Child Safeguarding Practice Review

Learning identified from considering Child R

Contents

1. Introduction page 1
2. Process page 1
3. Learning page 2
4. Recommendation's page 11

1 Introduction

1.1 The Wolverhampton Safeguarding Together (WST) agreed to undertake a Child Safeguarding Practice Review (CSPR) by considering a case to be referred to as Child R .

1.2 Child R was 8 days old when they were taken to A&E with significant head injuries[1]. There had been ongoing concerns about parental neglect of Child R 's older siblings. At the time of Child R 's birth all of the children were the subject of child protection plans.

1.3 Both parents had learning needs and some mental health issues and there was known to be conflict in their relationship. Allegations of historic domestic abuse[2] were not made by the parents until after Child R 's injuries.

1.4 Learning has been identified in the following areas:

- Knowing and considering the parent's history and vulnerabilities when working with the family
- Understanding a child's lived experience and what they may be communicating by their behaviour
- The likelihood of child neglect coexisting with other forms of abuse
- The impact of 'growing families and growing children' on the ability of parents to manage
- The cumulative impact on children of long-term neglect
- **The need for professionals involved with adults to be aware of plans for the children in the household**
- How COVID-19 effected the family and the services received
- Bespoke safe handling and coping with crying advice, to include older siblings
- Following child protection procedures regarding parental contact following an injury

2 The Process

2.1 An independent lead reviewer[3] was commissioned to work alongside local professionals to undertake the review. Information provided to the rapid review meetings was considered and additional information was requested from individual agencies, including the identification of single agency learning and any improvement actions required.

[1] The police investigation concluded without any charges. The children are the subject of care proceedings.
[2] Professionals were aware of regular parental arguments which were thought to be an unhealthy feature of their relationship, this was not considered to be domestic abuse at the time.
[3] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and entirely independent of the WSP.

2.2 Professionals involved at the time were involved in discussions about the case and the wider system. Due to the on-going response to Covid-19, the practitioner participation session was held in January 2022 using video technology.

2.3 The lead reviewer met with the parents of Child R to identify any learning from their perspective. This is included in the body of the report.

3 The Learning

3.1 The learning identified for the safeguarding system and partnership is highlighted below, followed by detailed and case specific analysis.

When undertaking assessments and making plans for children, there must be a full understanding of the parent's histories and vulnerabilities, and consideration of the impact on their functioning and parenting ability

3.2 It was evident to all of those working with Child R 's parents that they had learning needs. The interventions were sensitive to this and included careful and particular consideration of how best to ensure that both parents understood what was being discussed and what was expected of them. There was no evidence that the professional input was purely mother focused, with both parents being assessed and worked with by those involved including the social workers, the IFS workers and the health visitor. There was also evidence that the professional input was provided equally to both parents, which was good practice.

3.3 What was not entirely clear was the extent of their learning needs. Since the injuries to Child R , there have been cognitive assessments undertaken on both parents. The review was told that the father has an 'extremely low cognitive ability[4]' with 'extremely poor verbal comprehension and working memory and no functional literacy'. This was likely to have had a significant impact on his parenting ability and understanding about how to implement the changes being requested by the agencies working with him in regard to the children. The mother was also assessed to have 'extremely-low cognitive ability[5]' with 'just about functional literacy'. Both meet the criteria to be described as having a 'learning disability'. It appears that the father attended a special school. The GP information shared during this review states that the mother attended a mainstream school with provision for children with learning needs, and she told the review she had a lot of one to one support in school.

3.4 Those working with the family at the time told the review that while it was evident that the parents had learning needs, they were shocked about how severe these needs were. The school recognised that the children's father was lacking in 'common sense'. He reportedly had very little traffic awareness and did not seem to retain much of the information and advice the school provided. Neither parent seemed to recognise the psychological impact on the children of things like them wearing dirty or inappropriate clothing and poor personal hygiene. None of those involved fully appreciated how limited their cognitive ability actually was. It is not routine practice to undertake cognitive assessments when there are concerns about the learning ability of the parents, although in this case the ICPC which was held during the pregnancy with Child R stated that this should be requested as part of the child protection plan (CPP). They were requested but not agreed. The PAMS[6] assessment that was also planned went ahead however, and it was hoped that this would give a clear indication of the parents learning needs and the impact on their care of the children.

3.5 The PAMS model does not give any early results or feedback, with the need to complete all sessions before a 'result' is available, 12 weeks after it commences. However, the IFS worker

[4] His full scale IQ is in the range 54-62 which places him at the 0.2nd percentile and thereby below 99.8% of the population.
[5] Her full scale IQ is in the range 60-68[5] (1st percentile) which places her below 99% of an age-matched population.
[6] PAMS stands for 'Parent Assessment Manual' a guide that takes into account parents with learning difficulties or disabilities.

completing it was experienced and noted that the couple both had identifiable learning needs prior to the results of the completed assessment being available and ensured that her input to the family reflected this. PAMS are undertaken jointly on a couple and the results consider them this way, as it is recognised that one can compensate for the other in some areas. There had not been consideration of undertaking the assessment when there were past concerns about the older children.

3.6 There was undoubtedly awareness across agencies of the need to work with the parents in a way that took their evident learning needs into consideration. Those involved used visual aids for example and were aware of the need to regularly repeat advice and instructions. Good practice was evident from a number of professionals who provided a significant level of support to the parents with the aim of improving the care of the children. This included the health visitor and intensive family support worker, both of whom worked hard to build relationships with the parents. Both parents had the support of advocates at key meetings such as child protection conferences, with the referral form stating this was due to their learning needs. The CP process was difficult for them to understand and those involved worked hard to ensure that the plans were outlined in a way that enabled them to make sense of what was being asked and what was expected of them. Those involved reflected that despite this, there were concerns about the lack of impact and minimal sustained improvements. This may have been due the true extent of their learning needs not being known.

3.7 Those involved due to child in need (CiN) and child protection plans (CPP) during 2020 and 2021 had very little information about the experiences of the parents during their own childhoods. An ACEs (Adverse Childhood Experiences) assessment was completed with the parents by the social worker at the time of the ICPC in 2021 and the school completed ACE work with the children as suggested at the ICPC. The parents provided very limited information, specifically stating that they did not want to speak about their history due to their upset at recent bereavements in both families. This impacted negatively on the assessment. While it is important to speak to the parents about their childhood, there is also a need to seek out information from historic records and from other agencies, such as the GP, when undertaking assessments or work with a family. This is to check out what the parents are reporting and to provide additional information. During this review it was established that the children's father had a number of periods of CSC involvement during his childhood that had not been considered by those working with the family in 2020-21. The robust and detailed consideration of this type of involvement is required, even if it requires a request for paper files from archives, which can be time consuming. In father's case the neglect and physical abuse he experienced as a child is likely to have had an impact on his well-being as an adult and on his parenting.

3.8 Research into ACEs show that when a person experiences abuse or neglect as a child, and the longer they experience it, the worse their physical, mental and social outcomes are likely to be. This includes the possibility that their children will be known to safeguarding services, and that they will require support in the future with their longer-term mental health. Professionals were aware that both of the parents had issues with 'low mood'. The mother had contact with Healthy Minds[7] on four occasions prior to 2017 but the referrals did not progress due to her non-engagement. She was historically prescribed antidepressants by her GP and during 2016 received some support from the out-patients clinic of the mental health home treatment team. She confirmed this to the review. There was initially no information about the parent's mental health shared with this review by the couple's GPs, due to information sharing concerns. As this limited the potential learning for the GP service and for the wider review, a recommendation has been made in respect of this issue. It is acknowledged that after challenge from the lead reviewer, some helpful information was provided prior to this report being completed. This confirmed that the father has been prescribed

[7] Healthy Minds provides talking therapies for people struggling with their mental health

antidepressants for low mood a number of times over the years. He was registered at a different GP to the children so it appears that his GP record does not include any information about his children being on a CP plan. This is a systemic issue that has been raised nationally in a large number of reviews and can lead to a significant gap in knowledge if information is not shared with and noted by the parent's GP as well as the children's when there are any safeguarding concerns. **In Wolverhampton it is customary for the health professional in the MASH to check all adult health information when a referral is made and for the parent's GP to be contacted as part of any assessment. When a plan is made there needs to be information sharing with the GP for any adults in the home to ensure that they are able to flag that the adult lives with a child/ren on a plan.**

3.9 The father had contact with mental health services just prior to the pregnancy with Child R when the couple briefly separated. The police were involved as the father was reported to be suicidal. He agreed to mental health support initially, and a Healthy Minds assessment was completed over the telephone. Father reported anxiety and low mood due to family bereavements and relationship difficulties with his wife. He was referred for counselling and anger management, but there is no evidence he attended. He did agree to work with IFS around his anger and emotional regulation however, and his good relationship with the IFS worker means he has been provided with good support. It was known to some professionals prior to the birth of Child R that there was a parent with issues relating to anger and aggression in the household. There were a number of reports that the older children regularly used aggressive and racist language, which they appeared to get from their parents. The Healthy Minds assessment identified a need for anger management support, but it appears this was not considered a specific risk to the children as there is no evidence that this was shared. It is not known if Healthy Minds were aware that a new baby was due. Neither parent's GP appear to be aware of any concerns about anger or aggression, however as stated there was a difficulty in gaining access to the GP records for the parents for this review.

3.10 The identified need for a pre-birth social work assessment when the pregnancy with Child R was confirmed was appropriate and proportional showing recognition of the factors impacting on parenting capacity and ongoing concerns about the care of the older children. It was recognised that a growing family is an increased risk in a family where there are safeguarding concerns, which is good practice, also that as babies become toddlers and toddlers become children their needs change. Parents need to alert to, and able to adapt to, the increasing demands.

Professionals need to explore and understand a child's lived experience, including considering what they may be communicating by their behaviour. When a baby is expected, there needs to be specific consideration of their likely lived experience

3.11 As well as understanding the parent's vulnerabilities, all professionals need to be aware of the impact of this on the children, with particular regard to the lived experience of the children within their family. The importance of professionals having a child centred approach is well recognised in safeguarding work, and there is evidence of a commitment to this in Wolverhampton. In the case considered, it is noted that professionals worked hard to provide the older children in this family with opportunities to speak to them about their home life and to consider their views, including at school. While speaking directly to children is essential, it is also important to understand that children may not be able to express themselves or that they may feel conflicted and/or concerned about sharing too much about their lives or any concerns they have. It is therefore necessary and important to also consider a child's behaviour and what they might be saying without words.[8] There were on-going and regular concerns about the behaviour of the older children who were described as 'out of control' and 'unmanageable' when with their parents, sometimes in the school setting, and when visited at home by professionals.

[8] The voice of the child: learning lessons from serious case reviews. Ofsted 2010

3.12 There were two known incidents of physical injuries to the two eldest siblings when they were very young. These were investigated at the time and determined to be accidental, with issues identified about the parent's management of the children and concern about lack of supervision. (This is considered further below, from 3.17.) Those involved throughout the children's lives noted that the parents struggled to put boundaries in place, and did not respond to advice about how to ensure the children were adequately supervised and kept safe. The school told the review that they were regularly concerned about the children while they were being taken to and from school and about their dangerous behaviour around a main road. Poor supervision by the father, who did most of the school runs, was regularly raised as an issue with him and shared as a concern with other professionals.

3.13 The children's school attendance was poor, and when in attendance they often spoke to the school about their home life, including making allegations about domestic abuse, rough handling, and the inappropriate ways that their parents coped with poor behaviour.[9] Staff at the children's school built good relationships with the children and they were able to capture their voices and notice changes in their behaviour. The parents always denied what the children had shared when they were challenged. Those involved were clear that the children's exceptionally boisterous behaviour in the home, at school and when in the community was due to a lack of boundary setting and inconsistent parenting. This also led to lack of supervision being seen as the reason for any injuries seen on the children, with the alternative possibility of physical abuse not considered.

3.14 Overcrowded housing and poverty were also issues for the family, which is well known as a source of stress. The children spoke of monsters coming to the house wanting money (thought to be debt collectors), food parcels and food bank referrals were regularly provided by professionals and there was often noted to be a lack of nappies, toiletries and toilet paper in the home. The children did not appear to know how to use soap and were often dirty. While none of this was necessarily an unusual factor for the most deprived families in the city, it is an indicator of neglect and professionals need to ensure that they are not desensitised or that indicators of neglect are accepted the normal. The lack of understanding or acknowledgement from these parents about the impact on the children of the physical neglect that was evident was noted at the time and contributed to the concerns.

3.15 The property was private rented and it was recognised that it required repairs and essential maintenance[10]. The poor state of the accommodation was felt to be largely down to the family rather than the landlord and there was a notable lack of motivation from the couple to improve the conditions without a lot of encouragement and support from the professionals involved. Those involved were concerned about the impact on the children's lived experience of their home environment. The family were on the waiting list for a social housing/council property and professionals worked hard to support them with this. However there was confusion about the bidding process for suitable properties. Learning has been identified about the need for professionals to ensure that the relevant housing agency is invited to child in need or core group meetings when a housing issue is impacting on the progress of a child's plan. There was some confusion amongst professionals about which housing department needed to be contacted to ensure that the re-housing need was prioritised. Wolverhampton Homes is an organisation which provides allocation of social housing, whereas the private sector housing team[11] is part of the City Council, which is confusing and hard to negotiate for busy non-housing professionals. Wolverhampton Homes is in the process of updating their website and training their staff to ensure

[9] For example alleging that they are locked in the bathroom when they are naughty, and stating that their father told the children 'if you kick me, I will kick you back.'
[10] This included a lack of working locks on the windows, which was an issue as it was an upstairs property and the children had been seen leaning out of the windows.
[11] The review was told that the family could have privately rented a larger property, but did not have access to a deposit.

that effective advice and support is given to other professionals who require support in helping families with a housing need.

3.16 It is important to consider the voice and the likely lived experience of the unborn and then new-born baby as well as the older children. When a baby is on a child protection plan, the conference can be a good place to ensure that this is evident in assessments and plans. There has been helpful reflection from the conference chair and their team about the need to provide particular focus on the unborn child in conferences, particularly when there are older children whose needs may otherwise dominate the meetings.

Professionals need to recognise and consider the cumulative harm to children who experience long term neglect

3.17 A new social worker had taken on the case in 2021 and she recognised that the children's continued poor lived experience, a lack of sustained progress, and the likelihood of a further deterioration when the expected new baby arrived, warranted a child protection response and an ICPC. Her 'fresh pair of eyes' and assertive decision making was what the case required. There were well known and reported incidents of concern about the care provided to the children over a long period of time. When the decision was made to make the children subject to a CP plan this was acknowledged and there was a good awareness of the impact on the children of their lived experience. Poor home conditions and the physical neglect of the children and self-neglect by the parents had been regularly evident. (As well as their neglect of the children, the parents also struggled with their own personal hygiene and dental health.) While the neglect concerns fluctuated, with improvements in the home and the children's presentation often linked to a period of sustained professional intervention, by the time of the ICPC it was acknowledged that the children were suffering 'significant harm' due to the long-term nature of the neglect concerns and the inability of the parents to maintain any improvements.

3.18 The national Safeguarding Practice Review Panel's annual report published in May 2021[12] states that 'the recognition of cumulative[13] neglect and its impact continue to be a key challenge for practitioners' nationally'. There is a danger when working with cases of neglect that professionals wait for a serious one-off incident to happen to provide evidence that the children are suffering significant harm on a given day. With neglect, a large number of smaller issues when collated, may show significant harm over time. Recognising this fact does not always lead to sustained change for the children however. The review is aware that the courts both locally and nationally rarely support care plans that request removal of a child from their parent's care, despite evidence of significant cumulative harm from neglect. This can lead to a systemic disincentive for those working in these complex cases, and an issue that is recognised in Wolverhampton.

3.19 The decision to make the children subject to a child protection plan, along with unborn Child R , was also due to the recognition that the care of the children would be impacted by a new baby in the home and concern about how the parents would manage. There was no consideration of any immediate risk of harm to the new-born baby, with the risks thought to be longer term and in relation to neglect and a lack of parental boundaries and control. The ICPC and resulting CPP did not include consideration of safe handling and the ICON programme being used in Wolverhampton or safe sleeping advice, and single agency learning for the safeguarding service has been identified in regard to this.

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984767/The_Child_Safeguarding_Annual_Report_2020.pdf

[13] The terms 'cumulative risk' and 'cumulative harm' were first identified by Bromfield and Higgins in Australia in 2005. They defined cumulative harm as 'the effects of patterns of circumstances and events in a child's life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.'

3.20 Working with cases where there is long term neglect can be particularly difficult for professionals. As well as families being overwhelmed by their circumstances, professionals can also struggle to know how to proceed. Balancing the needs of the children and the parents is difficult and exhausting work. This can lead to drift and delay for the children and a risk that plans will be ineffective. The issue needs to be considered within a context of large case loads and high demand for services. Professionals can also effectively become immune to the child's life experience due to an acceptance of poor home conditions and the needs of the child not always being met. 'Poverty blindness' can also occur where professionals are working in areas of high deprivation. Because poverty is widespread in Wolverhampton, there can be an 'associated desensitisation to poor hygiene, dirty clothes and poor dental hygiene.'[14] There was a degree of sympathy among professionals for Child R 's parents due to their circumstances, and an accepted view that they were willing to work with professionals and wanted to improve. It was not straightforward however as there was evidence of the father being defensive, unapproachable and aggressive when challenged. Focused, reflective and challenging supervision for the multi-agency team working with a case like this is a way of ensuring that being overwhelmed by a case is less likely, and that the cumulative impact on the children is considered. In Wolverhampton they are introducing a system where a place is available for professionals to have a reflective and creative discussion about how best to work with a family, which will be very helpful in cases that require it.

3.21 There has been a positive focus on child neglect by agencies in Wolverhampton in recent years and this continues. The safeguarding partnership is about to relaunch its 'We Can' Tool Kit and is planning to review the city's Neglect Strategy. The Local Authority have a new neglect Share Point that provides details of resources and services available to help in the identifying and planning where child neglect is an issue.

Domestic abuse can be subtle. All professionals need to understand how it may manifest

3.22 As well as the cumulative impact of physical and emotional neglect, there were concerns about the impact on the children of the problematic relationship between the parents. While there was an awareness of difficulties between the couple, the criteria for a DASH risk assessment was not met at any stage prior to Child R 's injuries. Domestic abuse was not identified despite the children sharing concerning information, including in November 2020 when one of the older children stated at school that his father had punched his mother.

3.23 In January 2021, when the children had been on a child in need plan for around ten months, their father reported feeling suicidal because the mother stated that she wished to separate from him. This was not seen as a sign of domestic abuse at the time, although such a threat is a well recognised controlling behaviour and is emotionally abusive. Those involved, including the police who undertook a safe and well check, were concerned about father's mental health and the impact of this on the children, but did not identify it as a symptom of a domestically abusive relationship. The review found that there is a need for increased awareness of this aspect of coercive and controlling behaviour among police officers and other professionals. In this case the children's mother was seen as the dominant partner, and she tended to be the one to take the lead when speaking to professionals. This may have provided a false sense of security about her potential vulnerability in the relationship.

When neglect is a known issue for children in a family, consideration should also be given to the risk or occurrence of other types of abuse

3.24 A published study of all the case reviews undertaken following the death of a child between 2005-2011[15] found a context of known neglect more often than known physical abuse prior to the child's

[14] Serious Case Review (SCR) analysis for the education sector: Neglect. SCiE 2020
[15] Brandon, M., Bailey, S., Belderson, P.and Larsson, B (2013) Neglect in Serious Case Reviews, NSPCC/UEA. https://www.nspcc.org.uk/Inform/resourcesforprofessionals/neglect/neglect-scrs-pdf_wdf94689.pdf

death. Neglect alone is rarely associated with the death of a child, but the case reviews undertaken at the time show that both physical abuse and neglect often coexist in a family, as they did in almost half of the reviews considered. In the cases where non-fatal injuries were present, as was the case for Child R , the co-existence of neglect was found to be higher than 50%. This is something that is not always considered when professionals are working with children where the primary concern is neglect. It is acknowledged that neglect is more prevalent as a safeguarding concern than physical abuse and that the two types of abuse do not necessarily co-exist, but having an open mind to this as a possibility is good practice. In the report, Brandon et al considered why the risk of physical abuse is often missed when working with a case where neglect has been identified. Some of their findings were evident in the work undertaken with Child R 's family. They include optimism about the family appearing to engage with professionals, efforts not to be judgemental, the impact of increased family size being underestimated, injuries readily being accepted as accidental and a 'this is only neglect' mindset. Neglect is often seen as a passive form of child abuse, where the parents unintentionally harm their children. A child being harmed by a direct violent action may not then be considered as something that these particular parents are likely to do.

3.25 When injuries to the older children were considered in 2016 and 2017, it can now be seen that physical abuse may have been identified had more rigour and curiosity been applied to considering the injuries and the parent's explanations. For example during the response to injuries in 2017 there is evidence that the A&E doctor had concerns about bruising to the eye and thighs of the then two year old child, and about the father's explanations and demeanour. An appropriate referral was made and a child protection medical was undertaken. On balance the consultant paediatrician felt the injuries could be accidental and identified a lack of parental supervision as an issue. This led to a period of child in need planning then early help support, including parenting work.

3.26 There is no doubt that there were long term and on-going issues about the parent's management of the children and the state of the home. This focus can lead to the risk of or coexistence of other forms of abuse being overlooked. Nationally, neglect is the most common reason for a child to be made the subject of a child protection plan. In Wolverhampton around 70% of children are on a CP plan for neglect. The parent's issues in this case led to neglect of the children and while there were indicators of anger control being a concern, statements by the children that could indicate a risk of physical abuse, and past suspicious injuries, any concerns about the risk of further physical abuse were either not acknowledged or secondary to the concerns about the poor physical and emotional care of the children and the state of the home. Those involved in the case were shocked at the extent of Child R 's injuries and that serious non-accidental injuries should occur in this particular family.

There is a need to ensure that safe sleeping and safe handling information is shared in an appropriate way with families by all involved professionals

3.27 It is not known how Child R 's injuries were caused or who the perpetrator was. However this review is a good opportunity to consider how safe handling and coping with crying information is shared with families around the birth of a new baby and in the weeks following the birth. It is clearly recorded that information was shared both in the hospital and when Child R and the mother were discharged from hospital in regard to both safe sleeping and safe handling. This was specifically shared despite them having older children, and with an awareness of their need for information to be shared in a way that was understandable to them. Mother told the review that during sessions with the family support worker, both safe handling and safe sleeping were discussed with both parents. The father confirmed he was aware of the need to avoid unsafe sleeping.

3.28 The ICON[16] programme has been launched in Wolverhampton and professionals are being trained in the methods. Health workers were trained and using it at the time of Child R 's birth. It was in the process of being rolled out further but this had yet not happened. ICON is a programme developed to help professionals provide consistent and accessible advice and support to families to prevent shaking and abusive head trauma. The rolling out of the programme needs to ensure that it equally includes the fathers or co-parents as well as mothers, that older siblings are considered in any advice given and that all professionals are aware of how to give and reinforce the advice. In families like this, where there are additional challenges, there needs to be careful consideration to how safe handling information is provided, how to reinforce that it must ***always*** be adhered to and an exploration of the family specific challenges. This was particularly necessary during the COVID-19 pandemic where there was less direct contact with parents from a number of agencies.

3.29 In the case of Child R 's parents, while programmes like ICON are helpful, the messages given need to be bespoke and regularly reinforced and provided by all professionals working with them. There are interesting parallels in the area of safe-sleeping, where provision of advice verbally and in written form (often a leaflet) at key points during antenatal and postnatal care is expected practice nationally. The Lullaby Trust[17] state that 'for some in more vulnerable situations, additional support in understanding and implementing safer sleep practices is required.' This is relevant to, and should also be required, when it comes to safe handing and coping with crying. This case shows that consideration also needs to be given to the risk the older children in a family may pose to the baby on a case by case basis.

3.30 Specific consideration needed to be given to how to ensure that any ICON plan considered the need for the older children in the family to be made aware of the need for safe handling and careful behaviour around the new born baby. Given the chaotic environment, lack of boundaries and the children not attending school on occasions during the pandemic, there was a possibility that the baby could be harmed by their older siblings and this needed to be considered and part of any plan, although this is not something that is usually part of the ICON programme.

COVID-19 had an impact on the family stressors and on the support provided

3.31 The national Child Safeguarding Practice Review panel published a briefing paper last year that considered serious safeguarding incidents reported to them during the initial COVID-19 outbreak (March – September 2020). Their analysis shows that COVID-19 exacerbated risk due to an increase in family stressors (including an increase in domestic abuse and mental health concerns alongside less wider family support), children not being seen as regularly, school closures, and difficulties with the requirement for ensuring safe professional practice. As stated by the health visitor in this case, there is an anxiety about what you may be missing when predominantly contacting families by phone. The national panel agree, by noting that 'virtual visits are not always effective in assessing changing needs and risks.'

3.32 In the case of Child R and her siblings, COVID-19 had a further impact. Although they largely continued to receive services despite the pandemic, the parents did not wish the older children to attend school due to fear of them catching COVID-19 and bringing it home. While most schools remained open for the most vulnerable children from day one of the first national lockdown and these children were invited to attend, they did not. The family reportedly had extended family members die from COVID-19 and Father had a long term health issue that they felt made him more vulnerable. This increased their fears and lessened their ability to manage during the national lockdowns. They were also living in overcrowded housing with no outdoor space, which was reportedly an additional stressor. Mother told the review that it was very hard managing the

[16] ICON stands for **I**nfant crying is normal, **C**omforting can help **O**kay to walk away and **N**ever ever shake a baby
[17] A charity that raises awareness of sudden infant death syndrome (SIDS) and provides expert advice on safer sleeping

children with no break. The school were aware of the vulnerabilities and worked to ensure contact, including undertaking door step visits to the family with food and school work for the children.

3.33 Children's social care and IFS continued to visit the most vulnerable children throughout the national lockdowns. This was the case even if there was COVID-19 in the home as they had access to some PPE (personal protective equipment) if needed. A red, amber, green assessment was undertaken in all cases, and this determined the risk to the children if a visit was not undertaken to a particular family. The children in this family were referred to CSC just prior to the first national lockdown in March 2020 and an assessment was undertaken regardless of the pandemic. A child in need plan followed which remained in place until the ICPC was held just less than a year later, during another lockdown.

3.34 It is relevant to note that recently published research shows that abusive head injuries in children have increased nationally over the period of the COVID-19 pandemic.[18] This is apparently due to the risks associated with children spending more time at home, less professional interaction, and the associated increase in parental mental health concerns. The NSPCC has highlighted the heightened risks to children of a non-accidental injury during the pandemic due to the increase in social isolation, and a lack of access to services and the ability for professionals to pick up on early warning signs. Financial insecurity[19] has also been a pressure for many families, which has historically been linked to an increase in non accidental injuries in children[20]. Data from April to September 2020 outlines a 31% rise in reported incidents of death or serious harm to children under 1 when compared with the same period in 2019.[21] The family of Child R were under increased pressure at the time, including from their experience of COVID and non-COVID related bereavements.

3.35 The rolling out of the ICON model of working with families to help them to cope with babies crying has been impacted by the pandemic, as it was a new model and not yet embedded at the time of the first national lockdown. The ICON message is not as powerful on the phone, tends to only be shared with the baby's mother, and there is no guarantee they will pass it on to others who may be caring from the baby, including fathers. By the time Child R was born, families were being visited and community midwifes and health visitors who were sharing the ICON coping with crying and safe handing / sleeping advice. Following a hospital birth is another good time to share the ICON message. In this case the father was unable to visit in hospital, so the ICON discussion and leaflet was shared with mother only in this setting. When a baby is on a child protection plan, as was the case with Child R , it is good practice for the conference chair to use the opportunity of the pre and post birth conferences to check that the ICON programme has been delivered, that the information was appropriate for the particular family's needs and to reinforce the ICON messages.

3.36 There was a particular impact on social workers across Britain who were often the only professionals going into family homes during the initial COVID-19 lockdown[22]. While guidance was clear that social distancing and basic PPE was required, social workers in the UK have reported that this is very difficult when visiting families in crowded housing, particularly when younger children initiate physical contact with the worker. There was also personal anxiety due to the expectation that social workers take health risks to try to protect children during the pandemic. There was also a capacity impact in CSC and other services when colleagues needed to shield due to health conditions or isolate for a period. For example just after the birth of Child R , the allocated social worker was isolating and a duty social worker had to undertake a planned visit to the family.

[18] Sidpra J et al (2021), Rise in the incidence of abusive head trauma during the Covid -19 Pandemic.
[19] Both parents in this case were said to be stressed about their financial predicament and housing situation.
[20] Huang, MI et al (2011) Increased incidence of non-accidental head trauma in infants associated with economic recession.
[21] Child Safeguarding Incident Notification System, 2021
[22] Harry Ferguson, University *of* Birmingham. Professional Social Work magazine 6.12.21

3.37 Not all services were undertaking direct work at the time due to COVID-19. The family were referred for a family group conference (FGC) when plans were being made for the arrival of the fourth child. This was appropriate as the wider family were known to be supportive and to have an awareness of the professional concerns. The IFS worker had a good relationship with family members and were aware they had concerns about the family. The school had also been told that the family were worried about the children. The FGC meeting was held on the telephone using group call functionality. The family plan was also reviewed without a face to face meeting. Those involved acknowledged this was not ideal and was likely to have been particularly difficult due to the learning and communication needs of the parents in this case. It may also have had an impact on the willingness of family members to share their concerns, and indeed they did not do so. How much this is due to the FGC model generally or the impact of attempting it remotely in the early days of the pandemic is not clear.

All professionals need to be reminded that when there is an injury to a non-mobile baby, child protection procedures need to be followed[23]

3.38 Prior to the non-accidental injuries being identified at the hospital, Child R 's mother contacted one of the midwives known to the family to report that the baby had a lump on their head, and that they did not know why. The midwife visited later the same day and described it as a 'grape sized lump'. The midwife sought advice and confirmed that the lump was not due to the birth. They suggested that the baby should be taken to the hospital and spoke to the paediatric medical assessment unit at the hospital to ask them to expect the baby. As she was aware that the baby was on a child protection plan and that there was an allocated social worker, this information was shared with the medical assessment unit. The family took the baby to hospital themselves. The midwife did not deem it necessary clinically to call an ambulance. She did not consider that that the baby should not be alone with its parents due to the potential of it being a safeguarding issue, and for the same reason did not consider informing out of hours children's social care of the injury (it was gone 5 pm by the time they visited the family). She did ring and leave a message on the allocated social worker's mobile phone. This message was not retrieved by the social worker until she returned to work some days later.

3.39 The relevant health trust have considered this matter and will reinforce how professionals need to respond to a non mobile baby with an injury and the need to follow child protection procedures in such cases even if it is an allocated case. This will include the process that should be followed to ensure that the baby remains safe until they are medically examined. The West Midlands procedures are clear that the health professional that identifies an injury needs to be frank and honest with parents/carers about the need to make a referral, and that they need to ensure that the baby is safe and not left alone with their parents/carers in the meantime. It is the responsibility of children's social care to arrange the medical and they need to be informed immediately to ensure that this happens as soon as possible.

3.40 When EDT[24] were contacted by the hospital sharing their concerns that Child R had presented with serious unexplained injuries, the hospital were asked to ensure that the parents had no unsupervised contact with Child R . However they returned home to care for the younger children. This was the case until 8:30am when the hospital safeguarding team and daytime CSC staff were made aware of what had happened and ensured that the parents were not unsupervised with the older children. This has been addressed with those involved in each agency and single agency learning has been identified.

4 Conclusion and recommendations

[23] https://westmidlands.procedures.org.uk/pkyzyz/regional-safeguarding-guidance/injuries-in-babies-and-children-under-2-years-of-age
[24] The EDT function is now (since June 2021) provided by the MASH 24 service.

4.1 This CSPR has considered the learning from Child R 's case and identified learning that will be helpful for the wider system. It shows that when long-term neglect is an issue due to the vulnerabilities and needs of the parents, support needs to remain in place[25] and there needs to be optimum communication between professionals and regular consideration of whether the children's needs can be met, even when a high level of support is being provided. The learning from serious case reviews and CSPRs shows that all professionals need to recognise neglect, understand the long term and cumulative impact of neglect and take timely action to safeguard children. This review has found this, along with the need to consider the possibility that other forms of abuse often co-exist alongside neglect.

4.2 Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. There has been excellent cooperation with this review from the majority of partner agencies, which was essential in establishing the learning from this case.

4.3 Having considered the learning not addressed in the single agency actions, the following additional recommendations are made to ensure improvement actions are taken:

Recommendation 1

WST and the CCG to consider how GP information on parents is appropriately and helpfully shared with any CSPR, as this is a local issue that impacts on the timeliness of reviews.

Recommendation 2

WST to seek assurance that the learning from this review is considered by those responsible for ICON training and support, and that ICON recognises the need for bespoke plans about safe handling for parents with learning difficulties and where there are older children in the family.

Recommendation 3

That the Task and Finish Group reviewing the WST Neglect Strategy consider the learning from this review.

Recommendation 4

WST to request an update from partner agencies on improving awareness of control and coercion and non-violent domestic abuse, including the aim for more cases of this kind to be presented at the MARAC.[26]

Recommendation 5

WST to seek assurance from MASH 24 (who now provide the out of hours function) and the relevant health trust that action has been taken to ensure that services are aware of the need to follow child protection procedures when a non-mobile child has injuries.

Recommendation 6

WST to request that the CCG and WCC work together to ensure that when children are the subject of a plan, this is recorded on the GP record of any adults in the household.

[25] It was raised during the review that the support provided to the parents from their advocates is only funded while children are on child protection plans. The relevant representative on the panel has responded to the advocacy agency regarding this.
[26] There is a current review of the MARAC and the learning from this review should be considered.