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Neglect

Child Safeguarding Practice Thematic Review

Summary Review - Families A & B & C

V1.1

Published 1st August 2025

Executive Summary

1 . Introduction

Child Safeguarding Practice Reviews are undertaken when children or young people are seriously harmed or die as a result of abuse or neglect. The purpose of each review is to look at how local professionals and organisations worked together to safeguard those at the centre of any review and consider how practice and partnership working may be improved.

Warwickshire Safeguarding Children's Partnership (WSCP) agreed to commission a Child Safeguarding Practice Review in response to the notification of a family with three young people who were well known to multiple agencies and had experienced chronic neglect. (Family A).

During the planning stage, another family with a young person suffering from chronic neglect was referred to the partnership (Family B). Given the similarities in their experiences, the WSCP obtained agreement from the Child Safeguarding Practice Review Panel to undertake a Thematic Review, including the young people from both families.

Towards the end of the review, a third young person, who had been exposed to long-term neglect, was referred to the Partnership following their death (Family C). It was agreed with the National Panel that their experience would be compared to that of the two original families to determine whether the findings of the rapid review were relevant to this child and their family.

The timeframe for the review was set over 35 months to incorporate key practice episodes. This duration was determined based on findings from a previous Warwickshire Serious Case Review[1] of children experiencing chronic neglect. The thematic review also considers whether those findings had any impact on the work undertaken by agencies with Families A & B.

The young people and the parents of the families A and B were all encouraged to take part in the review although none of them wished to do so. A number of staff who had worked directly with families A and B in the past and some that currently work with the families, were able to reflect and give their opinion of what they thought family members might wish to say to the Review.

The review has had the involvement of two independent reviewers. Maureen Floyd[2] has been the Lead Reviewer and oversight has been provided by Bridget Griffin[3].

[1] *Serious case reviews (SCRs) were introduced in the first edition of Working Together, published on the same day as the Cleveland inquiry report in July 1988. They were replaced by a new system of local child safeguarding practice reviews (LCSPRs) in 2018-19.* Serious case reviews 1998 to 2019: Continuities, changes and challenges HMG December 2022

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Background

Family A

The married couple had three daughters, referred to in this review as Jess, Ashley, and Blake. All three young people have Education, Health, and Care Plans[4] in place. The two eldest attended special schools and the youngest received support within a mainstream school.

All three young people have experienced years of chronic neglect. Concerns about hygiene, chronic headlice infestations, and poor home conditions have been known since 2010. The young people have been subject to a myriad of multiagency interventions over a period spanning in excess of thirteen years.

Initially support and intervention was provided through Early Help and the Child Assessment Framework, Child in Need Plans and three periods with Child Protection Plans. Additionally, efforts were made to put the matter before the Family Court to seek to remove the children from their parents' care.

The first Child Protection Plan was prompted by a visit from Police and Children and Families during which the house smelt of urine and the carpet could not be seen due to clutter, rubbish and faeces. The family home was treated for flea infestations and the family moved out on several occasions to enable deep cleaning to be completed.

On numerous occasions the children were not brought for medical appointments, although multiple visits were made to the hospital emergency department. The schools that they attended often washed and fed them in addition to giving them sanitary products as they were not provided with them, nor was their use encouraged at home. Routinely, they experienced being avoided **or** ostracised by their school peers. Multiple concerns of sexual abuse were raised, however investigations remained inconclusive.

The young people were exposed to, and frightened by, domestic violence and financially controlling behaviour at home. It is understood that father controlled the finances coming into the home. Mother would struggle to feed the children, although father was excessively obese and lived of takeaways brought solely for himself**.** The two oldest children's school noted their hunger and provided them with breakfast almost daily across the school years. Psychological assessments of both the parents found they had no specific learning needs or cognitive impairment.

During the scoping period of the review, the father died unexpectedly of natural causes.

Jess is the oldest sibling in Family A. She is classified as suffering Severe Developmental Delay, diagnosed with Autistic Spectrum Disorder (ASD), she had been frequently incontinent and left without pads to help. Since becoming an adult Jess has been made the subject of the Court of

[4] *An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs. Children with special educational needs and disabilities (SEND): Extra help - GOV.UK (www.gov.uk)*

Protection[5] in respect to her limited capacity. Following the review period, it was noted that Jess had moved from the family home into supported living where she has settled into a routine of eating healthily and learning self-care skills. Concerns have been raised regarding Jess watching YouTube animations of rape, sexual abuse, and domestic violence, which she reportedly finds 'very funny'.

Ashley, the middle sibling has been diagnosed with ASD, has learning difficulties and requires Social, Emotional and Mental Health support (SEMH) in school. Ashley has recently been questioning their gender identity and uses the pronouns their/them. Whilst living at home, Ashley experienced repeated Urinary Tract Infections and would often be sent to school wearing ill-fitting inappropriate clothing for the weather conditions. For Ashley, school was a safe place, and they would often articulate they wished they could live there. Ashley now lives in an independent single person accommodation with support provided.

Blake, the youngest sibling in Family A, has experienced a significant shift in their gender identity over the past three years. Blake was born female and throughout the three-year scoping period they identified as male and asked to be referred to as such. However more recently they have asked to be referred to as female. It seems that Blake's needs may be influenced by their home environment, where they might not have had their needs consistently met. Academically, Blake has faced challenges and has often been behind their expected level of achievement. Additionally, Blake has a long history of poor school attendance, poor hygiene and presentation which contributed to social difficulties with peers. There is no formal diagnosis of a learning disability for Blake. Blake expresses a strong desire to continue living at home with their mother, and efforts are being made to support this arrangement.

Family B

Family B consists of one daughter born to married parents, who for the purposes of the report will be known as Maisy. She lived with both parents until they separated when she was 13, and since then she has lived for varying periods with each of them. Mother was injured as a child resulting in long lasting impairment. Father has a learning disability and receives support from Adult Services. In respect of Maisy, there is a history of chronic neglect, poor hygiene and nutrition. Maisy would remain unwashed for long periods of time. Maisy has excessive tooth decay, wears size XXXL men's clothing and in the GP's view, has difficulty walking due to rarely leaving her bed and not exercising. Maisy suffers from social anxiety and has presented with selective mutism[6] since primary school, speaking only to close family. She had not been in school for several years. No boundaries have been in place regarding her online use and there have been several incidents where exploitation was a concern. Her parents were reluctant to challenge her as she would shout and threaten them physically. Father advised to social care staff at the time, that he would often try to play the same online game as Maisy to enable him to monitor her use but frequently would be blocked by his daughter. Both parents have said they were scared of Maisy.

[5] *The Mental Capacity Act created a new Court of Protection which is a specialist court that deals with all issues related to the MCA. It deals with decisions concerning both the property and affairs and the health and welfare of people who lack capacity. It is particularly important in resolving complex or disputed cases, for example, about whether someone lacks capacity or what is in their best interests.* Mental Capacity Act. Making decisions A guide for people who work in health and social care. OPG603

[6] Selective mutism - NHS (www.nhs.uk)

Maisy has been known to services since she was 4 years old. At the age of 14 she became subject to a Child Protection Plan. Subsequently, at the age of 16, she was made subject to a Care Order which enabled the Local Authority to share parental responsibility, and Maisy was moved to live in a suitable placement, where she maintained regular contact with her parents. It is understood that she returned home to live with father when she reached 18.

Family C

The final child referred to the Partnership for a case review will be referred to as Taylor. Taylor, an older teenager, was part of a large family and sadly passed away unexpectedly due to a chronic medical condition that had not been managed effectively.

The family were known to services from 2005, initially due to domestic abuse and later from 2010 due to issues regarding poor home conditions.

At the time of Taylor's death, the home was described as in a very poor state. Reports highlighted that it was extremely cluttered and unclean, with strong odours of urine and cannabis. There was no bedding, the bathroom was unusable, and cat litter trays were overflowing. Mould was present, and the overall condition of the property was described as unkempt and unsanitary.

Taylor and their siblings were reported to have missed a significant amount of school. Despite this, the school made considerable efforts to support Taylor, including providing uniform and developing individual lesson plans to encourage attendance. Taylor had also disclosed to school staff, and on one occasion to police during an unrelated visit, that they were experiencing hunger.

2 Key Lessons and Recommendations

Identification and Response to Neglect and Emotional Harm

1. Recommendation One – Warwickshire Safeguarding Children's Partnership

The WSCP to agree and implement a standard Neglect Assessment Tool to help staff make decisions. This tool needs to be part of a clear multiagency pathway to ensure consistent decision-making. The chosen Neglect Assessment Tool should be introduced across the multiagency workforce and used when there are concerns around neglect.

All these children were identified as suffering neglect at a young age, and all have received multiagency services thereafter. What is recognised is that the neglect has been a persistent, chronic factor, and whilst multiagency measures were taken, none of the children's experience really changed until very recently. Historic interventions led to short term improvements, which in turn led to focus and support being reduced; and the situation deteriorated again. This pattern was repeated in all the families. There was challenge, particularly from schools about change not being sustained, but their view did not hold sway.

On a fundamental level it would be useful if all practitioners used the same measure for determining whether the child is experiencing neglect. By their own admission practitioners' clear

recognition and understanding of neglect is at best ambiguous; therefore, adopting an accepted multiagency tool by which to identify and measure neglect, would ensure there was consistency across the workforce.

This would provide the same starting point and measure to determine what has or has not changed when revisiting the child's circumstances. This would enable clarity in determining whether changes had occurred, over what timescales and where challenge and or focused support might be required.

This approach would help the legal team in neglect cases by addressing the common issue of not being specific about the harm suffered and the meeting of thresholds during the pre-proceedings process. This lack of clarity can make it hard to evaluate parental progress, which risks being too subjective, and can cause delay.

Children & Families Service confirmed that there is an extensive piece of work being undertaken on neglect in general and specifically in relation to embedding the toolkit originally devised from the Wilson CSPR. A task and finish group has met, and the work is in progress. Confirmation was provided that membership will increase to reflect the wider multiagency group.

In April 2024 Warwickshire was accepted into Wave Two[54] of the government funded Families first for children (FFC) pathfinder programme and family networks pilot (FNP). This was a government response to the findings and recommendations of the Josh MacAlister review of Children & Families Service[55] and has four main objectives:

1. establishing local multi-disciplinary family help services
2. a child protection system which protects all children from significant harm
3. greater use of family networks
4. stronger and clearer multi-agency safeguarding arrangements

The collaborative whole safeguarding systems change has been positively welcomed and embraced by the partnership. Currently, multi-disciplinary teams are in the early stages of being formed and anticipated to bring positive change particularly with multiagency audits and joint supervision arrangements. Consideration will be given to exploring best practice models such as the Norfolk Joint Agency Group Supervision (JAGS)[7] approach.

2. Recommendation Two: Warwickshire Safeguarding Adult's Board and Warwickshire Safeguarding Children's Partnership

Raise awareness of the important role that adult agencies play when working with families known to Children & Families Service. Ensure that in every assessment completed on a parent, reference is made to their parenting role and how the duties under the Care Act and Think Family will be addressed and explored. Ensure clear information is provided to inform decision making in respect of the children; and support to parents is clearly described.

[7] https://norfolklscp.org.uk/about/policies-procedures/managing-individual-cases-where-there-are-concerns-about-a-childs-safety-and-welfare/316-joint-agency-group-supervision-procedure

There were examples across the lives of these families that a Think Family approach was not achieved. For example, the father in Family B was the primary carer for his daughter, however when the Care Act assessment was finally completed; consideration was not given to whether he required any support with carrying out his caring responsibilities. This should have been addressed within his eligible needs and included in his support plan.

It is important that, as far as possible, services assessing parents can provide clear information to support the decision making of children's services.

Child Protection Planning

3. Recommendation Three: Warwickshire Safeguarding Children's Partnership

The WSCP to consider and effect a specific escalation process, which includes multiagency overview of cases that do not achieve consensus at CP Conferences, be that in adding or removing children's names from CP Plans.

Eileen Munro in 2008 said '*...the best guide to future behaviour is past behaviour*[53] this was true for both families. The neglectful care of the children was known at a young age, repeated efforts were made to engage, help, and support parents to bring their care to an acceptable standard to promote the safe care, welfare, and development of their children. Despite much intervention, this was not achieved.

Whilst it was beyond the scope of this review to scrutinise what got in the way of achieving those aims in the children's early years.; it is however important to note that whilst good work is routinely done by the child protection workforce in safeguarding children from neglect, providing a robust timely response to cumulative neglect remains a national challenge.

For those more intractable cases it is vital that there is a clear multiagency overview of the children's history and their daily lived experience in addition to their parents' history and ability to recognise and work to address the concerns. This must be in the context of the children's timescales; two were adults and the other two 16 years old when positive change was finally achieved. For Family C, the death of Taylor led to statutory child protection intervention to safeguard their siblings.

In one of the families when it was decided to end the child protection plans there were objections voiced by members of the multiagency network on the basis that sufficient improvement had not been achieved or sustained. These were valid objections, however, there was no evidence that these objections were formally considered.

4. Recommendation Four: Children and Families Service & Legal Services

Evidence based parenting assessments are critical in safeguarding children from neglect. The assessments should inform professional judgement overtime and be a benchmark on which progress is measured; they should not be overly repeated in the same family.

When considering legal proceedings, Legal Services should give clear guidance as to the type and standard of assessments that are acceptable to the Courts. By taking this approach to neglect, unnecessary repetition and delay in achieving better outcomes for children will be avoided.

Family A took part in a minimum of five Parenting Assessments between 2014 and 2021 and despite the parents repeatedly being unable to evidence that they could provide good enough care, the children remained living together with them.

In August 2020, the children were made subject to a third CP Plan, and it was agreed that the local authority would begin the Public Law Outline to instigate court proceedings to have the children removed from their parents' care. A further parenting assessment was deemed necessary to start the court proceedings, which was completed in November 2021.

Overall, seven years of parenting assessments repeated the same conclusion that the parents could not adequately parent their children. It would be helpful if the standard of formal parenting assessments was identified and agreed in order that repetition and delay could be avoided to get the matter before the Courts.

Parenting assessments were undertaken repeatedly with Families A and B. The first, in 2015, concluded that the parental care was not good enough. Programmes of work were undertaken which included both sets of parents engaging with parenting courses, albeit unsuccessfully.

Family A competed the Triple Parenting Course three times, with little or no discernible difference being achieved. Slight improvement within the home conditions were often seen as sufficient reason to step down from child protection, yet the improvements were achieved by external intervention rather than the parents' actions and despite these interventions, there was little or no improvement in the children's day to day lived experiences.

Robust evidence-based assessments are vital tools used to determine whether children are suffering or likely to suffer significant harm; furthermore, they can help establish whether the parents or carers are capable of meeting the child's needs now or in the future; and what support is required to help them achieve that aim.

5. Recommendation Five – Warwickshire Safeguarding Children's Partnership

The WSCP recognises that multiagency chronologies are appreciated as a highly important tool in safeguarding children and their introduction requires early implementation to become routine across the multiagency workforce.

To support this, WSCP will complete a briefing to facilitate the embedding of multiagency chronology use.

Multiagency chronologies are important not just to safeguard children from physical or sexual abuse, but in particular, in cases of cumulative neglect, where physical abuse and child sexual abuse can coexist.

The schools had extensive records of incidents of concern about the children in these families such as witnessing domestic abuse, exposure to and acting out inappropriate behaviour and multiple examples of chronic neglect. These were regularly reported, but issues continued to be dealt with in isolation. In Family A there were many missed medical appointments and evidence that hospital Emergency Departments were used akin to the GP. Maisy in Family B was facing multiple extractions and fillings, which required intervention when she was finally seen by a dentist.

The involvement of multiple agencies, that collectively held a vast amount of information about all of the children's experiences, was not brought together to provide a holistic view. Experience of CSPRs, Rapid Reviews and the experiences of those partnerships who currently use multiagency chronologies has illustrated the power of multiagency chronologies in grasping the holistic view.

6. Recommendation Six – Warwickshire Safeguarding Children's Partnership

In all cases where there are concerns about sexual abuse, in-depth pattern analysis of all multi-agency information should be undertaken. Ensure that information held by agencies within sector, community and voluntary sector is included. Analysis should include consideration of a child's behavioural patterns and of the language used.

To support this, WSCP will complete a briefing to facilitate the embedding of the learning.

Allegations of sexual abuse from the children in Family A, and their sexualised behaviour, were responded to in isolation. Their worrying and 'odd behaviour' in school; particularly prolific sexualised comments and drawings, references to concerning situations with other adults in their home, and multiple incidents of urinary tract infections, were all elements of the concerns raised. Collectively, this information was not pulled together as showing patterns of behaviour over time.

Given the increased vulnerability of children with disabilities it is important for the multiagency group to collectively consider any such allegations and behaviours using guidance, such as the Brook Sexual Behaviours Traffic Light Tool[8]. Whilst this tool is currently in use within Warwickshire, there is no evidence to suggest there was any focus on the possibility that the children were being sexually abused. Their behaviour and presentation were not considered collectively nor the specific sexual abuse tool used to assess their circumstances.

7. Recommendation Seven – Warwickshire Safeguarding Children's Partnership

For children exposed to domestic abuse, any plans (CP, CIN or Early Help) drawn up for them are required to make specific reference to the type of domestic abuse and the impact of this abuse upon them and their parenting and what support is to be provided to address the issues.

To support this, WSCP will request all partner agencies to include the above requirement into their relevant training programmes.

The norm of living in a household where domestic abuse was the everyday experience did not appear to be documented, challenged or addressed. It is not clear if there was explicit recognition of the children's experience or understanding of what they were experiencing on a day to day basis. The domestic abuse was an additional risk on top of the chronic neglect and caused considerable anxiety and fear to the children in their daily lives. The consequences of the children's daily exposure to domestic abuse did not feature in the plans that were made.

It is understood that recognition and acknowledgement of a child's experience of exposure to domestic abuse must be overt and actively addressed. Ensuring children's plans make specific reference to this abuse promotes the child and adult's understanding that domestic abuse is harmful and should not be tolerated. The impact of such exposure on the children should be clarified and be addressed within any plans.

Findings from previous Serious Case Review

8. Recommendation Eight: Warwickshire Safeguarding Children's Partnership

The multiagency partnership to determine what would make a tangible difference to the Escalation policy, consider the benefits of introducing an independent element at the final stage and multi-agency workshops to practice and promote professional dialogue and challenge.

To foster a robust culture around professional challenge and escalation, WSCP will undertake further work to embed the Escalation Policy effectively.

[8] CPD: Brook Sexual Behaviours Traffic Light Tool (RSE) Course

This review considered whether the learning from a recent Warwickshire Serious Case Review, where neglect was evident, had been disseminated and embedded effectively. Learning from the Review has been disseminated but it is not clear that the culture, including a systemic approach to challenge and escalation, has fundamentally changed. Feedback from practitioners confirmed the high staff turnover of social workers and first tier managers within Children & Families Service may provide insight into why little tangible difference has been achieved.

Conference Chairs and Independent Reviewing Officers are well placed to bring informed challenge to multiagency meetings, despite this and incidents of escalation, formal review and change to usual practice was difficult to achieve in these cases.

It was recognised that staff need time to become familiar with case histories, for multiagency chronologies to be completed in addition to using supervision and multiagency discussion to challenge approaches and outcomes. These should be common practice.

It seems important for an analysis of escalations, submitted through the Escalation Procedures, and the use of internal or external challenge to be reviewed. In addition, feedback from the referrers on the outcomes would help nurture a culture of healthy and open challenge. It was agreed that opportunities to reflect on multiagency practice is of benefit to all concerned and are welcomed, and that consideration should be given to holding workshops to practice and promote professional dialogue and challenge. Joint Agency Group Supervision, previously mentioned, would provide a forum where this could routinely happen.

Equality and Diversity

9. Recommendation 9 – Warwickshire Safeguarding Children's Partnership

The WSCP to ensure multi-agency partnership continues to raise awareness of issues of disadvantage and other protected factors that impact on safeguarding children. WSCP to put strategies and support in place to address any issue that may rise case by case.

To embed the learning, WSCP will request all partner agencies to include the above requirement into their relevant training programmes.

WSCP will complete a briefing to facilitate the embedding of the learning.

The families had multiple experiences of potential discrimination and disadvantage including, parental Learning Disability, mental ill health, impoverished living conditions, limited income, children with Special Educational Needs. There was evidence that some of these characteristics were impacting upon their lives although it was unclear how these experiences were explored or considered.

The experiences of these families highlights the importance of supporting multiagency services to understand how experiences of inequality and discrimination are considered when seeking to engage families in providing the support they need.

10. Recommendation 10 – Warwickshire Safeguarding Children's Partnership

The WSCP will complete a briefing to enable the multiagency workforce to increase their awareness in working with parents, children and others where there are gender identity needs identified.

Two children within Family A have questioned their gender identity, the youngest has for some years described themself as a 'trans male' and changed their name to the masculine version. There was evidence to show that their preferred gender identity has been recognised by all practitioners working with them

The middle child has more recently identified as non- binary and has asked to be called by a non-gender specific name, their wishes have been heard and their non-binary identity recognised. What is not clear is whether any work is being undertaken, or support provided to either of them to help them understand what this means for them and determine if they are protected from any potential discrimination because of their preferred gender identity.

The outstanding issue is predominantly with ensuring that the children are getting support with their gender identity decisions, that will enable them to have understanding and awareness of some of the issues they may need to face in the future. Agencies and practitioners would welcome more training and support to gain confidence in working with children and their families with questioning gender identity.

Conclusion

The experiences of these children reflect the experiences of other children who suffer long term cumulative neglect, which can typically include sexual, physical and emotional abuse. Intervening effectively in cases of cumulative neglect is a complex area of safeguarding work and is recognised as a national challenge. Multi-agency partnerships across the country are at different stages in developing a coherent multiagency response to neglect. The Child Safeguarding Practice Review Panel have recognised these national challenges and a report addressing these issues is due for publication this year. Warwickshire Safeguarding Children's Partnership are clear about the systemic changes that are needed and, in learning from the experiences of Jess, Ashley, Blake, Maisy and Taylor, are committed to taking forward the recommendations set out in this CSPR.

Maureen Floyd

Independent Lead Reviewer
March 2025