Neglect: Thematic Serious Case Review

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1. INTRODUCTION

The events that triggered the review

Between July 2019 and March 2020 Luton Safeguarding Children Board (the LSCB) carried out a review of the services provided for an infant age 7 months who is referred to in this report by the name Tahira. As part of the same exercise it undertook a wider thematic review of aspects of safeguarding practice identified in earlier Luton serious case reviews.

The SCR was conducted under the guidance Working Together to Safeguard Children 2015. Its purpose is to undertake a 'rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children'. The LSCB is required to 'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.[1] This document sets out the review findings.

In March 2019 Tahira was taken to hospital severely undernourished and gravely ill. It became apparent that her mother had not fed her or her sister (who is 13 months older than Tahira) properly for some time. The children's mother had no money because she was sending much of her state benefits overseas to help her husband move to the UK. Over the previous two years Tahira's mother had been receiving help from a number of professionals, but there had been few visits in the weeks before this, no professional had accessed the property or was aware that the children's circumstances had deteriorated so drastically.

Reasons for conducting a thematic review

The LSCB decided that the circumstances met the criteria for a Serious Case Review (SCR) on the grounds that Tahira had suffered serious harm that there were '*concerns about the way in which organisations or professionals worked together to safeguard the child*'.[2]

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[1] *Working Together to Safeguard Children* (2015), 4.1 and 4.6

[2] *Working Together to Safeguard Children* (2015), 4.8

When considering the circumstances of the case, the LSCB identified a number of similarities with the concerns and learning of reviews previously undertaken by the LSCB, particularly the SCRs of Child E and Child F published in 2016 and 2017.[3] Both of those reviews had published recommendations and action plans which had been overseen by the LSCB.

The LSCB therefore agreed that the review of services provided to Tahira and her family would be conducted in a thematic way. In practice this meant that it would:

- Establish if there were any similarities in the characteristics of the cases or the ways in which professionals had worked
- Identify repeated themes in the learning while being open to new lessons
- Seek to understand whether long-term improvements had been made as a result of the earlier SCRs and document those changes
- Make recommendations for further action.

This approach is consistent with the desire to learn from specific local examples set out in the borough's early help strategy document:

> *'Learning from serious case reviews also indicates the points at which early intervention could help reduce risks. The learning is as important for children known to universal and early help services, where they do not see a social worker, as for children with known child protection risks.'*[4]

The SCR is being conducted at the same time as two other reviews of cases where children have died or been seriously harmed. There has been discussion with the authors of these reviews to ensure that areas of mutual concern and shared learning are identified.

The scope of the review and the information considered

Information about Tahira has been made available by the following agencies and services:

- Luton Borough Council (early help and social care services)
- Cambridgeshire Community Services NHS Trust (health visiting services)

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[3] Both reviews are published in the NSPCC Serious Case Review Repository. https://learning.nspcc.org.uk/services/library-catalogue Kevin Ball (2017) Nicki Walker-Hall (2016)

[4] Luton Borough Council, *Early Help Strategy 2017* – 20, page 1

- Children's Centres
- Primary care services including general practice
- Luton and Dunstable NHS (maternity and paediatrics)
- Bedfordshire Police

The review has had full access to information about the implementation of learning from the earlier SCRs. At the beginning of the review there was a full discussion of its scope and remit at a well-attended meeting of the LSCB.

Early learning specific to the case

At an early point Bedfordshire Police recognised that it had failed to act quickly on a concerning call about the welfare of the children from a member of the public. The call came from someone well known to the police who suffered chronic mental illness and as a result was taken less seriously than it should. This important learning was immediately made known throughout the police service and steps taken to avoid a reoccurrence.

2. AN OVERVIEW OF THE THREE CASES AND THE CHARACTERISTICS THE CHILDREN AND THEIR FAMILIES HAVE IN COMMON

Introduction

This section of the report provides a brief narrative of the services provided to the three children and their families.

BRIEF NARRATIVE OF EVENTS IN RELATION TO TAHIRA AND HER OLDER SISTER

Tahira's mother was estranged from her own family and lived away from home from the age of 16.

Tahira's older sister

Tahira has a sister who is 13 months older. When she was pregnant with Tahira's sister, her mother booked at the local maternity unit reporting a history of depression and a previous desire to self-harm. Her husband was noted to have made a failed asylum claim and had been required to return to Pakistan.

Luton's early help services were involved during the last two months of the pregnancy. The need for additional support from the health visiting service was recognised. An early help episode was opened shortly before the birth to provide help with housing, parenting and financial difficulties, taking account of the history of the mother's difficult relationship with her own family.

The health visitor's new birth visit in July 2017 raised concerns about the baby's health, lack of sterilisation of baby feeding equipment, and poor sleeping arrangements. Advice was given and the baby gained weight.

The mother did not attend the Team Around the Family (TAF) meetings that were held subsequently, saying that she only needed help getting items for her baby. As they still had concerns, the professionals involved decided to use the early help assessment and Graded Care Profile (GCP) to assess needs and, if necessary, work towards a referral to the local authority for a social work assessment (use of the GCP is discussed in detail in see Section 3.2 of the report).

In October 2017 the early help team decided to raise the case to level 3 which meant that the early help worker would make home visits to see the family. This was because the baby was not gaining sufficient weight and was not registered with a GP, so could miss immunisations. Her mother refused or failed to engage with services over these concerns. As a result, the family was referred to the multi-agency safeguarding hub (MASH) which decided that more work needed to be attempted by the early help service.

The family was supported at level 3 of the early help service during October and November 2017 during which time the mother registered the baby with a GP and took her to be immunised. At the end of November, she travelled to Pakistan and, having established that she was there, professionals closed the case. The early help team noted that although there had been improvement over the period of contact, some concerns had remained at the point when the family left the UK. No work on the proposed GCP had been undertaken.

Services provided for Tahira

In June 2018 (when her first child was 11 months) Tahira's mother returned to the UK. She registered at a GP who referred the family to maternity services and the MASH as the mother was 30 weeks pregnant and living in a shared house. The MASH referred the family for early help assessment.

This assessment found that the family was living in unsuitable accommodation and that the mother had not made adequate preparations for the birth of her second child. A children's centre became involved and advice was given on housing rights. The health visitor had no specific concerns about the health or development of Tahira's older sister who had maintained a steady weight gain during the intervening period.

Tahira was born in August 2018. At a home visit in September the health visitor (a different health visitor because the family lived in a different part of Luton) was concerned about jaundice, marks on the baby's buttocks and weight loss since leaving hospital. There was no referral made or supervision discussion.

Despite failed visits by professionals the TAF meeting on 4 October 2018 closed the case. In part this was due to reassurance from the mother that the problems had been resolved, she was being supported by her husband's family and would be seeking a spousal visa for him to enter the UK. Details of the involvement of the extended family were never obtained.

On 31 October the GP noted that Tahira had not been registered and asked the health visitor to intervene. In November the health visitor spoke on the phone to the mother who told her that this had been resolved.

The chronology shows no further contact until February 2019 when the health visitor decided to make an opportunistic visit, having failed to make contact by phone. Shortly after this the police received calls from an individual they knew to have long-standing mental health problems alleging that the children were always crying. No welfare check was completed because the sole informant was viewed as being unreliable.

In February 2019 the mother attended the children's centre seeking clothes for the children. Later it was reported to the health visitor that she was trying to save a considerable sum of money to help her husband return to the UK.

On 4 and 5 March 2019 the police received a series of anonymous calls stating that the caller could hear shouting, crying and sounds of the children being hit. The police attended the home and observed that it was sparsely furnished with only one bed and no cot or toys. Tahira was observed to look like an 8-week-old baby, rather than an infant of 6 months old.

After making quickly arranged further visits to provide a much-needed cot, the children's centre and the health visitor recognised that Tahira was in a very poor condition. They immediately arranged for her to be taken to hospital immediately where she was found to be gravely ill. Her mother later admitted having recently sent money to her husband which meant that she had had no money for food.

BRIEF SUMMARY OF EVENTS IN THE EARLIER SERIOUS CASE REVIEW REPORTS

Summary of events surrounding the death of Child F in 2013

Child F died at home in October 2013 at the age of eight weeks. Although the cause of death was unascertained neglect of the children was a strong feature of the family background. At the time of Child E's death there were six children in the family aged 13 years to 8 weeks.

The family had been known to agencies in Luton from 2001. Concerns identified included late booking for pregnancies, failure to attend health appointments and poor school attendance; falls and accidents. There were also reports of domestic violence, the family moved frequently and there was concern about poor housing

For six months during April 2007 the children were subject to a child protection plan. Following de-registration concerns continued and the school requested a professional meeting to discuss a wide range of concerns about the way in which the children presented and the way they were being looked after. The school drew up a contract with the family in an attempt to address the concerns and social work support continued with the family for a further three years

From 2010 there was no local authority social work involvement but school and health professionals identified repeated concerns that pointed to possible neglect and emotional abuse. These included late immunisations and neglectful or unsafe home circumstances; failed home visits and unreturned telephone calls from professionals and multiple house moves.

The police attended two domestic violence incidents. The Urgent Care Centre and GP practice were aware of delayed immunisations, children were not brought to medical the parents would lose the children's medication. The health visitor, nursery nurse and children's centre had concerns around safety in the home.

Although these issues were largely the same as those that had led to child protection registration in 2007 and some attempts were made to understand them in more detail, no-one assessed these issues as meeting the threshold for child protection investigation.

Child F was last seen by professionals 6 days prior to death at an assessment designed to help avoid accidents and hazards in the home. Child F was found sleeping in a way that contradicted safe-sleeping advice and posed a heightened risk of cot death. Clear advice was given on this.

Summarised from Luton Safeguarding Children Board (February 2016) Serious Case Review - Child F, Nicki Walker-Hall

Summary of events surrounding the death of Child E in 2014

Child E died in the family home at seven months of age. The post-mortem examination was unable to ascertain a definite cause of death but highlighted a range of contributory factors indicative of a significant failure to thrive.

At the time of her death Child E was living with her mother, maternal grandmother and two older siblings, both of whom were under four. The children's father played no part in caring for the children although he is believed to have visited occasionally.

Child E's mother had received antenatal care for all of her children from local hospital services and postnatal care from community-based services including the GP, although this universal support offer was not always accepted.

Professionals raised concerns about the neglectful home environment and conditions in which the children were living from around the summer of 2010. Concerns included; a house full of 'clutter', often dirty due to pet bird droppings, safety hazards around the house, smoke filled due to heavy smoking, cramped living conditions, and bed sharing.

The local authority and the community health trust agreed that the health visitor would monitor the children and attempt to work with the family.

At the birth of each child similar concerns about the conditions of the home were raised but the mother was reticent to work with professionals. A number of professional assessments were considered or attempted with no impact. Improvements to the home conditions were limited and the mother's capacity to parent and care for three young children was never fully assessed.

Approximately four weeks prior to her death Child E was noted to be suffering from nappy rash during a scheduled hospital review. Additionally, it was noted that Child E's weight gain was erratic; advice was given to the mother about weaning and a feeding regime. These two issues became a focus for the GP and Health Visiting Service to address. Despite very clear professional advice, the nappy rash went untreated by the mother and became more serious. Advice about weaning and feeding was also not followed.

The mother became pregnant at about this time though no professional was aware of this.

Summarised from Luton Safeguarding Children Board (2017) Serious Case Review - Child E, Kevin Ball

SHARED CHARACTERISTICS AND CIRCUMSTANCES OF THE CHILDREN AND THEIR FAMILIES

Although there are some important differences, for example the families of Child E and Child F had been known to services for much longer, a number of common themes can be identified in the circumstances of the children examined by the three reviews. The implications for services are explored further in Section 3 of the report.

All of these children lived in poor families where children were prone to material and physical neglect. Each family had moved, sometimes several times, and their housing was often substandard or overcrowded. Considerable professional time was spent seeking to remedy neglect linked to this material deprivation. This neglect may have masked or co-existed alongside other kinds of neglect, such as emotional neglect in which carers allowed one child in particular to suffer or was indifferent to the specific needs of a very vulnerable baby.

All three families were from or had strong links to Luton's Pakistani community: Child E's mother was white but the father of her children was Pakistani; the mothers of both Child F and Tahira were from British Pakistani families and the children's fathers were born in Pakistan. Families in the Asian communities are disproportionately affected by poverty, poor housing and unemployment and there are often additional factors such as the impact of immigration control that can have an adverse impact on the care of children and the ability of professionals to maintain continuous relationships with families. In each of these families, the absence of the children's father added an additional pressure on the care of the children and (although professionals were told otherwise) the extended families provided no actual practical or emotional support.

Concerns had been identified and services provided for each group of children but at the time of the children's deaths (in Tahira's case a very near miss) risks to the child were underestimated by the agencies involved.

In each family the quality of parental care had deteriorated much more quickly or more severely than professionals had thought was possible. The impact on children who were very vulnerable because of their age, and because the care provided to them was particularly poor, was drastic

Serious neglect occurred at a time when there was less frequent professional contact with the child or when the focus of professional intervention was not focused on the possibility of there being serious neglect. Other matters were taking precedence such as the provision of material help or addressing health concerns. Signs and symptoms of neglect were concealed or their seriousness was not recognised.

Assessments had indicated that there was no need for social care involvement or a coordinated protection plan. As a result none of the children had an allocated local authority social worker at the time of the death/near-miss because 1) earlier assessments had not resulted in referral to the local authority or 2) referrals when made were not judged to have met the threshold for social care assessment or 3) concerns were believed to have lessened and no single event had been deemed sufficiently serious to trigger a referral. In none of these families had there been a single recent incident judged serious enough to merit a local authority assessment.

There were gaps in professional contact with the family, either because cases had been closed (to one or more agencies) or there were gaps in staff teams, parents failed to keep appointments, or the level of contact offered was at only at the universal level, rather than triangulating information from a number of agencies that would have allowed the correct allocation to an enhanced level of support.

To different degrees parents were reticent to engage with professionals, pretended to be more engaged and compliant with requests than they were in reality or engaged intermittently, limiting the focus of contacts onto practical issues such as housing. Gaps in contact or missed appointments were not always recognised as problematic or, if they were, professionals were not able to respond effectively.

As is often the case, serious neglect presented in the form of a series of individual signs and symptoms affecting different children in the family. In all three families, several agencies had had a little involvement in the family, making the coordination of information more difficult. Beyond appraisal of the presenting problem, there is often no formal or structured assessment. Lacking information about the family professionals and their supervisors can find it hard to accurately identify risk.

How common are these characteristics?

It is sensible to ask whether the experience of the children in these families points to the existence of a larger cohort of babies and small infants who are at high levels of risk that professionals in Luton may be underestimating.

The principle characteristics of this cohort would be defined as follows:

- Living in poverty and poor housing which is causing physical or material neglect
- There are additional strains on the family such as a large number of children, limited support from the extended family, social isolation, a father who adds pressure rather than providing support for the main carer
- Additional strains faced by minority ethnic families
- The family has only taken up professional support or brought children to appointments in a limited or sporadic way
- As a result, the professional network is fragmented, there is a very limited overall assessment of needs and a risk that the full history is not known.

While it is not possible to be sure that a large number of such children exists in Luton, the hypothesis merits further investigation. If the answer is yes, it is important to consider how best to modify the existing safeguarding system so as to make such children as safe as possible and promote their welfare as effectively as

possible. This would need to be taken into account in the way in which priorities and strategies for services are developed.

The work of this review was undertaken before the Covid 19 lockdown. The economic and social impact of the epidemic is likely to have exacerbated the factors identified in this section of the report.

3. AREAS WHERE THE NEED FOR PRACTICE IMPROVEMENT IS HIGHLIGHTED

Introduction

This section considers six aspects of the learning from these reviews in more detail:

- Working in the context of high levels of deprivation including poor or precarious housing
- The strategy to identify and work with the neglect of children
- The impact of race and religion
- Inter-disciplinary and multi-agency working
- Professional responses when families are hard to engage
- Supervision and management oversight of practice.

The learning relating to Tahira is incorporated in this part of the report. For both Child E and Child F reviews, detailed recommendations were made in the original reports and their implementation was monitored by the LSCB. The remainder of this report seeks to understand how the safeguarding system as a whole now stands in relation to the concerns that were identified in those reviews, recognising the value of not simply 'ticking off' actions in an action plan.

SAFEGUARDING CHILDREN IN COMMUNITIES WHERE THERE ARE HIGH LEVELS OF DEPRIVATION

This section considers the difficulties faced by professionals working in communities in which there are high levels of deprivation.

Review findings

The children in all three families experienced material deprivation because they relied on state benefits, unreliable contributions from an absent father, or a combination of the two. For families in these circumstances, financial pressures become particularly severe when there are a large number of children and when there is a new baby. The capping of some state benefit payments has increased this difficulty. Families find the benefits system more difficult to navigate when there are changes in circumstances such as moving home, something that is much more likely if accommodation is precarious or unsuitable. In Tahira's case her mother was sending money to her husband in the hope that he would be able to come to the UK legally, leaving her with little or no money for her children.

The reviews have all recognised the possibility that professionals working in deprived areas may become acclimatised to material neglect. If the circumstances become accepted as being 'normal for Luton' (or anywhere else), professionals will operate at thresholds that are too high to be in children's interests. Professionals do not do this deliberately and the reviews provide an opportunity to reflect on the ways in which it can happen.

For families in these circumstances, there are always numerous practical issues that impact on the care of children and need to be resolved, for example the money to buy a cot, stairgate, high chair or suitable and a mattress that is safe for a baby. All three SCRs showed that professionals understandably placed a strong emphasis on providing practical assistance. For their part, parents were happy to accept practical support but much more reticent to respond to other concerns (such as their failure to take children to medical appointments).

In Tahira's case it has been suggested that professionals fell into the view that she was cooperating (because she accepted material help) when in fact she was not taking up some important services (such as registering with a GP) and making choices about money that did not prioritise her children's needs.

What action has there been and what more is needed

The distinction between physical or material neglect that is caused or exacerbated by poverty and other forms of neglect needs to be clearly established, both in professional thinking and in the practice interventions that are made. This requires an assessment that is conscious of the distinction and open to discussing it, both with families and between professionals. If aspects of neglect are being caused by poverty, professionals have a responsibility to do everything they can to alleviate it, but they must equally be prepared to be mindful of other causes.

Sometimes addressing this issue might mean advocating on behalf of a family and ensuring that every option to increase their access to benefits and practical support is explored. Agencies should be able to signpost families to services that can give them practical help and advice. Agency representatives noted that in recent years a number of services that assisted families living in poverty had been cut, leaving fewer advice and advocacy options. It was agreed that concerns about this should be shared with the council Chief Executive who would be expected to have oversight of approaches to poverty in the town.

When poverty is not the sole cause of children's difficulties, professions must be willing and able to engage on other matters. This is an issue where practice can only be improved if professionals become more aware of the dilemma and discuss

it with one another. Supervision of professionals and group discussion with colleagues has an important role to play. The use of the Graded Care Profile (discussed in Section 3.3) should trigger this thinking. Member agencies should use the publication of the current case reviews as a focus for discussion with staff so that supervisors become more aware of the sort of neglect cases that their staff are dealing with and the approaches they are taking. Supervision is discussed in Section 3.6.

STRATEGY TO IDENTIFY AND ADDRESS THE NEGLECT OF CHILDREN

This section considers the work that has been undertaken by the safeguarding partnership to improve awareness and assessment of neglect. Much of this evaluation focuses on the implementation of the Graded Care Profile (v2), a tool that provides a framework for the assessment of neglect (the GCP2).[5]

The Graded Care Profile 2

Neglect often presents through a series of signs and symptoms that would not in isolation point to the risk of significant harm. The reviews of services provided to Child E and Child F found that not all professionals were sufficiently knowledgeable and confident in dealing with possible indicators of neglect such as measurements of growth (especially weight) of small babies, failure to bring children to appointments, poor school attendance or delay in GP registration, and that this led to an underestimation of the level of risk. As the symptoms of neglect are disparate, professionals need to be able to conceive, at an early point, of the possibility that children may be being neglected.

When Child E and Child F died in 2013 and 2014, Luton's approach relied on the existing version of the GCP, which had been developed by an experienced local paediatrician. For these children, the intention to use the Graded Care Profile was never followed. Few staff had been trained to use the GCP so it had fallen into disuse. As a result of these reviews, agencies acknowledged that they could not expect staff to recognise neglect cases and intervene effectively if they do not provide them with the necessary tools and expert knowledge and the

[5] http://lutonlscb.org.uk/professionals/graded-care-profile-2/

safeguarding board became part of a national programme to review and update the GCP assessment tool.[6]

In relation to Tahira the use of the GCP was suggested by one supervisor in relation to her older sister but the mother returned to Pakistan before consent could be obtained and the work begun. After the mother's return to Luton and Tahira's birth the suggestion was not followed up. The new health visitor had not accessed the earlier records so was not aware that it had previously been recommended. The early help service now recognises that there were grounds to use the GCP after the birth of Tahira.

This demonstrates that the GCP needs to be used in the context of good information sharing and multi-disciplinary working by professionals who are aware of key events in the case history including previous concerns.

Since the earlier SCRs the safeguarding partnership has updated its neglect strategy and promoted the GCP2 as a means of achieving greater understanding of neglect and greater consistency in assessment and thresholds. This work has been undertaken as a partnership with the Bedford and Central Bedfordshire safeguarding partnerships and the NSPCC. This has been a substantial project that has including revision of the GCP tool, development of associated guidance and procedures and a substantial training effort. Training has been provided by the safeguarding children partnership with refresher training to key staff such as health visitors and family workers in the early help team.

Audit reports have been provided to the partnership on all aspects of the strategy, including on the number and distribution of GCP2s undertaken. These show a substantial increase in the use of GCP2 particularly among health visitors, the council early help service and in children's centres. However, they also highlight a tendency for the GCP to be used as a single agency assessment tool, focused on information available to the individual professional, rather than being part of a multi-disciplinary or multi-agency approach drawing on all the information available to professionals. This necessarily limits its effectiveness, since signs of emerging neglect are often to be found in the knowledge available to the professional network as a whole.

As well as promoting the GCP2 as an assessment tool, the partnership needs to focus on the development of collaborative working arrangements which will make the use of the GCP more effective. Much better that two or more professionals working with a family undertake the GCP as a joint task. The community health

[6] https://learning.nspcc.org.uk/services-children-families/deliver-nspcc-services/

trust will seek ways of ensuring that health visitors are involved in GCP2s that are undertaken by children's centres and the early help service. Use of the GCP2 is or will become mandatory in agreed circumstances, such as referrals to the MASH and in child protection plans on neglect cases.

Individual managers need to be well informed about the way in which the GCP is being used by their staff in order to identify barriers to its further implementation. Some agencies such as the hospital have also considered the development of a neglect pre-screening tool to aid all staff in the identification of possible neglect cases that may need further assessment.

Chronologies and case transfer

All of the SCRs demonstrate the importance of professionals having a full and shared history to inform the assessment. This is seen in its simplest form in the Tahira review. There were two children and two episodes of professional contact: one involved the older child before the mother went to Pakistan; the second involved both children after her return and the birth of Tahira. For different reasons most of the professionals involved in the second episode knew little or nothing about the first. This left agencies unaware of the repeated nature of the problems that had been experienced.

Many of the patterns seen in the second episode (for example the mother's unwillingness to register the child with a GP) had also occurred in the first, pointing to a persistent unwillingness to provide for the child's health needs. However there were important differences between the first and second episodes. In the second the mother was sending significant amounts of money overseas which was a critical additional stress that was not present when she only had one child. The mother claimed (falsely) that her husband's extended family were supporting her in her care of the children. This assertion was never tested. Nor were professionals curious as to whether the same family had not helped out during the first episode.

Obtaining a comprehensive history is never an easy task. Professionals working at the early help level can only obtain and share information with parental consent and for the reasons explained in Section 3.2 their work often has a practical orientation. They do not tend to go back over old ground or research the full history until there is an apparent need to do so. In a context when staff have full workloads it is a challenge to be curious. Compiling combined histories would be easier if all agencies were working from a simple shared (or at least a similar) chronology format. This would also make it much easier to refer children to the MASH.

In some instances there are organisational barriers to obtaining a full history. For example specialist midwives who work with vulnerable mothers have their appointments in the hospital and so may find it more difficult to access information from GP records. Since November 2019 the health visiting service has made it a requirement that cases transferred into the service or reopened after a break in service should always be initially overseen by a senior health visitor who will set out expectations about how the work should proceed (e.g. through reallocation to the original worker, or a handover meeting to the newly allocated member of staff).

Focus on the individual child

All of the reviews highlight the death or serious harm done to an individual child. When there is serious neglect in a family it is very common for one of the children to be at a greater degree of risk. Most often the risk will be the greatest to the youngest child, especially if this is an infant, because children under the age of 12 months are particularly vulnerable to the neglect of health needs, including failure to thrive because of inadequate nutrition. However there will be instances in which another child is most at risk, perhaps because the child has a particular role in the life or the family or psychological significance for the parent. An essential part of any assessment needs to be an awareness of family relationships and 'dynamics', such as the meaning that a particular child may have. Indicators that focus on the physical and emotional health and development of an individual child (such as the careful monitoring of growth, or scapegoating within the family) need to be given more attention. Ideas on this should be tested in discussion with carers, in supervision and in multi-agency discussion.

THE IMPACT OF RACE, ETHNICITY AND RELIGION

All three of the children whose cases were reviewed lived in families from Luton's Pakistani community. The reviews found that this added pressures. These included:

- Additional practical problems arising as a result of the effect of immigration controls, leading to the separation of family members and additional financial burdens [7]
- Linked to this were obligations to extended family, for example sending 'home' money when resources were already scant, to the detriment of other family members

[7] Families may have no recourse to public funds (most housing and welfare benefits) because of their immigration status, though this did not apply in any of these cases

- Rights to housing are often restricted, as a result of which families move frequently so interventions were more likely to be incomplete and records are fragmented.
- All of the mothers in these cases had been born in the UK but there are instances in which parents do not speak English. This is likely to increase social isolation, limit knowledge of services and may make authoritative, well-informed parenting more difficult.

In some instances these factors may leave more vulnerable family members (often women and children) open to exploitative relationships. It became known that Tahira's mother was sending significant amounts of money to her extended family. In the other families the nature of the financial relationships between mothers caring for children and absent fathers was unknown. Financial arrangements within the family should be explored whenever it seems to be relevant, but often professionals did not ask basic questions about these issues.

Professionals may also be prone to basing their assessments on stereotypical and overly-optimistic cultural assumptions, for example taking it as given that the extended family is a benign influence that will always provide support for parents.

Such cultural issues are complex and impact in many ways but the review has identified a timidity and lack of confidence among professionals in discussing them. One agency report prepared for the review referred to this as '*a gap area with little wider awareness and no training available in this area… (this can contribute to a) lack of curiosity and potentially a reluctance to ask or challenge things in case this may be viewed as offensive or not even considered'*. If this is true it is disappointing. The reasons for it need to be understood. Improvements are less likely to happen if individual practitioners are left to make changes themselves and more likely to arise when there is close supervision and feedback on practice.

Similar factors may be important in families from other cultural and religious backgrounds, but given the size and significance of the Pakistani community in Luton it is important that professionals have the knowledge and confidence to explore and understand them when they may impact on the care of children.

If the hypothesis of this SCR is correct and there is a cohort of infants who are at risk of serious neglect, then it is very likely that families from the Pakistani and other south Asian communities will be over-represented among them. In partnership with communities and families, professionals need to be willing and able to develop a much better understanding of the factors that shape outcomes for children from minority ethnic backgrounds and actively investigate the reasons for disparities. The development of the tools and training that are needed to do this should be an area of priority for the safeguarding partnership and its members.

Training should take full account of the specific characteristics of Luton and its communities including the high degree of mobility of some of the population.

INTER-DISCIPLINARY AND MULTI-AGENCY WORKING

Introduction

The reviews found evidence of gaps in information sharing and communication between agencies and a lack of clarity about how work should be coordinated by targeted or universal services. The safeguarding partnership has recognised that these shortcomings are more widespread.

Identification of concerns and information sharing

Prior to the birth of Tahira both maternity services and the GP brought her to the attention of the early help services. It had identified the need to complete an early help assessment, though gaps in records mean that it is not certain whether this was completed. A referral was made from specialist midwives to a specialist health visiting team which resulted in additional support and an early help assessment. A year before this the hospital had also identified the need for additional support in relation to her sister.

Arrangements had been made to strengthen antenatal identification of concerns and service provision through the introduction of a specialist midwifery team in 2018. The work of the team is subject to periodic review. Consideration is being given to training the team in the use of the GCP2. The community health trust has developed a compatible health visiting pathway to support this.

Information sharing systems

Previous case reviews have also noted the large number of separate information systems on which professionals record their assessments and interventions. There are a limited number of shared systems and arrangements through which professionals can access one another's systems.

Steps have been taken to create systems that aid the sharing of information or to grant access to professionals from other agencies. For example the children's centres now have access to the local authority early help record keeping module, which allows them to check cases to view the history or current work activity. This allows them to be more informed and alerted at an earlier stage. Further work is underway with the health visiting service.

This approach proceeds at a different pace in different agencies. In January 2019 the hospital maternity unit introduced a database to track the women referred to early help services or the MASH. Since mid-2019 a pre-birth panel tracks the progress of work with the most vulnerable women. Generally progress enabling access between health systems is slower than in other sectors. The acute sector has no access to SystmOne, the most commonly used system in primary care. When access to additional information systems is granted, it is often restricted to a limited range of information and is time-consuming for staff who must separately log onto different systems and also prone to human error in reading unfamiliar systems. This serves to demonstrate that inter-agency working cannot rely on automatic electronic data sharing.

Reports prepared by agencies for this review indicate that individual professionals know that they are expected to share information but often need to be prompted to do so when a referral is being made, when an assessment or planning of work is being undertaken or as the case works through its stages at the point of case closure and handover.

Lack of coordination and a lead professional

At a number of points in the case history professionals from different agencies collaborated, for example identifying when it would be useful to refer the family for a service and sharing information, usually in meetings. However no agency took on the responsibility to act as the lead professional or coordinate the intervention. This can have a significant effect.

Without a coordinated approach there is less likely to be a shared understanding of the facts and it is very unlikely that there will be an agreed plan. This means there will be no shared focus on objectives. Professionals in different agencies are much more likely to have a different understanding of the history and the reasons why they are involved. Triangulation of the information held by individual agencies will assist allocation to the right pathway or level of care.

Busy professionals tend to be as curious as they think they need to be to accomplish their own tasks. Focus on individual issues can lead to a lack of curiosity about the day to day experience of these children or the history. In Tahira's case, interventions and decisions were made were made without knowing the context of previous events.

Agencies have told the review that points of case handover and closure are often points at which information can become lost or misinterpreted, making this an important area for further attention.

The partnership view

The safeguarding partners have recognised that there are difficulties in the systems for the allocation of a lead professional at the early intervention phase, especially for small children where the key agencies are often GPs, antenatal services, health visiting and children's centres or early help services. It has been recognised that professionals need to be more confident about taking on the lead professional role and helping others to do the same.

Luton Borough Council is currently considering how best to redesign the range of local prevention and early intervention services. This will include further research to understand which services are able to take on the lead professional role and what factors facilitate this. Where there are shortcomings the barriers need to be understood better in order that they can be addressed. This should also be addressed through the current local authority-led review of the local multi-agency threshold document.

THE PROFESSIONAL RESPONSE WHEN THEY ARE UNABLE TO ENGAGE WITH PARENTS TO PROVIDE SERVICES

Failure by parents and carers to take children to medical appointments or to take up other services recommended to promote their development and wellbeing may be an important indicator of neglect. This section of the report considers how professionals understand this and approach the problem of working with parents who are unwilling to take up services for their children. The previous SCRs had highlighted how professionals had found it difficult to engage with families or that engagement was sometimes only superficial.

Tahira's mother delayed the registration of both of her children with a GP for several weeks. This delayed the baby's immunisations and could have compromised their health care. She provided no rationale. She did not take Tahira to hospital appointments and did not attend 'team around the family' meetings with professionals to discuss the services that were being provided.

Agencies now recognise that sometimes too much reliance is placed on self-report (for example of attendance at appointments, involvement with services, height and weight measurements and support from the extended family) without information being confirmed. There can be only limited professional curiosity about whether the facts presented were true and presented a fully picture. Discussions were often limited to the issues that the mother was happy with and professionals did not persist in their efforts to steer the discussion onto their other concerns.

In order for the professional network to be able to consider the whole picture of compliance and engagement, information about missed appointments or services refused needs to be shared consistently. If this does not happen missed appointments will be seen as a one-off rather than being recognised as part of a pattern. This has been addressed by the hospital trust by updating its flowcharts and procedures for children who are not brought to appointments. From February 2020 this includes a specific arrangement for 8-week-old infants who have not been taken to GP baby checks to be identified and the allocated health visitor alerted.

The multi-professional meetings did not rigorously explore the fact that almost all the engagement was being directed by the mother. Some professionals now recognise that they had overestimated the strength and influence of their relationship with the mother and assumed rather than knew that she would 'do the right thing' for Tahira.

SUPERVISION AND MANAGEMENT OVERSIGHT OF PRACTICE

This section of the report evaluates the impact of supervision and management oversight. The previous SCRs found weaknesses in both. Improvements in these areas will be key to addressing the areas of service delivery and practice previously highlighted.

What the reviews say

Services for Tahira's family rarely appeared to warrant detailed supervision discussions because the circumstances of the children were in the main not viewed as being sufficiently concerning. The family's circumstances were discussed in early help supervision twice and in the health visitor's safeguarding supervision on only one occasion. Both focused on her sister's slow weight gain shortly after her birth. During the second episode the children's circumstances were never seen as warranting detailed supervision discussion.

Supervision is also very relevant to the decision to refer a child to the MASH with a view to local authority social care assessment, offering the opportunity for improvement in practice in relation to 1) decisions to make a referral and 2) responses when a referral is not accepted.

One agency contribution to the review notes that '*escalation continues to often be unsuccessful and there is no feedback as to why a threshold has not been met. This does not support the development of practice and it is felt that it discourages reporting, as it is unlikely to meet a threshold unless a significant event has or is occurring*'. Good supervision should give staff clear direction as to material that

should be included in a referral to the MASH, including information from the multi-agency network, and how it should be presented. It will also enable professionals to decide when and how to challenge decisions by another agency not to take on a case. For possible neglect cases that usually means either at the point when the MASH decides that an assessment is not necessary. However this can also occur later, for example if the decision to undertake a child and family assessment is reversed because circumstances appear to have changed.

Changes made in supervision arrangements

The nature and focus of supervision will properly be influenced by the level of experience of the workforce and pressures on capacity. The relatively inexperienced workforce and high caseloads and demands on services highlighted in relation to Child E and Child F remained a concern in some Luton agencies in 2019. Community health teams use of a 'skill mix', delegating some face to face work with families to less qualified members of the team. This puts an additional onus on their supervisors to help them draw lessons from their contacts with families.

Some agencies are extending the range of staff falling within safeguarding supervision arrangements. For example the acute hospital trust is developing individual and caseload supervision for paediatric staff and community midwives. It is also developing its level three safeguarding training to include direct supervision of current cases.

From late 2020 the community health trust will be implementing a revised model of supervision that will not rely exclusively on supervisees selecting cases they believe need to be scrutinised. This will allow supervisors to ensure that infants within the cohort identified as vulnerable by this review can be included. There will be supervision of caseloads by practitioner managers as well as specialist safeguarding supervision.

The revised approach will enable supervisors to read case notes before the supervision session. This is designed to address many of the issues identified in this review. Supervision will include monitoring the type of children who are allocated to the lowest level of 'universal' health visiting provision with the intention of ensuring that a greater number of children are allocated higher levels of services (at the health visiting 'Plus' or 'Partnership Plus levels'). The model of supervision will also address the problems of acclimatisation to neglect and help front line staff be better prepared to have challenging and difficult conversations with parents.

The Early Help service has developed supervision group meetings in order to improve risk assessment skills and develop critical thinking.

Agencies have all taken steps to improve compliance with supervision policies and surveys of staff have shown that staff are receiving supervision in line with policies and value the support they receive. There is a continuing need to ensure that supervision discussions and decisions are properly focused on outcomes for children and their day to day experience.

Further work required

Progress on all of the issues identified in Section 3 of this report requires continuous improvement in the quality of supervision so that staff are able to reflect and recognise concerning patterns of family behaviour and professional interaction.

If the hypothesis is correct that there is a cohort of children where risk has been underestimated, individual agencies should continue to explore the ways in which supervision can be used to identify these children so that services can better focus on them.

The safeguarding children partnership should provide closer oversight of the effectiveness of supervision arrangements in member agencies, with a particular focus on the areas identified above. There should be both single agency and multi-agency thematic audits of supervision focused on the issues identified in this report. The results of these audits should be reported to the multi-agency safeguarding partnership and challenged if insufficient progress appears to have been made.

Wider issues of management oversight and the management of caseloads also need to be considered. For example if lapsed contact and repeated missed appointments in different agencies are a significant indicator of risk, agencies should have a comprehensive overview of vulnerable children who have not been in contact with an agency when that was an expectation of the plan.

4. CONCLUSION AND RECOMMENDATIONS

The review has explored the circumstances of three infants, under the age of 12 months, who died or suffered serious harm as a result of parental neglect in Luton between 2014 and 2019. All three lived in materially deprived circumstances. Risk to them had been underestimated and their carers' pattern of poor engagement presented a particular challenge to agencies working in universal health services, early help services and children's centres.

The review suggests to the partnership that these children may be part of a wider, vulnerable cohort of children who need greater attention in the planning and development of services. If this hypothesis is valid, agencies will need to consider how best to adapt the system of universal and targeted services to make it as safe and effective as safe as possible for these infants.

On the basis of existing knowledge from the three SCRs the need for improved management oversight and supervision of work in these agencies is highlighted, focused in particular on the following areas:

- Heightened awareness in strategy and planning of the needs of vulnerable infants where there is a concern about neglect in the family
- A strategy for improved service provision and competence in working with families in the Pakistani and other South Asian communities
- Better implementation of lead professional and case coordination responsibilities
- More consistent information sharing and clarity on plans and responsibilities, particularly at the point of handover, the re-opening of cases and case closure
- More use of the GCP2 as a collaborative tool and a greater awareness of the history of previous concerns and attempts to provide services to families
- Clear agency strategies to address material neglect caused by deprivation and poverty, through advocacy, advice, signposting and where appropriate direct financial and material support
- An explicit focus in policy and training on the distinction between neglect caused by poverty and other forms of neglect.
- Professional practice should recognise the need to test and verify information provided by parents when it is crucial to the plan for a child
- Greater challenge when families fail to keep appointments of drop out of services.
- This should all be part of a broader training effort that is designed to enable professionals to operate within a framework that takes full account the specific character of their work in Luton. Luton is a town in which neglect

and poverty need to be successfully addressed in order for children to thrive.

Recommendations

This section of the report sets out the recommendations arising from the review. It includes:

- The overall recommendations to the multi-agency safeguarding partnership
- A recommendation to the partnership to test the implementation of the actions that individual member agencies say has been taken as a result of their internal learning from the case of Tahira.

Luton Borough Council should ensure that the redesign of prevention and early intervention services, and any revision of the partnership threshold document, take account of the lessons of this review, particularly in relation to the following:

- The specific heightened vulnerability of infants under 12 months living in materially deprived circumstances
- The sharing of information through proportionate access to systems held by partner agencies
- The value of developing a shared chronology format to enable more efficient sharing of information
- The development and strengthening of the lead professional role
- The need to improve arrangements for the referral of cases to the MASH and the resolution of concerns when there is a subsequent difference in professional judgement about the level of need or risk
- Improved supervision of staff.

Luton Safeguarding Children Partnership should develop a strategy for single and multi-agency training programmes that will enable professionals to address the specific character of their work in Luton where a combination of neglect, poverty and complex cultural and religious issues need to be successfully addressed in order for children to thrive. The partnership should test the effectiveness and impact of the programmes.

The partnership should agree an overall strategy for professional in Luton to work in a way that is more culturally competent, including specific action plans for each agency.

In collaboration with the safeguarding partnerships in Bedfordshire, Luton's multi-agency safeguarding partnership should review the neglect strategy to take account of the findings of this review in particular those set out in Sections 3.2 and 3.4. This will include:

- Distinguishing the impact of neglect caused by poverty and neglect of children with other causes
- Further work on the use of the GCP2 in order to strengthen its use as a multi-agency, collaborative tool which is mandatory in certain circumstances

In respect of the single agency recommendations made as a result of internal learning from this review, Luton Safeguarding Children Partnership should receive periodic updates on their implementation and undertake audits as required to verify the effectiveness of actions taken. This should include relevant actions described in the report above in the following sections of the report:

Section 1.11	Bedfordshire Police - taking seriously referrals from people well known to the police
Section 3.3.8.	Cambridgeshire Community Services NHS Trust - involving health visitors in GCP2s undertaken by children's centres and early help services
Section 3.3.9.	All agencies
Section 3.3.9.	Luton and Dunstable Hospital Trust (pre-neglect screening)
Section 3.5.6.	Luton and Dunstable Hospital Trust (maternity unit database)
Section 3.5.6	Access by health professionals to SystmOne
Section 4.6.4	Health visitor access to records of 8-week baby checks
Section 3.7.5	Luton and Dunstable Hospital Trust (extension of level 3 safeguarding training
Section 3.7.6	Cambridgeshire Community Services NHS Trust (revised supervision model)