise professional uncertainty and challenge explanations provided by Mother

1.5. The following definition of neglect from UK statutory guidance³ was used throughout the review process to guide discussion and analysis;

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *ensure adequate supervision (including the use of inadequate care-givers); or*
- *ensure access to appropriate medical care or treatment.*

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

1.6 The extent and significance of neglect in children's lives has been a key and recurrent theme within Serious Case Reviews. A recent analysis found that neglect was apparent in the lives of nearly two thirds (62%) of the children who suffered non-fatal harm, and in the lives of over half (52%) of the children who died⁴.

1.7 There is significant evidence to demonstrate that neglect has the potential to compromise progress across the seven dimensions of development identified in the Assessment Framework: health, education, identity, emotional and behavioural development, family and social relationships, social presentation and self-care skills⁵.

1.8. Neglect has serious consequences for children and young people of all ages however there is evidence to suggest that it has a particularly adverse impact on

³ **Working together** to safeguard children. Statutory guidance on inter-agency working to safeguard and promote the welfare of children. DfE, 2013 p86

⁴ Pathways to harm, pathways to protection: A triennial analysis of serious case reviews, 2011 -2014. Sidebotham P et al. DH 2016 (p43)

⁵ Ibid. P8

the development of very young children⁶. This is an important factor of relevance to this review as much of the involvement of professionals within the time line focussed on the wellbeing of new born babies and very young children.

2 Process

- 2.1. TWSCB agreed that this Serious Case Review (SCR) should be undertaken using the Significant Incident Learning Process (SILP) methodology. SILP is a learning model which engages frontline staff and their managers in reviewing cases, focusing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in Working Together to Safeguard Children 2015.
- 2.2. The SILP model of review adheres to the principles of;
 - child focussed
 - proportionality
 - learning from good practice
 - the active involvement of practitioners
 - engaging with families
 - systems methodology
- 2.3. This review required the completion of Agency Reports followed by a Learning Event which was attended by practitioners, managers and agency safeguarding leads from LA2 and LA1⁷. Participants involved in the initial Learning Event were invited to a Recall Event to study and debate the first draft of the Overview Report. The contribution of all those involved enabled a greater understanding of the context in which practitioners and managers worked and maximized opportunities for organizational learning.
- 2.4. Due to ongoing criminal investigations there was a delay in meeting with the parents). The author and representative from the WSCB met with parents at the end of the SCR process. It is important to note that whilst parents provided a different explanation to that of professionals about some of the factual details⁸ they were in full agreement with the findings and recommendations of this review. The information provided by parents will inform the dissemination of learning from this review.

⁶ Missed opportunities: indicators of neglect – what is ignored, why and what can be done? Brandon M, Ward H et.al. Research Report DH Nov 2014

⁷ The Learning and Recall events were facilitated by Donna Ohdedar, Head of SILP. The Report Author was Cath Connor, a SILP associate reviewer. Both Donna Ohdedar and Cath Connor are independent of TWSCB and its partner agencies.

⁸ For example; Mother said that she advised professionals that her step grand mother had died and not her mother, parents said that they made efforts to have the dogs removed from the family home whilst in LA1 and parents were clear that if asked they would have complied with an Early Help Assessment.

- 2.5. It was agreed that the scope of this review would be from June 2015 when the Health Visitor in LA1 requested a new birth visit, to December 2016 when the Section 47 investigation commenced and resulted in the children being placed in foster care. This period includes the family's move from LA1 to LA2 and the birth of Q4 and Q5.
- 2.6. Relevant information prior to these dates⁹ was also considered and included an anonymous referral to the NSPCC in 2012 due to concerns about neglect, records of School 1 attended by Q1 and Q2 and observations by the Health Visitors of home conditions following the birth of Q3.
- 2.7. It is important to note that during the timeline considered within this review the family resided in LA1 for twelve months and LA2 for six months. This review was commissioned by the LSCB in LA2 as the children were taken into care whilst living in this area. It is important that the LSCB in LA1 consider the findings of this review and have an opportunity to respond to recommendations for the improvement of practice.
- 2.8. The decision to undertake a Serious Case Review was made by the Independent Chair of Telford & Wrekin Safeguarding Children Board. Mother and Father were informed about the review and were updated regarding progress by TWSCB.
- 2.9. The Terms of Reference considered throughout this Review and addressed by authors of Agency Reports were:
 1. How well did agencies recognise neglect at various key points? Were assessment tools used? Did assessments inform analysis?
 2. How was the family history incorporated into assessments?
 3. To what extent did practitioners Think Fathers?
 4. Evaluate the response of agencies to emerging concerns.
 5. What did agencies know about the children's lived experience? Did this have an impact on the services provided and work undertaken?
 6. Analyse transition arrangements (including information sharing) within and between areas.
- 2.10. Much consideration was given to obtaining the wishes and feelings of the children in a way that was meaningful, child-focused and least likely to cause additional distress. Children's Services remain involved with the family and following significant reflection it was decided not to involve the children directly in the review process. On balance it was thought that would be likely to risk further trauma at what is known to be a difficult time. It was considered unlikely that information provided by the children would change the learning identified.
- 2.11. Prior to publication Mother and Father stated their agreement with the findings and recommendations of the Review.

⁹ When the family were living in LA1

3 Family Structure

- 3.1. The subject children will be referred to as Q1, Q2, Q3, Q4 and Q5 aged between six weeks and nine years old.¹⁰ The parents of the children are referred to in this report as Mother and Father. Other family members will be referred to by their relationship to the children e.g. Maternal Grandmother and Maternal Aunt.
- 3.2. Mother, Father, Q1, Q2, Q3 and Q4 lived in LA1 until the family moved to LA2 in 2016.
- 3.3. The Children, Mother and Father are White British and of no religion.

4 Introduction to the Case

- 4.1. Information about possible indicators of neglect with specific reference to home conditions was detailed in records of the Health Visiting Service in LA1 and LA2. Some information had been provided by the Midwifery Service in LA1 and subsequently recorded by the Health Visitor.
- 4.2. There were issues regarding the hygiene of Q1 and Q2 whilst attending School 1 in LA1. These were not considered sufficient to require a referral to children's services and were addressed directly with Mother.
- 4.3. Q3 and Q4 were born in different areas within LA1 in 2014¹¹ and 2015 respectively. The family moved home on two occasions during the time line considered within this review and Q5 was born in LA2 in 2016.

¹⁰ At the time of removal from the family home

¹¹ The birth of Q3 is outside of the time frame considered by this Review

- 4.4. In December 2016 School 2 in LA2 made a referral to Children's Social Care as Q2 had a bruise on his ear and said that Mother had caused it. A joint Section 47 investigation took place between the Police and Children's Social Care.
- 4.5. When Police Officer 1 and Social Worker 1 entered the family home in LA2 they found that the children were living in extreme squalor in a dirty and potentially dangerous environment. Dogs had defecated in the house and were also neglected. The Police Officer and Social Worker were surprised to see that Q2 had four siblings as information on the initial referral noted that Q2 lived alone with Mother and Father. Immediate action was taken to ensure the safety of the children and they were made subject to Police Protection and taken into foster care¹². Mother and Father were arrested and subsequently pleaded guilty to child neglect. At the time of writing this report sentencing had not taken place.

5 Background information from LA1 prior to the scoped period

- 5.1. The Family became known to the Health Visiting Service following the birth of Q2 in 2011. In 2012 an anonymous referral was received by the NSPCC for concerns regarding neglect. There was communication between a Social Worker and Health Visitor and following initial enquiries no further action was taken.
- 5.2. Records from School 1 attended by Q1 and Q2 detail concerns regarding the personal hygiene of Mother and the cleanliness of Q2 who was reported to smell of faeces on one occasion. Mother explained to family practitioners at the local Children's Centre that she forgot to wash Q2 as she had been upset by the landlord saying the family had to move house. Mother was referred to the Citizens Advice Bureau.
- 5.3. In 2013 during the 2yr targeted development review for Q2, Mother informed HV1¹³ that she was a carer for her husband who had a learning disability. Mother also explained that a friend had made the referral to the NSPCC as Mother was of low mood at the time because she was unable to visit her Father who was ill. This was the last routine contact by the Health Visiting service as part of the Universal Provision of the Healthy Child Programme¹⁴.
- 5.4. HV2 made a new birth visit to Q3 in April 2014. The house was noted to be cluttered and dirty and the furniture heavily chewed by the family dog. Mother had cleaned the floor just before the visit. Mother told HV2 that the family was

¹² The following day Parents agreed to voluntary accommodation of the Children under Section 20 Children Act 1989

¹³ HV 1 to HV6 worked in LA1, HV7 to HV9 worked in LA2

¹⁴ Healthy child programme from 5 to 19 years old. London: Department of Health 2009

about to be evicted and HV2 advised mother not to leave Q3 alone with the dog. There was no arrangement for further contact with the Health Visiting Service.

- 5.5. HV2 attempted to arrange a further home visit six weeks later and was informed that the family had moved into another privately rented house in a different part of LA1. HV2 advised Mother that a Health Visitor from the new locality would contact to offer support. There was a lack of information in Health Visitor records about the handover of care from one locality team to another in LA1.
- 5.6. Mother attended a drop in well baby clinic with Q2 and Q3 in the new locality in LA1 and HV3 completed a transfer in assessment. HV3 did not have access to electronic information about the observations made by HV2 on the New Birth Visit and would have been dependent on Mother self-reporting in the clinic. Parents did not respond to the letter offering a one year review for Q3 in March 2015.
- 5.7. Mother booked late for antenatal care with Q4 and explained that this was due to a family bereavement. The late booking in pregnancy pathway was initiated and no concerns were identified.
- 5.8. Mother attended the GP surgery many times with Q1 and Q2 suffering from recurrent urinary tract infections and upper respiratory tract infections, however, this was not identified as a cause for concern.

6.0 Key Episodes

- 6.1. The period under review has been divided into five key practice episodes of significance to the development of the case:
 - Telephone contact between HV 4 and HV 5 (located in the MASH) in LA1
 - Overnight Hospital admission of Q3 in LA1
 - Family move from LA1 to LA2
 - Home visits following the birth of Q5 until the children were removed from the family home in LA2
 - Safeguarding referral from Primary School 2 in LA2 regarding Q2
- 6.2. The key episodes detail practitioner and agency involvement thought to provide maximum opportunity for organisational learning and the improvement of systems and processes to safeguard children. The key episodes do not form a complete history.

Key Episode 1: Telephone contact between HV4 and HV5 (located in the MASH) in LA1

- 6.3. Midwife (MW) 1 made a home visit in May 2015 when Q4 was three days old. It was recorded¹⁵ that the house was '*messy and untidy*', a request to view the

¹⁵ This information was gained from telephone discussion between HV4 and MW1 and was recorded by HV4

bedrooms was declined and there were a lot of closed circuit television (CCTV) cameras outside the house. Mother refused further visits by MW1¹⁶.

- 6.4. MW2 made a home visit when Q4 was 10 days old. It was recorded that the home smelled of dogs and Mother reported that the Hoover was broken. The children were observed to be dressed in clean and appropriate clothing.
- 6.5. In June 2015 HV4 was unable to arrange a new birth visit for Q4 as initially Father was resistant and there was no response to subsequent telephone calls. HV4 liaised with MW2 who informed of concerns due to the late booking for ante-natal care following a family bereavement. HV4 recorded that parents had refused MW2 entry to the family home following discharge from hospital because they said that the house was messy.
- 6.6. HV4 made a new birth home visit when Q4 was 16 days old and recorded that there was an '*overwhelming atrocious smell*' and the house was dirty and untidy¹⁷. The day following the new birth home visit HV4 discussed concerns by telephone with HV5 based in the Multi Agency Safeguarding Hub (MASH). It was thought that Mother would be very resistant and unlikely to engage with an Early Help Assessment (EHA). The Health Visitors agreed that it would be appropriate to set objectives to improve home conditions at the next visit which had been arranged for six weeks later and consider escalation if improvements were not made. Recorded actions included; to involve the Community Nursery Nurse and contact the school attended by Q1 and Q2.
- 6.7. HV 4 informed Mother of concerns regarding the home conditions and arranged a further visit in five weeks' time. Q4 and Mother were identified as requiring Universal Plus level of service¹⁸. Mother subsequently cancelled the scheduled visit by HV4 stating that Maternal Grandmother had died.
- 6.8. In September 2015¹⁹, HV4 made a home visit and further concerns about home conditions were recorded²⁰. Mother said that Q4 had not received vaccinations because the GP had requested identification for Q4 to enable Mother to register the child at the surgery. Mother told HV4 that Father was not at home at the time

¹⁶ Mother said that she only refused further visits from MW1 and had agreed for any other professional to visit the house

¹⁷ It was recorded that a large amount of small objects, nails, nuts and rubbish were at toddler height.

¹⁸ Universal Plus threshold is met when there are any factors that impact on the health of the family e.g. poor housing, mental ill health, A progressive service with increased visiting depending on the needs of the family should be offered

¹⁹ After a number of failed attempts to reschedule the cancelled visit

²⁰ House was said to be extremely dirty and mother had sprayed deodorant immediately before the visit to disguise the smell

of the visit as he was obtaining the necessary paperwork for the GP. The children were noted to be playing happily.

Key Episode 2: Overnight Hospital admission of Q3

- 6.9. In June 2016, Q3 was admitted to Hospital overnight in LA1 and diagnosed with a viral infection. Concerns were raised about Q3 who was noted to be drinking sugary fizzy drinks and wearing clothes which smelled of smoke. It was recorded that Mother was unkempt and wore dirty clothes. The hospital Safeguarding Nurse liaised with the Health Visiting Service and spoke with HV6 who arranged for a Community Nursery Nurse to visit.
- 6.10. Q3 was not seen by the Community Nursery Nurse although attempts were made by telephone and letter to arrange a development check for Q3. Two months later following unsuccessful attempts to speak with Mother on the telephone, HV6 informed the GP of non-attendance at the development check.

Key Episode 3: Family move from LA1 to LA2 and information sharing

- 6.11. The Q family moved from LA1 to LA2 in June 2016. It was not clear if this was a planned move although Mother had informed the Family Support Worker at School 1 that the family would be moving to LA2 to be nearer to family support.
- 6.12. Immediately prior to the move to LA2 Mother was referred by the GP to Maternity Services in LA1 for an emergency scan which confirmed a pregnancy of 22 weeks gestation. Mother was referred for antenatal care and there was no further contact between Mother and Maternity Services in LA1 regarding the pregnancy with Q5.
- 6.13. Mother presented at Maternity Services in LA2 when 31 weeks pregnant with Q5. A social history was taken, and health advice shared. Mother said that she was not allowed to book for antenatal care or provided with any paperwork by Maternity Services in LA1. Mother disclosed that Father had a 13 yr old daughter and was refused contact by his ex-partner. There was no communication between Maternity Services in LA1 and LA2.
- 6.14. In August 2016, Mother registered with the GP in LA2 as she was pregnant with Q5. Q1-4 were not registered with a GP until late November 2016 and some of the children were not up to date with their immunizations.
- 6.15. At the end of the summer term in 2016, an application was received at LA2 for a Primary School Place for Q1 and Q2. Places were allocated at different schools²¹ and both attended the new school in October 2016. The School Nursing Service in

²¹ There were limited school places available when the application was received and Q1 was allocated a place at School 2 and Q2 was allocated a place at School 3

LA2 became aware of Q2 in January 2017 following an invite to a Strategy Meeting and became aware of Q1 when health records were received from LA1 and the children were in the care of LA2.

6.16. It was made explicit in records transferred by School 1 in LA1 to Schools 2 and 3 in LA2 that there were no safeguarding concerns²². Whilst attending Primary School 1 in LA1 both children were reaching the expected level of development for their age and Q2 exceeded the expected level in two areas. Records indicate that Q2 smelled of urine at times, both children were described as having grubby uniforms and smelling unclean and of stale smoke. The class teacher for Q1 spoke to Mother about Q1 attending school with head lice and hair that was not brushed.

Key Episode 4: Home visits following the birth of Q5 until removal of the children from the family home in LA2

6.17. In October 2016, The Community Midwife made two home visits when Q5 was 2 and 3 days old and it was recorded that Mother was *“happy at home and supported by family”*²³. The Community Midwife was unable to access the home for a subsequent visit²⁴ at 11 days old. Mother visited the clinic when Q5 was 13 and 17 days old. As Q5 had regained birth weight, care was handed over to the Health Visitor for further advice and monitoring.

6.18. HV8 was unable to access the family home at the end of October for a pre-arranged New Birth Visit to Q5. HV8 completed the New Birth Visit a few days later and recorded that the Moses basket was *“unclean and sheet on the mattress was stained”* there was a *“very strong smell with flies inside the house”*, a dog was shut in an adjacent room and the kitchen was extremely cluttered. Mother informed HV8 that the family had just moved into LA2 and were living with Maternal Grandmother whilst the house, rented through a private landlord, was being re-decorated. It was recorded that Mother received a lot of support from Maternal Grandmother and Father.

6.19. HV8 noted that mother showed emotional warmth to Q5 and that birth weight had not been regained but the midwife was visiting the following day. Mother told HV8 that she had four other children living with her (Q1-4) although none were seen on this or subsequent visits.

6.20. During a second home visit²⁵ on 9.11.16 HV8 recorded that Q5 was appropriately dressed for a cold day and looked clean although flies remained in the house and

²² School records include a series of boxes to tick if there were safeguarding concerns and the box to note there were no concerns had been ticked

²³ Shrewsbury and Telford Hospital NHS Trust Agency Report p4

²⁴ Visit had been arranged over the telephone

²⁵ To complete a hearing screen

there was a strong smell. Mother advised that flooring in the house was being replaced that week and the family continued to live with Maternal Grandmother.

- 6.21. HV9 and a practitioner from the Newborn Hearing Screening Service made separate home visits on 12.11.16 and 17.11.16 to repeat the hearing screen. There was no information recorded about home conditions following either visit.
- 6.22. In November 2016 HV7 made a home visit to complete the six week review for Q5 and it was recorded that the visit was conducted at the home address. Concerns about home conditions were recorded and it was noted that there was a "*strong smell of animal urine*"²⁶ and internal doors and floors required replacing. Mother did not express any concerns about Q5 who was observed to be bright and alert. HV7 did not plan to make a further visit and the next scheduled contact was the one year review for Q5.

Key Episode 5: Safeguarding referral from Primary School 3 regarding Q2

- 6.23. Shortly after Q2 started at Primary School 3 Mother told the Head Teacher that Q2 was upset as another pupil had flicked his ear. The Head Teacher made significant efforts to try to identify who this was²⁷ Q2 did not identify anyone and did not talk to staff at any time about bullying at school.
- 6.24. In December 2016, Primary School 3 made a referral to Family Connect to advise that Q2 had a bruise to the ear and had told staff that Mother did it. The referral noted that Q2 had no siblings and lived with Mother and Father. In response to this referral safeguarding records were opened at Primary School 2 and 3.
- 6.25. It was decided at a Strategy Discussion held on the same day²⁸ that the threshold had been met for a Section 47 joint investigation²⁹ Q2 had disclosed to teachers that his mother had caused the injury, but he did not repeat this to the Police Officer and Social Worker during the Section 47 Investigation³⁰. Mother tried, without success, to divert Police Officer 1 and Social Worker 1 from making a home visit.
- 6.26. Mother attempted to contact Father to inform him that she was returning home with representatives from the police and social services. Initially Police Officer 1 and Social Worker 1 were refused entry by Father who was said to be very aggressive. On entering the house it was evident that Q2 had four siblings found

²⁶ Mother said this was due to one of the dogs being incontinent

²⁷ The Head teacher took Q2 round the playground and around the classes and repeated this a couple of days later.

²⁸ Strategy discussion between the Harm Assessment Unit, Family Connect and Children's Services.

²⁹ The Local Authority have a statutory duty to carry out a Section 47 Enquiry where there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm

³⁰ Mother was not present at the time Police Officer 1 and Social Worker 1 spoke to Q2.

to be severely neglected and living in very poor conditions. The youngest three children were below school age and said to be dirty and in a state of undress. Sleeping arrangements for the children consisted of badly stained quilts on the floor surrounded by dog faeces. There was insufficient food in the house and it was decided that it was unsafe for the children to remain at home. Parents were arrested on suspicion of neglect and the children made subject to Police Protection. The following day Parents agreed to the children being accommodated by LA2³¹. Four dogs in a state of neglect were also removed from the family home.

7 Analysis

- 7.1. The analysis section of this report will consider the Key Episodes with reference to information provided by practitioners and managers who attended the Learning Event and Recall Event and information contained in Agency Reports prepared for this Review. The views of Parents will be incorporated into this Report prior to publication.
- 7.2. Specific themes emerged following systematic analysis of all the available information, guided by the Terms of Reference for this Review. Exploration of each theme enabled rigorous examination of practice and identification of opportunities to improve the systems to safeguard children across LA1 and LA2.
- 7.3. Whilst analysis of the themes will be presented separately it is important to note that each theme impacted on the others in a systematic and dynamic way. Professional recognition of neglect influenced the effectiveness of assessment and adequacy of information sharing within and between agencies which in turn informed the understanding that professionals had about the lived experience of the children.
- 7.4. The themes identified were:
 - recognition of neglect
 - effectiveness of assessment, and use of available tools
 - information sharing, inter and intra agency communication
 - professional understanding of the children's lived experience, and
 - parental engagement and professional challenge

Recognition of neglect

- 7.5. During the period of consideration for this review there were indicators of potential neglect which were not identified as such by professionals working with the family. Information that was known and action(s) taken by practitioners during the timeline of relevance for this review is included at Appendix (i).

³¹ The children were accommodated under Section 20 of the Children Act 1989

- 7.6. Given information that was known to practitioners at the time of this review and taking into account the context in which professionals were working it was evident that there were missed opportunities to share information and assess professional observations appropriately. The omission to identify neglect was not specific to one agency or an individual, and emerged within this review as an issue, of relevance to agencies in both LA1 and LA2.
- 7.7. It is important to note that neglect is a strategic priority for both TWSCB and BBSCB. Much work is taking place within both LA1 and LA2 to ensure that agencies respond appropriately and in a timely way to identify and address neglect. Early recognition of neglect is a strategic aim within the neglect strategy for both areas and a specific focus of work for the TWSCB Neglect sub-group. Both TWSCB and BBSCB have implemented the Graded Care Profile 2 (GCP2)³² as the primary tool to assess and measure when children are at risk of neglect. During the time period covered by the review the TWSCB were in the early stages of implementation of the tool. It is acknowledged, that at the time, not all professionals in LA2 had received training on the tool. Professionals from LA1 involved in this case had not completed GCP2 training.
- 7.8. Neglect is the most common form of child maltreatment in England and features in over 60% of serious case reviews. The challenge for professionals with safeguarding responsibilities to identify neglect has been illustrated in various high profile cases. A recent study to assist practitioners with recognition of the indicators for actual neglect and risk factors associated with a likelihood of significant harm or future harm is of relevance to this review³³. There were indicators of neglect and evidence of risk factors within the timeline for this review in both LA1 and LA2.
- 7.9. Brandon et al. 2014³⁴ acknowledged that health and education professionals and social workers often find it difficult to identify indicators of neglect or recognise their severity. One characteristic of neglect that contributes to this difficulty is that unlike physical abuse for example, the experience of neglect rarely produces a crisis that demands immediate attention. This was of particular relevance in this review as professionals in LA2 only became aware of the extent of neglect experienced by the children in the Q Family during enquiries to explore an allegation by Q2 of physical abuse by Mother.
- 7.10. There was an immediate response to the allegation by Q2 which resulted in the home visit by Police and Social Worker and led to removal of the children from the family home. Prior to this incident concerns about home conditions had been

³² The Graded Care Profile is an assessment tool to assist practitioners to identify when a child is at risk of neglect. The GCP2 is an authorised update of the original tool

³³ Missed opportunities: indicators of neglect – what is ignored, why and what can be done? Research Report. Brandon M, Ward H et al. DH Nov 2014

³⁴ Ibid p7

recorded by HV7 and HV8 in LA2 although it is important to note that for two visits Mother said the family were not living at the property and this had been accepted³⁵.

7.11. In LA1 concerns regarding home conditions were recorded by Health Visitors and Midwives however the possibility of inadequate home conditions being linked to chronic neglect was not explored. It is important to note that, had practitioners in LA1 shared information in an effective and timely way, there may have been a more robust response to home conditions observed by practitioners in LA2.

7.12 The ability of professionals involved in this review to identify neglect was influenced in part by the following factors: normalisation of inadequate home conditions, involvement of different professionals, increased focus by professionals on the completion of mandatory visits and lack of professional curiosity. Each factor will be discussed below.

a) Normalisation

7.13. At the Learning Event professionals from both LA1 and LA2 said that they were accustomed to working in areas with large numbers of children and high deprivation. It was noted in Agency Reports that child protection notifications were a daily occurrence at School 1 in LA1 and Schools 2 and 3 in LA2 had a high number of children subject to Child in Need and Child Protection Plans.

7.14. The Healthy Child Programme sets out the good practice framework for prevention and early intervention services for children and young people 5-19. It is emphasized that all staff in school should be sensitive to the warning signs of possible abuse or neglect for example poor physical care, smelly and/or dirty clothes, poor dental care and untreated caries³⁶. It is acknowledged that failure to provide appropriate health care, including dental care is a form of neglect. The dental health of Q1 and Q2 was very poor and they required treatment which included extractions when taken into care. Although the children were only at school in LA2 for a short period and were said to be very quiet during this time, practitioners expressed surprise at the learning event that they had not noticed the tooth decay as it was described as very extensive. There are many possible reasons why the tooth decay had not been noticed by practitioners and it is important to acknowledge the possibility that when working daily in areas of high deprivation practitioners may become less alert to potential indicators of neglect.

7.15. Managers responded quickly to learning from this review and training will be offered to all schools to highlight the significance of dental health as a potential

³⁵ Mother said that she panicked when asked about home conditions and did not think it would be believed that the family were living elsewhere

³⁶ Healthy child programme from 5 to 19 years old. London: Department of Health 2009 p85

indicator of neglect. Consideration about wider dissemination of learning from this review is included in Section 10 (Opportunities to improve practice).

- 7.16. At the Learning Event practitioners³⁷ from LA1 acknowledged that conditions observed during home visits to the Q family home were no worse than what they had seen at other houses³⁸. Some practitioners explained that they were working with other children and families assessed to be at greater risk and had to be prioritised over the Q children. It was acknowledged in an Agency Report from LA1³⁹ that critical reflection in supervision may have challenged and exposed the practitioners' normalized view in this case.
- 7.17. Working with children and families within high levels of deprivation may have contributed to lack of professional sensitivity to possible indicators of neglect such as home conditions and physical presentation of the children including dental hygiene. It was acknowledged in an Agency Report from LA1 that *'observations made by HV4 give a concern that the home environment was hazardous for a cruising baby and potentially harmful to the health of all the children'*. It was acknowledged in an Agency Report from LA2 that professional *'observations of home conditions in November 2016 evidenced that the physical environment the children were living in was not satisfactory'*.
- 7.18. It is possible that as professionals in both LA1 and LA2 were accustomed to working in areas of high levels of deprivation that this experience impacted on their acceptance of what was reported as inadequate physical conditions within the home in which the Q family lived. In addition records from LA1 evidenced that there were also concerns about the physical presentation of the children at school however these were managed internally and not identified as potential indicators of neglect.

b) Involvement of different professionals - lack of consistency

- 7.19. Home visits were completed by three different professionals in LA1. In LA2 three different Health Visitors and a Hearing Screener, visited the Q family home on five occasions during October and November 2016. Home conditions were not monitored and this was due in part to the involvement of different professionals and omission to read notes from previous visits. Whilst records evidence that conditions were inappropriate and potentially unsafe (LA1) and not satisfactory (LA2) for young children, they were not recognized as such and this resulted in a lack of urgency and appropriate action to keep the children safe. There was no

³⁷ Including Health Visitors in LA1 and LA2 and teachers from School 1 who visited the children at home in LA1 prior to starting school

³⁸ Mother said that it was clear that the family were in chaos and not coping and Parents said they did not know what help and support would be available and felt that professionals had walked away

³⁹ Essex Partnership University Foundation Trust 1-19 Team p12

evidence in agency records in LA1 or LA2 of a discussion with Parents about changes that were required to ensure the wellbeing and safety of the children.

7.20. In the time considered by this Review, practitioners were operating in challenging circumstances as detailed in Section 8 (Organisational Context) of this report. Nevertheless in LA1 the number of professionals involved with the family contributed to observations being made in isolation and the opportunity to assess whether conditions had improved or deteriorated was not taken. In LA2 it was evident, from information available to this Review that HV8 had intended to monitor home conditions although it was understood that the family were living with Maternal Grandmother at the time. HV8 was not available for work at the time of the six-week review for Q5 and this was undertaken by HV7. It was recorded that the review took place at home and there was no evidence that HV7 took into account previous observations made by HV8 which resulted in an inconsistency of approach to address home conditions.

7.21. It was noted in a previous SCR⁴⁰ that adoption of an incident by incident approach even when there were reports of the family home being dirty, untidy and smelling of faeces prevented escalation by practitioners to meet the needs of the children concerned. Managing incidents in isolation could also be described as a form of silo practice with agencies and individuals working independently with very little discussion or sharing of information. This was a finding in the TWCSB SCR for Child B published in June 2015. Findings from the current Review indicate that there were missed opportunities for agencies to work effectively in partnership which is likely to have limited the ability of practitioners to recognise potential indicators of neglect in both LA1 and LA2.

c) Focus on tasks - completion of mandatory visits

7.22. All contacts between Health Visitors, Community Midwives and the Q family were part of the mandated elements of the Universal Healthy Child Programme⁴¹. It was acknowledged that there was a heightened managerial focus on team and individual performance in LA1 and practitioners were working under significant constraints which were likely to have had an impact on the service offered to the family.

7.23. The increased focus on delivery of the full Universal Offer and drive to improve performance in LA1 may have reduced the capacity of practitioners to think beyond the immediate task, identify additional needs and vulnerabilities and manage complex cases. It is possible that the pressure on professionals resulted in them seeing the case within a narrow frame of their own professional background which has been identified as another form of silo practice by Sidebotham et al (2016). In addition, the NICE Guidelines on Child Abuse and Neglect (NG76)

⁴⁰ Child A 2014 NOT TWCSB

⁴¹ Antenatal health promoting visits; new baby review; 6-8 week assessment; 1 year assessment; and 2-2½ review;

highlight the importance of critical thinking and analysis and guards against over reliance on protocols, proformas.

d) Lack of professional curiosity

- 7.24. There was very little evidence of professional curiosity throughout the timeline considered for this Review. Practitioners⁴² who attended the Learning and Recall events stated that they accepted information provided by Mother as they had no reason to think it was incorrect. Professional readiness to accept parental explanations without showing any curiosity about whether the explanations are correct has been a consistent finding within Serious Case Reviews⁴³. On several occasions, Mother provided information to professionals which was incorrect and served to deflect attention from indicators of neglect and effectively distance the children from contact with professionals as detailed in the paragraph below.
- 7.25. In LA1 home visits were made by HV4, MW1 and MW2. Refusal of the Parents to allow professionals to access the family home on discharge from hospital⁴⁴ or to allow MW1 to see the sleeping arrangements for Q4 did not result in further assessment or professional curiosity/concern about the possibility that home conditions were unsuitable. It was unclear if consideration had been given to the vulnerability of newly born Q4 given the seeming reluctance of Parents to work with professionals. In LA1 Mother cancelled two home visits by professionals stating there had been a family bereavement when this was not the case.
- 7.26. In addition, when Mother registered with the GP in LA2 she did not disclose that she had other children who also required registering with the GP although there was space on the form to do so⁴⁵. In LA2 Mother informed HV8 that she was living with the children at Maternal Grandmothers which was in fact not correct.
- 7.27. The ante-natal booking for Q5 in LA2 took place at a weekend when fewer midwives were available. Further enquiries could have been made at a later date about Mother's maternity care in LA1 to inform a future care plan. There was no documented evidence to indicate professional curiosity about information shared by Mother regarding the move from LA1, lack of maternity records and reasons for Father not having contact with his daughter from a previous relationship. It was unclear if the Midwife considered seeking additional advice via safeguarding supervision; however, it was reported that there was limited availability of safeguarding supervision at this time and this had been recorded as needing

⁴² Health visitors, midwives, GP and teachers

⁴³ Pathways to harm, pathways to protection: A triennial analysis of serious case reviews, 2011 -2014. Sidebotham P et.al. DH 2016

⁴⁴ Because Parents said the house was messy

⁴⁵ Mother said that she assumed this information would have been transferred when the family moved from one GP to another.

improvement on the service at risk register. Midwives caring for women should have accessible safeguarding supervision to reflect and identify whether additional support is required to prevent escalation of risks to the unborn and siblings within the family.

- 7.28. In LA2 workforce constraints resulted in practitioners working with a high case load and a significant number of children and families with complex needs and vulnerabilities. Delivery of core contacts placed the team under physical strain and emotional stress. This may explain why practitioners focused on the contacts that they had been allocated to complete and the opportunity to make links with previous home visits was not taken.
- 7.29. There was no evidence from LA1 or LA2 that professionals critically reflected on their practice or exercised professional curiosity. The importance of professional curiosity and questioning and lack of confidence of some professionals to challenge parents was highlighted in a report published by the NSPCC (2014)⁴⁶.
- 7.30. It is expected that Health Visitors have access to clinical and managerial supervision and at least three-monthly safeguarding supervision⁴⁷. There were significant organizational constraints which impacted on the supervision of Health Visitors in LA1. The provision of effective managerial and supervisory oversight would have increased the opportunity to robustly challenge the normalization of home conditions and the absence of professional curiosity which, in this case, appears to have put the wellbeing of children at risk. Whilst safeguarding supervision was available to Health Visitors in LA2 concerns about home conditions were not discussed with a Safeguarding Children's Supervisor⁴⁸.

Effectiveness of assessment

- 7.31. Professional observations were not recognised as possible indicators of neglect which impacted on the effectiveness of decision making. This was a significant factor which contributed to the lack of assessment by practitioners.
- 7.32. In June 2015, following a New Birth home visit in LA1 HV4 recorded that the house was dirty and untidy with an "*atrocious smell*". The next day HV4 contacted HV5 at the MASH and proposed undertaking an Early Help Assessment (EHA). It was thought that Mother would be very resistant to this and unlikely to cooperate. The Health Visitors were aware that Midwifery colleagues had experienced difficulty in accessing the family home⁴⁹ and this information appeared to have weighted their decision not to progress an EHA at this time. It was noted in the Agency

⁴⁶ Realising the Potential: Tackling child neglect in Universal Services, Haynes, A. (2014) NSPCC

⁴⁷ National Health Visiting Service Specification 2014/15, NHS England

⁴⁸ Every HV and School Nurse in LA2 has an allocated Safeguarding Children Supervisor.

⁴⁹ Mother said that visits tended to be early in the morning when she was taking the children to school. Father was unable to support with this.

Report⁵⁰ that the practitioners appeared to have lost sight of the potential detrimental impact of inadequate home conditions (as indicated by the accumulated facts) on three young children. The potential lack of engagement by Mother in an assessment was not considered as an additional risk factor likely to increase the vulnerability of the children.

7.33. Use of the referral pathway in LA1 into the MASH or completion of an Early Help Assessment would have been a more appropriate and proportionate response to the lived experience of the children. At this time the MASH was in the first six months of development and the MASH Health Visitor was new to the role. It was noted in the Agency Report that lack of clarity about the role of the Health Visitor in the MASH, together with previous experience of cases not meeting the threshold of intervention by Children's Social Care, strongly influenced the misplaced mutual conclusion that the case did not warrant a referral to MASH at this time. There is evidence to suggest that assumptions by professionals which prevent indicators of neglect being acted upon include a reluctance to refer based on previous experience of referrals not being accepted⁵¹. Reassurance was provided by Managers during the process of this Review that correct procedures are now established and would be followed by relevant practitioners.

7.34. In June 2015, at the time of the second home visit⁵² undertaken by HV4 in LA1 it was evident that little had changed. Q4 had not received vaccinations and Mother had taken active steps to disguise the smell immediately prior to the visit. The children were reported to be clean and playing happily and no further visits were planned although Q4 was assessed as requiring Universal Plus level of service. This was not an adequate response and it would have been more appropriate to undertake an Early Help Assessment to fully assess the family circumstances and support the Parents to make appropriate changes to ensure that the needs of the children were met.

7.35. At the learning event practitioners stressed that there were no concerns regarding the behavior of Q1 or Q2 at school in LA2, and they did not stand out as at risk of neglect. It is likely that there was a false sense of reassurance as there were no overt signs of neglect and presentation of the children did not raise concerns.

⁵⁰ Essex Partnership University Foundation Trust 0-19 Team, p6

⁵¹ Brandon M, Bailey S, Belderson P, Warren C, Gardener R. and Dodsworth J. (2009). *Understanding Serious Case Reviews and their impact*. London: Department for Children, Schools and Families

Missed opportunities: indicators of neglect – what is ignored, why and what can be done? Research Report DH Nov 2014. Brandon M, Ward H et.al.

⁵² After a number of failed attempts to re book the cancelled scheduled visit

- 7.36. In October 2016, following the birth of Q5 in LA2 HV8 made two home visits to Q5 and Mother. Records of the visits include factual observations of home conditions which evidenced little improvement between the visits. Mother was not asked about the lack of improvement which was possibly due to HV8 believing the family were living with Maternal Grandmother at the time. Completion of an EHA was not considered.
- 7.37. At the end of November 2016 (ten days before the children were removed from the family home) HV7 completed the six week review for Q5. It was recorded that the visit took place at the family home. From information contained in Health Visitor records which noted the presence of a strong smell of animal urine, it was evident that the home conditions remained unsuitable and unsafe for children particularly Q5, a new baby who was exposed to unsafe and unhygienic conditions.
- 7.38. Mother was not offered a further appointment to review progress and this was a significant omission. The author of the Agency Report⁵³ in LA2 noted that it was evident that ongoing targeted support was required to ensure that the children's needs were met and it was not appropriate that Q5 was assessed as requiring a universal service.
- 7.39. The Graded Care Profile 2 had been implemented in both LA1 and LA2 at this time and could have been used to explain to parents the changes that were required to benefit the children. At the Learning Event it was noted that 58 practitioners had completed training by November 2016 regarding the use of GCP2 in LA2 and there was ongoing training provided in LA1. There was no reference in records of the Health Service to the use of guided conversations to inform family assessments and care planning. In addition, there was a lack of evidence in Health Visiting Records in LA1 and LA2 of the expected use of prescribed documents for assessment.
- 7.40. At the Learning Event, it was acknowledged by practitioners and managers in both LA1 and LA2, that the use of tools to support the early identification of neglect, specifically GCP2 was not embedded across the authorities. Currently enquiries are being made to fully understand why efforts to implement the GCP2 have not been fully effective. At the Learning Event it was suggested that there remains lack of understanding about the value of the GCP, some practitioners believe the tool is labour intensive and there are also concerns that resources would not be available to meet assessed needs.
- 7.41. Maternal Aunt brought Q1 to and from Primary School in LA2 as children of her own also attended. There were no concerns regarding Maternal Aunt or her children and professionals at the Learning Event indicated that this may have

⁵³ Shropshire Community Health NHS Trust p10

contributed towards their overall positive perception and assessment of Q1 and the family.

- 7.42. In June 2013, prior to the timeline for this review, Mother had advised HV1 in LA1⁵⁴ that she was a carer for Father as he had a learning disability. This information was not considered further and should have made a difference to the assessment of risks and vulnerabilities and informed the understanding of additional support needs for the whole family.
- 7.43. There was little mention of Father in the records of Mother or the children. Routine enquiries were made at the new birth visit for Q5 in LA2 and basic details about Father were included in records made by Health Visitors. The need for practitioners to be more inclusive of Fathers in their assessments and interventions with families was identified as a learning need in a recent SCR in LA1⁵⁵. Omission to assess the contribution that Fathers can make to safeguard children as well as identifying potential risks that Father's may pose has been a consistent finding within Serious Case Reviews⁵⁶. It is important that the LSCB's reflect on why the Father of the Q children was hidden throughout the timeline of this Review, given the available knowledge and professional understanding regarding the importance of involving fathers.

⁵⁴ At the 2 year development review for Q2 which took place at the family home in LA1

⁵⁵ BBSCB Baby Sama, 2017

⁵⁶ Hidden Men: Learning from Serious Case reviews. NSPCC, 2015

- 7.44. There were missed opportunities by practitioners in both LA1 and LA2 to initiate an Early Help Assessment which would have supported gathering of information about all family members. This was a significant omission which impacted on the support provided to the children and family. Given the lack of assessment there are many unanswered questions which would have informed this review which include; parental capacity, relationships within the family, support of extended family, wishes and feelings of the children. This information was potentially knowable to practitioners but unknown during the timeline for this review.
- 7.45. It was noted in an Agency Report⁵⁷ from LA1 that management of this case by 0-5 practitioners fell short of effective practice to identify likely child neglect and provide a timely and proportionate effective response to ensure the well-being and safety of this large sibling group.
- 7.46. Previous SCR's⁵⁸ completed by TWSCB made a similar finding regarding the omission by practitioners to complete timely multi agency assessments. TWSCB will be keen to fully understand why this finding has persisted and this will be addressed Section 10 (Opportunities to Improve Practice).

Information sharing: inter and intra agency communication

- 7.47. Most of the Agency Reports prepared for this review highlighted limitations in information sharing which impacted on the understanding that professionals had of the family, assessment of concerns and subsequent provision of support. There were examples of ineffective information sharing within agencies, between agencies and between LA 1 and LA 2, as discussed below.

a) Inter-agency Information Sharing

- 7.48. It was acknowledged in Agency Reports that there were some inaccuracies in recording by professionals which impacted on information sharing. Information pertaining to one child was on the record of a sibling and some information pertinent to all siblings was only recorded on the record of one child. Consequently, some of the records for the Q children were incomplete and others inaccurate. This hindered professional analysis of information, as evidenced when in LA1, HV6 was contacted by the Hospital Safeguarding Nurse to share concerns about the presentation of Q3 and Mother during the hospital admission. Previous observations of home conditions had only been written in the record for Mother and Q4. As HV6 did not check the records of siblings' this information did not inform analysis and decision making following receipt of information from the Safeguarding Nurse. Had information about poor home conditions been recorded on all children's records, it is likely that the information received by the Hospital

⁵⁷ Essex Partnership University Foundation Trust 0-19 Team, p 20

⁵⁸ Child A 2016 and Child B 2013

Safeguarding Nurse⁵⁹ would have been considered to have greater relevance and importance. At the Learning Event practitioners acknowledged that sometimes it can be difficult to check the records of all relevant children when discussing the case with another professional.

7.49. Professionals, particularly those undertaking home visits in LA1 and LA2 appeared to be working in isolation and there was a lack of consistency of approach and limited information sharing which resulted in issues identified in one visit not being addressed in the next. This was particularly evident between the home visits made by HV7 and HV8 immediately prior to removal of the children from the family home in LA2. There was little evidence of information sharing within Maternity Services in LA1 to clarify why Mother did not present for ante-natal care following the emergency scan at 22 weeks gestation. Whilst Mother did present at Maternity Services in LA2 this was not known by the GP who made the emergency referral or Maternity Services in LA1. There does not appear to have been any effort within LA1 to ensure the safety and whereabouts of Mother and her unborn baby.

7.50. It was the view of professionals at the Learning Event that a missing alert should have been raised to ensure that Mother and Unborn Baby were effectively safeguarded.

b) Information sharing between agencies

7.51. The Health Visitor records from LA1 do not contain any information from local Midwifery services regarding ante natal care. It is unclear whether this was due to a lack of communication by Midwifery Services or a failure to scan communications onto Mothers electronic record.

7.52. Following the discussion⁶⁰ between the Hospital Safeguarding Nurse and HV6 in LA1 there appeared to be a de-escalation of concerns. The referral by HV6 to a Community Nursery Nurse did not result in the provision of additional support to the family. There was a delay of two months before the GP was informed of non-attendance at the development check arranged by the Community Nursery Nurse. It was acknowledged within the Agency Report⁶¹ that given the concerns expressed by the hospital for Q3 this response was not adequate or timely. HV 6 did not discuss this case with her manager as it was not one of her active cases and it was thought that the Safeguarding Nurse would have made a direct referral to Social Care had the concerns been significant.

7.53. Information shared verbally between agencies in LA1 lacked clarity at times and practitioners had a different understanding of what was agreed. The conversation between the Hospital Safeguarding Lead and HV6 appears to have been

⁵⁹ About Mother and Q3 appearing unkempt and wearing dirty clothes and Q3 drinking fizzy drinks

⁶⁰ About observations regarding Q3 during the hospital admission in LA1

⁶¹ Essex Partnership University Foundation Trust 0-19 Team, p7

misinterpreted and there was no record of the discussion. HV6 thought this was a request for health promotion/education and not a referral for the assessment of home conditions. The assumptions and expectations following this discussion were not clarified by either professional.

- 7.54. Information sharing between HV4 and MW2 in LA1 was reactive and it was noted in the Agency Report⁶² that it is expected that the observations and experiences of the Midwifery Service are proactively shared with relevant agencies during the antenatal and post-natal periods. There was a missed opportunity for both Midwifery and Health Visiting services to undertake a joint comprehensive assessment. This would have enabled the exploration of factors such as late presentation in pregnancy, significance of the family bereavement and missed ante natal appointments and may have resulted in an opportunity to explore the provision of Early Help.
- 7.55. Records made by HV4 in LA1 noted the intention to involve the Community Nursery Nurse and contact the school attended by Q1 and Q2. These actions were not completed and there was no discussion with the school nurse on the same team as Health Visitor 4. Pressure of work and lack of experience were identified by practitioners at the Learning Event as the key reasons why actions had not been followed up. It is important to note that service managers have a responsibility to ensure effective service delivery and it appears that there was an omission to provide sufficient oversight and support for a practitioner who had limited experience.
- 7.56. This Review has highlighted an issue around internal communication between the Health Visiting and School Nursing Service in LA2 as the older children (Q1 and Q2) were not seen by School Nursing even though Health Visiting colleagues were aware of the older siblings since October 2016. A recommendation⁶³ has been made to implement a formal system of communicating this information between agencies to ensure children are not missed and their needs are addressed.
- 7.57. At the New Birth Visit for Q5 in LA2 Mother informed HV8 that she had four other siblings living with her (Q1-4). The siblings were not seen by a Health Visitor even though two siblings were under five. There was a delay in requesting the records from the previous Health Visitor service following registration of the children with the GP in LA2 due to the system in place in LA2 at that time. The need to clarify a timescale for transfer-in visit once a child under five has moved into the area to prevent delay and drift was identified as a single agency recommendation as a result of this review.

⁶² Essex Partnership University Foundation Trust 0-19 Team, p10

⁶³ Appendix ii details all recommendations made by single agencies during the Review process

7.58. The only information held by Primary School 2 and Primary School 3 in LA2 was contained in the normal admission form completed by parents when children were admitted to the school. There was no information about siblings and it was noted in the referral to Family Connect by School 3 that Q2 lived alone with Mother and Father. Whilst this did not appear to impact on the outcome of the referral practitioners were not prepared to encounter a large sibling group during the Section 47 Enquiries.

c) Information sharing between services in different areas

7.59. Effective partnership working and information sharing is essential when families move areas to ensure continuation of support and intervention to address the health and social care needs of vulnerable children. There was an absence of proactive information sharing between all agencies in LA1 and LA2.

7.60. Midwifery Services in LA2 omitted to contact Midwifery services in LA1 following the weekend booking for antenatal care when Mother was pregnant with Q5. This would have highlighted historical inconsistent engagement with health services and provided an opportunity to enquire about social history and develop a clearer understanding of why the family had moved and the needs of the children.

7.61. As Q3 and Q4 were not registered at the GP practice a transfer-in visit with the Health Visiting Service was not arranged and Health Visiting records from LA1 were not requested. This was a missed opportunity to assess the health needs of the children and identify strengths and vulnerability factors within the family. It was acknowledged that children can be missed or become invisible as happened to Q3 and Q4 if the transfer in appointment with the Health Visitor is dependent on registration with a GP. A recommendation to review the Health Visitor allocation system when new children move into LA2 has been made by the relevant agency as a result of this Review.

7.62. It was highlighted during this review that difficulties in transferring data between GP practices may constitute both a clinical and safeguarding risk. Historical safeguarding issues may not be immediately evident which would limit the ability of a practitioner to make an informed and holistic appraisal of any situation. There was no information in the GP medical notes in LA2 from either the Health Visitor or Midwife to indicate any concerns regarding home conditions.

7.63. When Mother registered with the GP in LA2 a request for medical notes was made to the GP in LA1. There was no evidence of curiosity by the GP in LA1 about why the medical notes for the children had not been requested at the same time as Mother's. The system for transfer of information was dependent on Mother providing information about the children, as this did not happen effectively, the children (Q3 and Q4) were hidden from professional view. It is important that learning from this review informs system change regarding transfer of records between GP surgeries and registration of new patients to reduce the possibility of children being missed when families move areas.

- 7.64. The Nursery in LA2 was not informed by other agencies that Q3 had been taken into care and were told by Mother when enquiring where Q3 was for attendance monitoring. The Nursery should have been informed more promptly by agencies involved and this would have avoided a very difficult conversation between Mother and staff member.
- 7.65. There are clear pathways for transfer in and out of Health Visitor records however these were not followed in LA1 and LA2 due to staff leave and capacity issues. Improvements to the transfer process when children move areas have been made during the process of this Review and are detailed in Appendix ii.

Professional understanding of the children's lived experience

- 7.66. There was very limited understanding of the children's lived experience and absence of the voice of the child was noted in the Agency Record for School 1 in LA1. In addition, there was over reliance on Mother's explanations about home conditions, cleanliness of the children, non-attendance at medical appointments⁶⁴ and late booking for ante natal care in pregnancy.
- 7.67. Q1 and Q2 attended the same school in LA1 and different primary schools in LA2 for nine weeks before the incident which resulted in them being taken into care. They were described by the respective schools as quiet children who settled in well and quickly made a small group of friends. Q1 and Q2 were not identified as being in need of additional intervention or support.
- 7.68. Q1, Q2, Q3 and Q4 were not seen by the School Nurse or Health Visitor in LA2. Health Visitor records contained minimal references to the physical presentation of Q5. Following the new birth visit the emotional warmth shown by Mother towards Q5 was noted by the Health Visitor and at the six week check Q5 was described as bright and alert.
- 7.69. Although Q3 had only attended Nursery in LA2 for a short time individual plans had been put in place to provide support with speech and language and staff appeared to have a good understanding of his likes and dislikes. It was noted in the agency report that staff linked the support provided to activities of specific interest to Q3 which included cars, small world play and outdoor play. Nursery staff met the physical needs of Q3 when required which included nappy changing, providing dry clothes and at times washing Q3.
- 7.70. Information recorded by Health Visitors in LA1 and LA2, following home visits, evidence that the physical environment was inadequate and unpleasant for young children. There appears to have been no consideration given to the physical and emotional impact on the children living in inappropriate physical conditions. There was an absence of professional reflection about emerging concerns and the impact of these on the children.

⁶⁴ Ante-natal care and immunisations for the children

- 7.71. There was little information about the children having access to toys or appropriate stimulation and there was no information about the interaction between the siblings as they were not observed playing together. At the Learning Event Social Worker 1 (LA2) reported that when asked if they wanted anything the older children had asked for a hairbrush and socks, basic requirements which had not been met.
- 7.72. Whilst professionals had contact with the children, work was not conducted in a way that was consistently child focussed. The lived experience of the children was not at the forefront of the practitioners practice and there was a missed opportunity to provide timely and proportionate planned intervention.
- 7.73. Listening to the voice of the child is a strategic priority within the TWSCB's Business Plan and it is a concern that this review found that there was limited understanding of the children's lived experience. There is extensive evidence which highlights the importance of professionals with responsibility for safeguarding children having an understanding of their lived experience⁶⁵. Statutory guidance emphasises the importance of remaining child focussed and ensuring that the child is at the centre of all decisions which impact on their lives⁶⁶. In addition there have been many examples from serious case reviews of the serious and potentially fatal consequences when professionals lose sight of the children whom they have a responsibility to protect⁶⁷.
- 7.74. Understanding the lived experience of the child is a complex process and the importance of professionals having a child centred approach is well recognised. All the themes considered within the analysis for this review have impacted on the ability and capacity of professional understanding of the life of the Q children.

Parental engagement

- 7.75. Difficulty engaging with avoidant families and failure to provide sufficient challenge to parents have been identified previously in research and serious case review reports⁶⁸.
- 7.76. Efforts were made by both Mother and Father at times to divert the attention of professionals away from the family home and the children. There was little evidence of effective challenge by professionals and on one occasion following a challenge by MW1 in LA1 Mother refused further visits from MW1.

⁶⁵ Developing an effective response to neglect and emotional harm to children. NSPCC, 2008 Gardner R

⁶⁶ Working together to safeguard children. DfE, 2015

⁶⁷ In the child's time: professional responses to neglect. Ofsted 2014

Missed opportunities: indicators of neglect – what is ignored, why and what can be done? Research Report DH Nov 2014. Brandon M, Ward H et.al.

⁶⁸ Learning Lessons from Serious Case Reviews 2009-2010, Ofsted

- 7.77. Father refused to book a new birth appointment for Q4 in LA1 stating that Mother was not available and there was no consideration given to whether Father was being obstructive⁶⁹. On two further occasions in LA1 Mother did not allow professionals to have access to the family home stating that it was messy. Mother also refused Midwife 1 permission to view the bedrooms during a new birth visit when Q4 was three days old. Events were recorded factually without reference to the additional vulnerability of a new born baby. There was a missed opportunity to reflect whether additional support was required or if Mother was being deliberately obstructive.
- 7.78. Mother informed the HV8 at LA2 that the family was living with Maternal Grandmother whilst the family home was being decorated. There was no consideration given to whether the family required additional support and a referral to Early Help Services was not made. Mother was described by practitioners as articulate and persuasive at the learning event. When asked about the CCTV outside the house Mother said Father had a pushbike stolen and had always had CCTV. It was noted in an Agency Report from LA1 that there was professional concern building that parents may be avoiding professional's access to the family home as conditions were poor. There was an omission to develop an effective response to the emerging concerns of professionals detailed within Service Records.
- 7.79. Practitioners accepted Mother's explanations of events and there was no evidence of professional curiosity from practitioners in LA1 or LA2. The NICE Guidelines on child abuse and neglect highlights the principles of effective work with parents and carers. *Development of a good working relationship involves working in a way that enables trust to develop whilst maintaining professional boundaries and maintaining professional curiosity and questioning while building good relationships.*⁷⁰
- 7.80. Due to lack of assessment and absence of professional challenge, the motivation, intent and capacity of Mother and Father are unclear. Whilst there were incidents that could be described as disguised compliance⁷¹ it is important to exercise caution as there was no plan for the parents to comply with and lack of information about the capacity of Parents to meet the needs of the children in their care.

⁶⁹ Father had a Learning Disability and suffers from anxiety

⁷⁰ Child abuse and Neglect NICE Guideline (NG76) 2017
<https://www.nice.org.uk/guidance/ng76/chapter/Recommendations>

⁷¹ The term is attributed to Peter Reder, Sylvia Duncan and Moira Gray who outlined this type of behaviour in their book *Beyond blame: child abuse tragedies revisited*

- 7.81. Mother cancelled appointments with professionals on two occasions stating there had been a family bereavement. At the Learning Event it was confirmed that Maternal Grandmother was still alive although mother had cancelled an appointment by a Health Visitor in July 2015 stating that she had died. There was no evidence within records that professionals had considered the impact of bereavement on the family or an understanding that bereavement is likely to be accepted by professionals without further enquiry and could in this case support concern for parental disguised/ non-compliance.
- 7.82. Mother initially attempted to deter the Police Officer and Social Worker from visiting the family home and then pre-warned Father that she was returning home with professionals. Father was aggressive towards Police Officer 1 and Social Worker 1 and initially refused them permission to access to the family home. It is reasonable to conclude that the behavior of both Mother and Father may have been an indication that they recognized the home conditions were unacceptable for the children.
- 7.83. It was likely that the behavior of parents which ranged from prevention of professional access to the family home to cleaning immediately before visits and attempting to disguise smells was illustrative of disguised compliance as noted in an Agency Report⁷². This was not addressed effectively by professionals.

8 Organizational Context and impact on Practice

Local Authority1

- 8.1. During the timeline of relevance for this Review there were significant challenges to the delivery of services by the 0-19 team in LA1 which had an impact on workloads and team dynamics. The team had moved base in April 2015 to co-locate with the link team. Health Visitors had further to travel for visits and were encouraged to mobile work and attend the base for support and supervision.
- 8.2. Management changes to increase support were experienced as disruptive to daily practice by some practitioners. This may have compounded the pressures experienced due to high case load as a result of staff shortage due to vacancies and long term leave. It was acknowledged in the Agency Report that staff morale was low and anxiety heightened.
- 8.3. Significant staff shortages and a change in line management impacted on service delivery. One of the health visitors had recently returned from long term sick leave and reported that there was a lot of pressure from management to improve team performance and undertake the mandated key visits. In addition, there was significant emphasis on discussing baby brain development and other

⁷² Essex Partnership University Foundation Trust 0-19 Team, p13

key issues at the mandated visits. At the time antenatal appointments were only offered to families with identified vulnerabilities⁷³.

- 8.4. The new team manager had not been aware of the expectation to delegate supervision and had struggled to supervise a team of 26. Management supervision had focused on cases in the Universal Partnership Plus category, operational contractual targets and mandatory training compliance and sickness management
- 8.5. There had been a significant investment in training and development to enable health visitors to undertake comprehensive family assessment. Further investment has been made into the development and support of professionals through a comprehensive supervision system it was reported that practitioners made appropriate use of ad hoc supervision.
- 8.6. In LA1, there was a lack of clarity about the role of the Health Visitor in the MASH. The Health Visitor was new in post and the MASH was being developed.

Local Authority 2

- 8.7. In LA2 the health visiting team responsible for Q3, Q4 and Q5 were operating with a significantly reduced staffing capacity with less than half the team working⁷⁴. In addition, one health visitor was covering another post within the service whilst working their hours within the team.
- 8.8. In an attempt to address challenges in delivering the service, the manager worked on the case load herself and also asked another team to provide cover. Concerns about service delivery had been made verbally by the team manager to their line manager however the internal reporting system (DATIX) had not been used. Had a DATIX report been completed this would have highlighted the risks to the team and caseload on a formal level and additional support could potentially have been provided.
- 8.9. Subsequent to the timeline for this review two Health Visiting teams were amalgamated and changes were made to the allocation and staffing of the caseload. The two teams continue to operate from different bases and whilst there are plans to co-locate, work continues to be delivered in isolation.
- 8.10. It was acknowledged in the agency report and by practitioners at the Learning Event that ongoing difficulty with recruitment means that the vulnerability of the case load currently remains the same as at the timeline for this review.

9 Good Practice identified

⁷³ At the time of the review performance for ante natal visits was 50%. Current performance for ante-natal visits is 91% and 97% of post natal visits are made within 14 days as of September 2017

⁷⁴ In November 2016 1.6 health visitors were covering a case load of 950 children

- 9.1 Within the SILP learning model, equal emphasis is given to what worked well in a case as to any shortcomings in practice. Within this case the following areas of good practice made a difference in this case;
- HV2 contacted the midwife to obtain information when struggling to arrange a home visit.
 - The Head teacher at Primary School 3 in LA2 made significant attempts with Q2 to identify peers that Mother alleged had been bullying him.
 - Police Officer1 and SW1 in LA2 insisted that the children were visited at the family home and were not influenced by Mother.
 - Police and Children's Social Care in LA2 worked effectively without delay to ensure the children were safeguarded.

10 Conclusion

- 10.1 This Review has benefited from the generous participation and reflections of practitioners and managers at the Learning and Recall Events. Effort has been made within this Review Report to build on similar findings from local and regional serious case reviews with reference to relevant research. Consideration has been given to the current work plan of TWSCB to ensure that recommendations complement and enhance work in progress and avoid duplication.
- 10.2 Whilst it is evident that the early identification of Neglect is a strategic priority for both TWSCB and BBSCB there are significant issues which have had a negative impact on this work. Training programmes have been provided in both LA1 and LA2 however this review has highlighted that efforts to embed the use of GCP2 have had limited impact.
- 10.3 This Review has highlighted the importance of undertaking a holistic assessment of children and families when there are emerging concerns. Completion of a thorough assessment in this case would have furthered understanding of the needs and additional vulnerabilities of the children including pre-birth. In the absence of a comprehensive assessment there was an over reliance by professionals on the explanations provided by Parents and the physical presentation of the children.
- 10.4 A holistic assessment would have identified a pattern of parental engagement which included; non-attendance at development reviews for the children, reluctance to allow professionals into the family home and critically in this case long standing history of poor home conditions and inadequate explanations provided by Mother.
- 10.5 This Review found that there were indications of parental disguised compliance. However, in the absence of professional challenge, critical reflection and full assessment, the intent, motivation and capacity of the Parents were not known. The impact on Mother of caring for a very young family and a partner with additional needs whilst moving house on two occasions was not known.

- 10.6 From information provided to this review it could be inferred that mother and Father were engaged in disguised compliance however it is not possible to conclude this with absolute confidence for reasons outlined above. Whilst disguised compliance emerged as a possible contributory factor in this case this must be considered alongside other findings which included; absence of professional challenge, omission to share information, missed opportunities to identify neglect and limited understanding of the lived experience of the children. Each finding had some influence over the decision making and intervention of practitioners in LA1 and LA2.
- 10.7 It is important to acknowledge that the findings within this Review are similar to those identified in previous national SCR's. In addition, information sharing, the importance of remaining child focussed and adoption of a critical questioning approach to Parents are relevant to the safeguarding responsibilities of each agency involved in this review.
- 10.8 Identification and intervention in neglect cases is complex and multifaceted. It is important that all partners in LA1 and LA2 share responsibility to ensure that the systems to ensure early identification of neglect are as robust and effective as possible.

11 Opportunities to improve practice

Single agency action plans resulting from learning from this Review are available as Appendix (ii).

11.1 Recommendations:

- The TWSCB and BSCB request that partner agencies review early help policy and information sharing processes regarding emerging concerns about neglect (which include dental health) when a child moves within and between local authorities.
- The TWSCB Chair and relevant managers should work with local and national forums to improve information sharing processes regarding emerging concerns about neglect (which include dental health) when a child moves within and between local authorities.
- The TWSCB and BSCB identify with partner agencies the barriers to effective use of tools to support the early identification, assessment and analysis of neglect, specifically, Graded Care Profile 2.
- The TWSCB and BSCB ensure that risk factors and indicators of neglect are consistently identified and assessed across partner agencies and that any professional normalisation of neglect is robustly challenged.

- The TWSCB and BSCB seek assurance and evidence from partner agencies that the lived experience of children is central to holistic and timely assessments when there are possible indicators of neglect.
- The TWSCB and BSCB monitor the implementation of single agency action plans.
- TWSCB and BSCB ensure that learning from this review is shared across the workforce specifically the recognition of dental health as a potential indicator of neglect.

Date	Service	Information	Action
June 2015	Health Visiting HV4	Father reluctant to arrange new birth visit, mother said to be unavailable. No response to subsequent telephone calls	HV4 liaised with MW2.
June 2015	Midwifery MW2	Late booking in pregnancy Q4 due to family bereavement missed antenatal appointments. Refusal to access home for new birth visit as parents stated it was messy	HV4 contacted when unable to access family home and information was shared
June 2015	Midwifery MW1	Home visit Q4 three days old, house messy, mother refused access to bedrooms and refused further visits by MW1. MW1 recorded CCTV outside house	Emerging concern parents are preventing professionals access to the family home due to poor conditions (Explore at Recall)
June 2015	HV4	New birth home visit, observed house dirty and untidy with overwhelming atrocious smell. Mother spoke about birth control	Recorded action to contact community nursery nurse and school attended by Q1 and Q2 (no evidence these actions were completed). Birth control not followed up. Next visit arranged end July – 6 weeks later
June 2015 Day after home visit noted above	Health Visiting HV4 and HV5	HV4 contacted HV5 in MASH to discuss case; Internal discussion not referral in although HV4 recorded that threshold for referral had not been met.	Professional view that Mother would be resistant to EHA Agreement to monitor conditions in 6 week visit. HV4 recorded that threshold for referral to MASH not met.
June 2015	Midwifery MW2	Home visit Q4 10 days old house musty, smell of dogs, Hoover broken. Children dressed in clean appropriate clothing	Q4 and Mother assessed level of support; Universal Plus

July 2015	GP	Q4 seen by GP appears to be 2 centile drop in head and length circumference.	Information not shared with HV and no follow up (Explore significance at Recall Event)
September 2015	HV4	Scheduled HV was rearranged, Mother cancelled due to family bereavement. Q4 not up to date with immunizations as GP needed ID before registration at surgery. Mother advised that Father was obtaining ID. Ongoing concern re home conditions reported to be extremely dirty with multiple bits over the floor. Smell less though Mother had sprayed deodorant before visit. Children said to be clean and playing happily	Q4 remained at Universal Plus and one year targeted review to be next contact
September 2015 – June 2016	Primary School 1 LA1	Q1 and Q2 were reaching the expected level of development for their age and Q2 exceeded the expected level in two areas. Records indicate that Q2 smelled of urine at times, both children were described as having grubby uniforms and smelling unclean and of stale smoke.	The class teacher for Q1 spoke to Mother approx. 5 times regarding Q1 about attending school with head lice, hair not brushed.
June 2016	Hospital staff LA1	Q3 admitted overnight, wheezing and was noted to be drinking sugary fizzy drinks and wearing clothes which smelled of smoke Mother was unkempt and wore dirty clothes	Safeguarding nurse informed HV6 who referred to Community Nursery Nurse for dietary advice
July 2016	Community Nursery Nurse	No response to phone calls sent letter with appointment for Q3 development check in August.	Q3 not brought for development check
August 2016?	Midwifery Service LA2	Mother presented 31 weeks pregnant with Q5. Mother said LA1 refused to book for pregnancy or provide notes as Mother had said she was moving.	Explanation of Mother accepted without further exploration
September 2016	Health Visiting HV6 LA1	Unable to contact parents tried five different telephone numbers on record	Informed GP of non-attendance at Q3 development check.
September 2016	Health Visiting LA2 HV1	Arranged appointment for ante natal care Q5 was cancelled (unclear who by)	Mother did not respond to messages visit not rearranged
September - December	Early Years	Q3 attended nursery 15 hrs weekly attendance 74%.	Additional support offered re

2016	Setting	Concerns noted re communication and interaction with peers. Three incident records concerning; unpleasant smell, unclean bottom, damp jumper. Three accident reports; scratch on leg Mother informed occurred on way to nursery swelling to top lip and right cheek Mother informed occurred on way to nursery Q3 bit own arm during session at nursery	communication and language development. Concerns monitored internally, recorded that threshold for nursery to referrer to Family Connect was not met.
October 2016	Community Midwife	Home visit – Q5 2 days old no concerns noted Home visit – Q5 3 days old Slight physiological jaundice noted	Advice provided and appointment made for further checks on day 5 at Maternity unit – Mother attended and no ongoing concerns
October 2016	Community Midwife	Home visit as arranged – day 11 post-natal care. Unable to access home.	Left note asking Mother to rearrange appointment
October 2016	Maternity Unit	Mother attended with Q5 at day 13 and day 17	No concerns noted, hand over to Health Visitor for advice and monitoring
October 2016	Health Visitor HV3	Telephone call and home visit to try and arrange new birth visit, no contact. Home visit took place a week later. Mother advised four other children living with her. Poor home conditions observed, flies , smell, dirty Moses basket, private landlord Mother advised was living with maternal grandmother whilst house was decorated	Further appointment for hearing screen one week later
November 2016	Health Visitor HV3	Hearing screen completed – inconclusive. Home conditions poor, smell and flies noted. Mother advised that she was still living with MGM and flooring in the house was to be replaced that week	Repeat hearing screen arranged for 5 days later
November 2016	HV4	Home visit -second hearing screen inconclusive and referral made to new born hearing screener	No comments about home conditions made by HV4 or new

		New born Hearing Screener repeated test and obtained clear responses	born hearing screener Discharged to routine health surveillance
November 2016	HV2	Home visit to complete six week review for Q5. Q5 reported to be bright and alert, immunisations discussed. Home conditions; strong smell animal urine, undecorated, Mother advised internal door to be fitted and floors replaced before Christmas	No further visit arranged. Next planned contact was one year review for Q5. Information about open clinics provided
December 2016	School Police CSC	Ten days after the HV by HV2 Q2 attended school with bruising to his ear and said that Mother had done it.	Strategy discussion and joint S47 enquiries took place. At home visit children made subject to PPO as conditions unsuitable and unsafe. Parents arrested for neglect and children taken into care of LA2.

Shrewsbury and Telford Hospital NHS Trust

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
Embed the safeguarding supervision policy into Midwifery practice	Capacity to offer safeguarding supervision will be considered in the review of models of Maternity care. Further safeguarding supervision training will be offered to Community Ward Managers and other interested Midwives to increase the capacity to offer safeguarding supervision.	Named Midwife for safeguarding	31 st March 2019	Safeguarding supervision becomes mandatory every 3 months for all community Midwives. Safeguarding supervision to be mandatory every year for hospital Midwives and Dr's.
When women move across Local Authorities routine enquiries will be made with the appropriate Health services to gain more information	SOP to be developed to support recommendation Case scenario to be shared in safeguarding training 2017/18	Named Midwife for safeguarding	31 st March 2019	A request for relevant records from the original service will be made when notified of the move. A prompt appraisal of the safety and wellbeing of the unborn will be undertaken on all Mothers who move into the County during pregnancy. A verbal and / or written handover of care will be given to Health services receiving a pregnant woman from Telford and Wrekin into a new local Authority.

Shropshire Community Health NHS Trust

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
1. To ensure that a transfer in visit is offered to children who have moved into area within an agreed timescale (of receiving the notification).		Gwyneth Bowyer (Shropshire 0-19 Service Manager and Professional Lead) & Kit Pool (0-19 Manager Telford and Wrekin and School Nurse Professional lead)	31.01.2018	For all children to be offered a transfer in contact within an agreed timescale.
2. To review the process for children transferring into area who have not yet registered with a GP practice		Gwyneth Bowyer (Shropshire 0-19 Service Manager and Professional Lead) & Kit Pool (0-19 Manager Telford and Wrekin and School Nurse Professional lead)	31.01.2018	For all children to be allocated to a health visiting caseload and be offered core contacts as per the Healthy Child regardless of registration with a GP.
3. To ensure an agreed process is in place between school nursing and health visiting teams to ensure children who have transferred into area are notified to the respective team.		Gwyneth Bowyer (Shropshire 0-19 Service Manager and Professional Lead) & Kit Pool (0-19 Manager Telford and Wrekin and School Nurse Professional lead)	31.01.2018	For all children who transfer into area are notified to the respective school nursing and/or health visiting team as soon as they are identified.
4. For staff and managers to be reminded to complete a Datix incident report when risks are identified that impact on service delivery.		Gwyneth Bowyer (Shropshire 0-19 Service Manager and Professional Lead) & Kit Pool (0-19 Manager Telford and Wrekin and School Nurse Professional lead)	31.01.2018	For risks to service delivery to be recorded on the Datix incident reporting system. For risks to be mitigated and teams supported.

Telford and Wrekin Clinical Commissioning Group

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
To raise concerns of availability and/or delay in transfer of GP	To bring to the agenda of the next NHS England Regional Safeguarding forum meeting	Audrey Scott-Ryan	January 2018	NHS England to escalate/ raise with Capita providers medical records availability and delay concerns from practice managers/

records from out of area to NHS England.				front line practitioners.
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Telford and Wrekin Early Years Settings

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
Find out more about a child's family.	To develop 'registration' and 'All About me' forms to incorporate siblings and others in the household	Sharon Welsh (nursery manager)	30/11/17	To have a deeper understanding of the children's home and daily lived experiences.
To utilise the 'Child Journey' threshold document.	To refer to threshold document when making referrals. Staff to be updated. Document to be downloaded.	Sharon Welsh and DSL's	30/11/17	To be better prepared when making referrals to Family Connect, through an improved understanding of the threshold document.
Learn more about GCP2	DSL's to attend GCP2 briefing	Sharon Welsh	December 6 th 2017	To develop an understanding of this assessment tool.
Team member to attend GCP2 training	Allocate funding for training	Sharon Welsh	February 28 th or March 29 th 2018	To have a better understanding and ability to utilise the GCP2 tool.
To continue to develop and monitor child protection policies and procedures	Update forms processes regularly	Sharon Welsh and DSL's	Ongoing	That robust systems continue to maintain a culture of safeguarding vigilance.
Disseminate learning of the SILP process to all Early Years and Childcare providers.	Incorporate learning from the SILP process into Designated Safeguard Lead in Early Years and Childcare Settings training, Designated Safeguard Lead in Early Years and Childcare 2 Yearly Update training.	Lisa Seymour (Early Years & Child care Team Leader)	December 1 st 2017, March 12 th 2018 and ongoing	Raise the importance of robust record keeping and the SILP processes.

Telford and Wrekin, Education, Access and Inclusion

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
Review the number of Designated Safeguarding Leads trained at the schools	This will be raised as a reminder for all schools at the DSL update	Head has implemented for the school. Group Manager will raise with all schools	Head acted immediately. Group Manager will address before December 2017	All schools are aware of considering the number of DSLs they have being proportionate to the needs and size of the school
Ensure that schools have a means to capture low level messages and information shared in conversation with parents.	This will be raised as a reminder for all schools at the DSL update	Head has implemented for the school. Group Manager will raise with all schools	Head acted immediately. Group Manager will address before December 2017	Schools have a means to check on all concerns and be able to monitor is needed.

Bedfordshire, Families First

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
To complete a full assessment of the family well-being to safeguard children.	Nursery staff to complete home visits to understand the home learning environment	Nursery Manager	Spring Term 2018	Home visit programme
	To increase Staff confidence in the EHA process and tracking intervention and outcomes	Deputy Chief Executive	December 2018	All staff confidently tracking progress through Team around the family meetings and updating action plans.

	Partners are clear about the Information sharing procedures in the working together guidance Senior Managers to complete GCP2 training	Senior Management Team Senior Managers	Ongoing Spring Term 2018	A holistic assessment is completed. Single Agency recommendations Staff confident in identifying neglect and how to remove it.
Review Safeguarding Policy and Procedures	Review and ratify policy at the Trustee Meeting in Spring 2018. Complete early concerns and safeguarding audits for all service areas.	Deputy Chief Executive Nursery Manager	Spring 2018 Spring Term 2018	Charity trustees, staff and volunteers have up to date knowledge and understand processes. Policy and procedures are effective and working in practice.

Essex Partnership University Foundation Trust 0-19 Team

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome
1. Review use of the assessment and planning documentation as integral to assessments as part of Family Partnership Model and Ages and Stages questionnaires.	Audit to assess the take up by professionals using the Family Partnership Model inclusive of the supporting assessment and planning documentation	Deputy Director of Children's & Specialist Services	Jan 18	Assess the effectiveness of implementation of the Family Partnership Model
2. Review use of the Graded Care Profile 2 (GCP2, tool to measure neglect)	Audit the use of the GCP2 tool available to practitioners and how this is being used to inform comprehensive family assessments and tailored interventions.	Deputy Director of Children's & Specialist Services	February 2018	Assess the effectiveness of using the tools

<p>3. When vulnerability is identified the progressive process of ongoing assessment and tailored interventions needs to replace the practice of defaulting to a 'targeted' Universal assessment as the sole means of intervention with immediate effect.</p>	<p>0-5 professionals will be required to undertake comprehensive assessments of families when vulnerabilities are identified.</p> <p>Update to be delivered to staff to clarify factors that contribute to creating vulnerability</p> <p>Monitor through the peer review process.</p>	<p>Deputy Director of Children's & Specialist Services</p>	<p>November 2017</p>	<p>Assurance that families with identified vulnerabilities will be provided with a comprehensive assessment and tailored interventions. This includes the universal HCP provision.</p>
<p>4. EPUT BCHS staff, including the Health Visitor in MASH need to be confident and clear of their responsibility, using the Local Authority Threshold Documentation about when to direct referrals to either MASH or Early Help. In addition to this staff must be clear regarding the importance of consulting safeguarding professionals if there is a doubt that the referral will not be accepted.</p>	<p>The role and responsibilities of the Health Visitor in MASH needs to be refined and communicated to EPUT BCHS professionals. So that professionals direct their enquiries to the appropriate Named Safeguarding Professionals in the Trust when they have uncertainty about safeguarding concerns.</p>	<p>Deputy Director of Children's & Specialist Services With support of Head of Service Safeguarding Children</p>	<p>November 2017</p>	<p>Professionals make safeguarding enquiries to the appropriately qualified Named Safeguarding Professionals.</p>
<p>5. The process which supports EPUT BCHS 0-19 Service Team Managers oversight of cases in the progressive HCP needs to</p>	<p>The Team Manager's oversight of cases needs to be reviewed to ensure that it provides robust line of sight and is supportive of both the practitioners and managers</p>	<p>Deputy Director of Children's & Specialist Services</p>	<p>March 2018</p>	<p>Team Managers have appropriate line of sight for case management, which is deliverable.</p>

be reviewed for effectiveness	responsibilities			
6. EPUT 0-19 service managers need to reflect on the change management processes that supported the relocation and merge of this team. To extract the learning to assist with future management of change.	Critical reflection on the management of change to support staff to adopt new ways of working.	Deputy Director of Children's & Specialist Services	Jan 2018	To inform future change management
7. Review the EPUT 0-19 electronic patient record to ensure it is maximising the S1 potential to enable front line practitioners to work effectively and efficiently.	Review current layout of the record and identify improvements that could be made. Check best practice elsewhere in relation to use of the S1 record by Health Visiting teams. Implement improvements to the record.	Deputy Director of Children's & Specialist Services	Feb 2018	To improve the electronic record so that it better enables practitioners to work effectively and efficiently.