Child Safeguarding Practice Review:
BSCP 2019-20/01

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This review was undertaken in 2019 and therefore references statutory guidance at that time, and research, up to that point.

1. Background to the Report

1.1 In July 2019, Birmingham Safeguarding Children Partnership (BSCP) commissioned a Local Child Safeguarding Practice Review (LCSPR) following the death of a three-month-old baby, to be referred to in the report as 'the baby'.

1.2 The review focuses on identifying systemic learning. The Review has identified eight key themes which provide a framework for the emerging learning points that are aimed at improving how partners work together to safeguard children. The key themes are:

- Effectiveness of multi-agency working
- Professional curiosity
- Disguised compliance
- Understanding the risks to children when parents are misusing substances
- Effectiveness of the in-year admissions process for education
- Recognising what constitutes neglect and that neglect is a form of abuse
- Children hidden from sight
- Appropriate temporary accommodation for families

2. Introduction

2.1 The Family

2.2 The baby was the third child of a white British family. The two older siblings were aged seven and two years old (they will be referred to in the report as Child One and Child Two). The parents had been together for 14 years at the time of the baby's death. The family was known to agencies in Birmingham, in particular the father who had a history of drug and alcohol misuse and criminal behaviour. The family, and extended family, lived in Birmingham and the maternal grandparents helped care for the children, including taking Child One to school.

2.3 The father contributed his views to the review. Regrettably, the mother chose not to take part in the review and therefore the review has not been able to capture her views, nor learn from her experiences of the services the family received.

2.4 Summary of case

2.5 In May 2019, an ambulance was called to the family home. The baby was found deceased, and it was apparent that death had occurred significantly earlier. Both parents were arrested on suspicion of neglect. The mother tested positive for heroin and cocaine and admitted using three bags of heroin a day whilst pregnant. The father declined testing.

2.6 Both parents were found guilty of exposing Child One and Child Two to Class A drugs. The mother was found guilty of wilful neglect of the baby in October 2021. The cause of death of the baby was unascertained.

2.7 Significant Events During the Period Under Review

2.8 The table below provides a chronology of the key practice episodes that helped inform the Review Team's analysis of partnership intervention, assessments, decisions and actions taken during the period under review. Please refer to Appendix 4 for Glossary of abbreviations

Date	Event
24.3.17	Anonymous referral to National Society For the Prevention of Cruelty to Children (NSPCC) who then made a referral to Children's Social Care (CSC). Concerns of "parents taking and dealing drugs and children not fed properly and left to cry for hours". Child One had said previously at school that their father smelt of "weed". Child One's school bag smelt of cannabis. The father had been recalled to prison for breaching his Suspended Sentence Order four days previously.
8.5.17	Child One disclosed at school that Child Two, was 9 months old at that time, "hits me, punches me in the face".
9.5.17	Child One seen at school with "tennis ball size bruise on leg which looked like finger marks". Child One gave conflicting explanations for how the bruising occurred. School One informed CASS Education Officer.
25.5.17	The father was seen by prison assessor. Drug and alcohol use identified as significant factors. The father said he used £60 of heroin a day.
31.10.17	Referral to Children's Social Care from West Midlands Police (WMP) Sex Offender Manager. Intelligence that a registered sex offender was having contact with the family. Assessment done under section 17, Children Act 1989, Child in Need.
14.11.17	The father was seen with an injury to his arm. Says he was attacked outside his house the previous evening by men with baseball bats.

29.1.18	Family presented to the Council as homeless and rehoused in temporary accommodation.
26.1.18	School One makes referral to CSC stating the family's recent lack of engagement with professionals. The mother offered further assessment by CSC but declined the offer. Case then closed to CSC.
19.5.18	The mother attended Queen Elizabeth Hospital Emergency Department with an injury to finger which she said had been caused by punching a mirror two weeks previously. She was referred to hand surgeon but self-discharged against medical advice.
11.6.18	The mother attended the Early Pregnancy Assessment Unit. Approximately six weeks pregnant.
25.7.18	The mother arrested for stealing three bottles of whiskey in a shop and refused to give a drugs test.
2.8.18	The father was given a custodial sentence for burglary. He tested positive for Class A drugs on arrest. He said he was using £40's worth of heroin and £40's worth of crack cocaine every day. The National Probation Service made a referral to CSC.
12.9.18	Family moved to second temporary accommodation home.
11.10.18	The father was released from prison.
12.10.18	The Prison Service informs the father's GP practice that he will need to be prescribed Naltrexone - a drug used to treat opioid and alcohol addiction, now he is back in the community.
Early February 19	The baby was born at home. There were significant delays in the family contacting the Birmingham Women's Hospital Birthing Centre following the birth and bringing the baby into Hospital.
May 19	The baby died.

2.9 The family had limited engagement with agencies following the birth of the baby, so little is known about the baby's lived experience. The professionals supporting the family did not have any significant concerns. The home was always in a reasonable state and the parents presented well and so did the children, which is more likely not to be the case when parents are using Class A drugs. At a Learning Event hosted by the Lead Reviewer, practitioners indicated that there were many families that they work with about whom they have many more concerns. There is a normalisation for professionals working with families who are experiencing poverty and homelessness and a need to better understand the children's lived experience. Child One did not look malnourished but disclosed that they only had five cornflakes for breakfast and a neighbour had intervened to buy them fish and chips because they had no food, which was seen as unremarkable. Despite their limited

engagement, the information professionals had about this family should have led to greater professional curiosity and acted as a catalyst for further action.

2.10 It is easy to be wise with hindsight. It only became apparent after the baby's death that the mother was using heroin. However, there were signs that were overlooked or not understood at the time.

3. Key Themes and Learning

This review was undertaken in 2019-2020 and assesses multi-agency safeguarding practice against national guidance at that time. In the intervening period since the tragic death of the baby in 2019, there has been considerable change both nationally and locally in the partnership landscape and improvement in safeguarding practice. Agencies acted quickly to take forward the early learning from this review, with eight agencies identifying fifteen areas for potential improvement in their safeguarding arrangements and systems. Each agency had their own action plan, as well as being a part of a multi-agency action plan. All action plans are now complete. BSCP has sought assurance and evidence that the internal learning has been embedded and that significant progress on the implementation of the emerging multi-agency leaning has taken place.

3.1 Effectiveness of multi-agency working

3.1.1 There were some good examples of effective multi-agency working by a number of agencies and professionals, but there was also inconsistency in the quality of information sharing, to co-ordinate partnership intervention, and therefore on too many occasions agencies were working in isolation.

3.1.2 It was known that the father was unemployed and spending a huge amount of money daily on his drug and alcohol addiction. The father was in and out of prison – he had received 10 custodial or community sentences between 2006 and 2019 and had a very long history of offending, mostly for acquisitive crime and violence. There was a lot of anti-social behaviour directed at the parents and the family home. The mother was arrested for stealing alcohol, both parents refused drugs tests at different times, and the mother had grown up in a family environment where the use of Class A drugs was normalised. The parents argued frequently and there was insufficient food for the children on at least two occasions. Child One was frightened of their father being arrested again and the police coming. Child One disclosed being hit and also sustaining a leg injury, over a short period of time. The child also gave conflicting accounts of how the injury was sustained. There were also multiple missed or cancelled appointments for both the parents and the children across a range of agencies.

3.1.3 The prison communicated with the GP about the father's release, but this focused on the father's medication. Neither the prison drug service nor the

GP considered whether the father posed a risk to his children. CSC did not speak to the police about the sex offender who had contact with the children. Liaison with relevant agencies should have taken place as part of their assessment.

3.1.4 When the mother was pregnant with the baby the father did not attend antenatal appointments and the midwife knew nothing about him. Despite asking the mother, the midwife was not made aware of the father's history and his drug and alcohol misuse. The father was not fully considered by professionals, nor engaged with. The father said he had no engagement with health professionals but indicated he was not often at home in the daytime.

3.1.5 The community midwife was not aware of the circumstances of the baby's birth. This was crucial information that should have been shared with the Community Midwifery Service, with their specialist knowledge and experience. The unusual circumstances of the birth would have most likely triggered closer intervention and professional curiosity, which is what should have happened.

3.1.6 Professionals working with the family expressed shock and surprise that the family were placed in what they considered to be inappropriate accommodation but did not escalate their concerns effectively. None of the agencies spoke of the Resolution and Escalation Protocol[1] when discussing the challenges of speaking to other agencies.

3.1.7 If there had been more effective information sharing agencies would have had a better shared understanding of the family's lived experience, their strengths and the risks, as opposed to the perceived strengths and risks assessed by individual professionals and individual agencies operating in isolation.

3.1.8 Assumptions were made by professionals as to who was doing what, without speaking to those professionals. Sometimes the assumptions were incorrect. In addition to this, other than when CSC was involved, there was no lead professional identified to coordinate early help and support by partners.

3.1.9 In October 2017, CSC was informed by West Midlands Police that a known sex offender was associating with the family. This resulted in CSC undertaking an assessment under s.17 of the Children Act, 1989 i.e., Child in Need. There should have been a strategy discussion under s.47, Children Act 1989 i.e., Child Protection because of concerns about the mother's ability to protect her children. The father was in prison at that time.

[1] http://www.lscpbirmingham.org.uk/images/BSCP/Professionals/Procedures/Resolution_and_Escalation_Protocol_FINAL.pdf

3.1.10 In August 2018, the National Probation Service made a referral to CSC with regard to father's heroin and crack-cocaine use and the fact that the mother and two young children were living in temporary accommodation. The father had received a 26-week custodial sentence for acquisitive crimes. CSC responded to the referral the following day stating that "the referral did not meet threshold for intervention". They stated that "there seemed to be no clear consent for intervention and no safeguarding concerns shared, father has been sentenced and is taking drugs however we need to have further details of the impact on the children and whether mother consents for support. Your referral is recorded for information purposes only". There was enough information in the referral for Children's Advice and Support Service, to have instigated the multi-agency safeguarding hub to undertake checks with partner agencies, which would have confirmed Early Years and police involvement with the family.

Learning Point One

Effective multi-agency working is key to protecting children, the BSCP should consider and be assured that:

- Practitioners, including those agencies working with adults, are familiar with expectations and requirements in respect of information-sharing in line with Right Help, Right Time guidance.

- Arrangements are in place for effective communication between HMP offender managers, sex offender managers, GPs, CSC and all other relevant agencies on the release of a prisoner who may pose a risk to children.

- All agencies working with men need to consider whether those men have children in their lives, or a pregnant partner, and the strengths and risks the individual may present to those children to inform what action should follow.

- Probation (and with it their links to the Prison Service) are a key partner within MASH to help facilitate effective information-sharing and co-ordination of support.

- The exchange of information within CASS/MASH receives prompt responses from all agencies to enable professionals to make timely and proportionate decisions.

- Efforts are being made to make systems across agencies more compatible which allow professionals to communicate with each other with greater ease. It should be noted this is a national, as well as a local, issue.

- The multi-agency referral form should be amended to allow for the inclusion of information about those agencies already involved to offer

support to the family, such as Early Help, and details of the named professionals and practitioners.

- The quality of referrals is consistent and there is sufficient understanding of the Resolution and Escalation Protocol.

Learning Point Two

The Early Help and Support arrangements should highlight the importance of the lead professional role in coordinating the work of agencies involved with the child and the family.

3.2 Professional curiosity

3.2.1 The terms on which professionals worked with this family were very much dictated by the parents. The fact that the professionals liked the parents, and the parents seemed to make an effort with them, appears to have influenced how professionals viewed the family. The parents presented as plausible and too often professionals accepted what the parents said at face value.

3.2.2 A number of professionals working with the family knew that both the maternal grandparents had a history of drug misuse, as did the maternal aunt, whose child had been removed from her care. The mother was very close to her family and yet there was no curiosity around the fact that the mother had grown up in this environment and her partner misused drugs. This knowledge should have made professionals question the likelihood of the mother being an illegal drug user too. Part of the challenge was that some professionals knew about the father's drug misuse, whereas others did not, and some knew about the mother's family history, but others did not.

3.2.3 Child One had asthma. There can be a link between drug-using parents and children having asthma. This is something that should always be considered as a possible cause by health professionals and is also a theme which has arisen in two local child safeguarding practice reviews in Birmingham recently. This could have been an opportunity for professionals to explore, particularly as Child One mentioned their father smoking "weed" and the school had observed Child One's school bag smelt of cannabis.

3.2.4 When there was an anonymous referral to the NSPCC it was an opportunity for CSC to consider why someone was raising concern that the parents were taking and dealing drugs and the children not fed properly and left to cry for hours. Had lateral checks been done this could have provided a comprehensive picture of agencies' involvement with the family and led to multi-agency communication about the circumstances for the child.

3.2.5 As stated elsewhere, the parents would constantly rearrange appointments

but none of the professionals explored what the reasons were for this. Neither parent worked. Their mobiles were constantly switched off or engaged or numbers changed, and no professional demonstrated curiosity about the reasons behind this.

3.2.6 Because the family was so plausible they were able to control the contact between professionals to some degree. They would report to one professional what another was doing but when asked by one professional for the contact details of the Think Family worker the mother said she could not remember her name, which is highly unlikely as she had worked closely with her. Too often professionals accepted what the parents said, in terms of other professional involvement, without clarifying information with the other agencies.

3.2.7 None of the professionals working with the family knew that the mother had convictions for threatening behaviour, assault and antisocial behaviour. This was all relevant information because she was the primary carer of the children.

3.2.8 None of the professionals working with the family knew the details of the father's criminal history, which was long and included threatening behaviour, acquisitive crime and assaults. When he was arrested for a dangerous driving incident in 2009 there was an 18-month-old child in the car. The police found a knuckle duster and a knife in the car, that no one asked about, nor considered the child's safety and wellbeing.

3.2.9 When the father was released from prison a number of professionals knew that he had been attacked and there was antisocial behaviour directed at him and the family home, but no one questioned why, nor addressed this. It was also known by some professionals working with the family that he owed "acquaintances" money, but it was not known why or what for, and those questions were not asked.

3.2.10 As well as professionals not exploring why the antisocial behaviour was happening, no steps were taken to disrupt the behaviour, taking into account the impact on the children and the family if they moved. The solution was to move the family, with all the disruption that would bring, rather than addressing the problem. Consideration should have been given to the fact that Child One would be likely to have to change schools as a result of moving.

3.2.11 The father had been ordered to attend an alcohol treatment programme in prison, but he did not attend it and it was then removed as a requirement. There was no curiosity as to why he had not attended the programme and what the likely implications would be on his children and partner. There was also a lack of professional curiosity as to how he was coping with the stresses he had in his life. It was known that he was using heroin, crack cocaine, cannabis and alcohol, which suggests his drug use was out of control.

3.2.12 The mother missed a number of her antenatal and postnatal appointments and there was a lack of follow up, even though there is a strong link between mothers not attending antenatal and postnatal appointments and there being a cause for concern. At the time of the baby's birth a hospital midwife did do a lateral check when the baby and mother were admitted. They saw the family had been open to CSC but was now closed. There was no curiosity as to what CSC's involvement had been, or why the case had been closed.

3.2.13 Other agencies that knew Think Family was involved could have spoken with the Think Family worker to establish circumstances, and not relied on self-report by the parents.

3.2.14 When the mother said she was not allowing a convicted paedophile to have unsupervised contact with her children, even though at the same appointment she described him as being like a grandfather to the children, this was not challenged. It was also accepted when the mother said she would not leave the children alone with this man. No consideration was given to the fact that this individual may have groomed the mother – a vulnerable mother whose partner was in prison.

3.2.15 At the same meeting the social worker did not ask why the father had been in prison previously and why he had been assaulted when he came out.

3.2.16 Child One's attendance at School One was poor and no-one asked why.

3.2.17 The mother said she would ensure that there were rules and boundaries in place for Child One, after being involved in a fight at school. This was just accepted.

3.3 Disguised Compliance

3.3.1 The father told one professional that he smoked a bit of cannabis but agreed not to smoke around the children. The mother was fully aware of her partner's drug use but would tell other professionals that he did not smoke cannabis or use any other drugs. She said he only smoked cigarettes and always outside. All of these things were taken at face value. There were discrepancies which could have been identified if the professionals involved had spoken with each other.

3.3.2 Professionals are busy, and it is understandable why, when someone seems compliant, they will spend more time focusing on individuals they are working with where non-compliance is more apparent.

3.3.3 Disguised compliance is sometimes a feature in families receiving support from agencies. There are many reasons why families may not be forthcoming with professionals and hide what is really happening. This can involve shame

and/or fear about what might happen if the family is honest about circumstances.

3.3.4 A number of agencies and individuals were extremely tenacious and flexible in their attempts to engage with the family, including the Think Family worker, the Paediatric Eye Service, the Community Midwife, Health Visitor Three, the Student Health Visitor, the headteacher of School Two and reception staff at the GP practice.

3.3.5 Both parents were well liked by professionals. The father would always ring to rearrange his appointments with probation, rather than just not turning up. The mother would often miss or cancel appointments but seemed to know at just what point she should make herself or her children available again, so suspicions were not raised to the degree that professionals would take action. As stated previously, both parents were extremely plausible. A number of professionals who worked with them described them as "open" and "honest", "forthcoming with information" but we cannot know for sure if someone is being truthful, if there is no evidence, and in this case the parents were not. They knew exactly what to say and what to do to allay professional concerns. In addition to that, the children always appeared well presented, as did the parents, and were chatty and lively.

3.3.6 Too often professionals accepted what the parents said rather than looking at what they did, or rather did not do. The father told probation that he wanted to find employment, he attended appointments with the employment officer, but he never entered work. He also said that he only smoked cannabis occasionally and that he did not have money for alcohol, and, as stated previously, this was just accepted. Decisions were made based on self-reporting by the father but then he showed none of the obvious signs of someone who is using drugs. He did not smell of alcohol or cannabis, there was no change in his interactions, he would not be late for appointments and would not just miss an appointment. He would always telephone and ask to rearrange. He was also well presented. All of these things removed any suspicion he was using drugs.

3.3.7 Although it is unusual for a woman not to ring 999 if she goes into labour at home, or go straight to the hospital, the paramedics' suspicions were not raised. There were no concerns about the state of the home or the family and the parents' explanation for what had happened was believed. The parents also talked about what they had done – rung the Birthing Centre - which may explain why the paramedics were not concerned. The parents also told the paramedics, who asked them several times, that they did not know what time the baby was born – they said it all happened so fast. If professionals had been speaking to each other, for example the paramedics and the midwives, they would have known that the parents were saying different things to different professionals.

3.3.8 During the period under review CSC received five referrals from different agencies and an additional check was done by one. Apart from with domestic abuse cases, CSC has no mechanism for considering whether action should be taken if repeat referrals are made, or other agencies contact them about a family. Family history and the history of agency involvement is considered routinely as part of assessment. This is confirmed via audit activity.

3.3.9 The father told the review that he and his partner were not honest with professionals about their drug use because they thought the children would be removed from their care if professionals knew about the drugs. He also told the review that the agencies he was involved with, the police, prison service, probation and health services did not ask him if he had children. It should be noted that the National Probation Service did make a referral to CSC in August 2018 because of their concerns, as set out above.

Learning Point Three

The importance of professionals being curious is essential. This requires demonstrating respectful uncertainty and triangulating information to enable professionals to maintain a focus on the safety and welfare of children.

Specifically, agencies should consider:

- The need to continually reinforce to practitioners that they must question and consider any explanations given and be endlessly curious.

- Supporting practitioners to recognise and understand disguised compliance as an avoidance strategy used by some parents/carers.

- Professionals need quality reflective supervision, where supervisors ask probing questions, to better enable the frontline professionals to keep children at the heart of practice.

- The need for practitioners to view the incremental nature of changed/missed/cancelled appointments through a safeguarding lens and how systems can enable practitioners to question and challenge the pattern of avoidance and then consider what action should be taken. Not all agencies in Birmingham currently have a system for considering the incremental nature of missed/changed/cancelled appointments, which makes the system more reliant on individual practitioners. Systems must be in place to ensure practitioners question and challenge the pattern of avoidance to inform necessary action.

3.4 Understanding the risks to children when parents are misusing substances

3.4.1 The father had a long history of convictions for acquisitive crime and violence. He was also attacked when he came out of prison.

3.4.2 The mother was a late booker with her pregnancy with the baby. She then did not attend antenatal appointments and rebooked appointments a number of times. She was seen twice antenatally by the community midwife and then missed a number of postnatal appointments. Her explanation for booking late was because she said she planned to have a termination which does not explain why she did not take action when the pregnancy progressed.

3.4.3 There were significant delays by the parents in contacting and attending the hospital following the birth of the baby. Whilst it is not unusual for a mother to have a very quick labour and give birth at home unplanned, what is unusual is for the family not to ring the ambulance service as soon as the mother goes into labour. The paramedics did inform the hospital of the circumstances but because the mother seemed so credible, and maybe also because she had initially asked for a home birth, the hospital did not identify concerns. In such circumstances, combined with the mother being a late-booker, the missed ante-natal appointments and the mother's reluctance to go to hospital, lateral checks should have been completed.

3.4.4 There can be reasons why women who use drugs do not seek healthcare when pregnant or in labour;[2] there continues to be stigma regarding substance misuse and women can be fearful of the possible consequences. Women can be fearful of going into withdrawal and not being able to manage labour, particularly if they are still using illicit substances. Traditional pain relief given to women in labour, such as Pethidine, may have no impact on a woman who is using heroin. Anecdotally, women report feeling judged if their baby shows signs of neonatal abstinence syndrome and the possible consequences of this. The delay in requesting an ambulance and parent's inability to recall the time of the baby's birth should have been considered as causes for concern but were not raised by the ambulance service nor by the hospital. The community midwife and the GP practice and then the health visiting service were not aware of details of what had actually happened during and after the birth. The health visiting service were not even aware that the baby had been born at home.

3.4.5 As stated previously, the father told the review that he and his partner were not honest about their drug use because of their fear of having their children removed from their care. The father said they assumed that would happen if

[2] https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-015-0015-5

professionals knew they were addicted to Class A drugs. He told the review that he now knows that is not always the case and said he wished he had known that previously.

Learning Point Four

All professionals working with children and their families need to have some understanding of substance misuse and the barriers for parents/carers being honest about their drug use, and seek expert advice and input where necessary

Specifically,

- Risks and potential flags need to be identified. Training should also be embedded in practice and explored in supervision.
- West Midlands Ambulance Service's Level 3 Children's Safeguarding Training does not currently provide a section on recognising potential substance misuse within the home of a pregnant/in labour patient.
- It is essential that any training challenges stereotypes about those who misuse substances.
- It is essential that professionals recognise that the starting point for many parents/carers misusing substances will be the fear their children will be removed from their care if they tell professionals.

3.5 Effectiveness of the in-year admissions process for education

3.5.1 When it became apparent that Child One was not going to return to School One, the school took advice from the Local Authority Admissions Team and were advised of "The Schools Admissions Code 2014" criteria for removing a child from roll. Child One met the criteria on distance and confirmation was given that Child One would not be returning to School One. School One then removed Child One from roll. However, the mandatory paperwork to advise the Local Authority that this action had been taken was not completed. There was therefore no oversight for Child One as a child out of school.

3.5.2 School Two has a transient cohort of children and so they liked to get as much information about children as possible before admitting them to the school. They had therefore devised their own form in addition to the standard paperwork.

3.5.3 In this case School Two failed to follow mandatory national and local in-year admission processes. The Local Authority was not advised that the parents of Child One had applied for a school place and the request for additional information caused significant delays to admission.

Learning Point Five

The Local Authority must ensure effectiveness of local arrangements, and adherence to the 2014 Admissions Code, providing advice and challenge to schools and assurance to the School's Adjudicator.

3.6 Recognising what constitutes neglect and that neglect is a form of abuse

3.6.1 "Inattentive or unresponsive parenting has been linked to non-organic failure to thrive in babies and young children and to injuries, even fatalities, resulting from lack of supervision"[3]

3.6.2 There is an ever-increasing body of research that sets out the devastating and potentially life-long impact of neglect as a form of child abuse and yet around half of all children who are on a child protection plan in England are suffering neglect[4]. What is essential is that professionals understand and address the issues the parents are struggling with, in this case the primary factor being substance misuse.

3.6.3 One of the challenges for professionals is that neglect can take many forms. As stated previously, nothing stood out with this family. Although on their terms, the parents did engage with professionals, were chatty and friendly, well-dressed, as were the children, the home was always clean and tidy when unannounced visits were conducted. Child One was very chatty and engaging and there were no concerns about the other two siblings. Many of the Case Group, the frontline professionals working with this family, have worked with parents who are using Class A drugs, and these parents did not fit the stereotypical view of how parents on a low income and using Class A drugs present. All of this meant the professionals working with the family did not recognise the evidence and impact of neglect. This included Child One's comments about the lack of food, the mother associating with a convicted sex offender, the children not being taken to health appointments and circumstances around the birth of the baby, Child One's school bag smelling of cannabis, the parents' drug use and the risks that brought to the children.

3.6.4 Fundamentally, stating a child is being neglected is a judgement and individuals and agencies have different views as to what constitutes neglect. Greater understanding and consistency can only be achieved with clear, consistent messages from agencies and each organisation having a good

[3] NSPCC

[4] https://learning.nspcc.org.uk/media/1181/child-protection-register-statistics-england.pdf

understanding of the threshold document "Right Help Right Time[5]" as to what constitutes neglect. The document focuses on the "four levels of need" and the guidance takes account of the recent publication of '*Working to Build Stronger Family Foundations' – Childhood* Neglect Strategy (2022-2026)[6], and developments in City's Locality-based Early Help and Support offer for vulnerable children and families. The aim is to provide all professionals with clear advice about what to do and how to respond if a child and their family need extra support.

3.6.5 This review considered neglect in this case within the descriptions of different forms of neglect as identified by Jan Howarth[7].

Learning Point Six

Professionals need to recognise and understand what constitutes neglect to inform how they work with families in providing early help and sustained support.

Specifically, when using the Graded Care Profile responsibility lies with professionals to build trust and a relationship with families, so the family feels able to be honest and open with professionals.

3.7 Children Hidden from Sight

3.7.1 The focus was very much on the parents and not on the children. For the professionals who worked with the father, specifically, there is little evidence they considered what the impact on any children might be of the issues they knew about or were responding to. Examples include the knuckle duster and the knife being found in the father's car, the father saying he was using £60's worth of heroin a day and then later on £40's worth of heroin and £40's worth of crack cocaine every day, the trauma for a child of seeing their father being arrested, the antisocial behaviour being directed at the parents. The same is true when the mother was caught stealing alcohol.

3.7.2 When the parents requested to be moved because of antisocial behaviour directed at the father, as well as no one questioning why that might be happening, the response was to move the family, rather than dealing with the perpetrators. This meant the family was placed in an entirely inappropriate

[5] http://www.lscpbirmingham.org.uk/images/BSCP/Professionals/RHRT_Feb_2020/Right_Help_Right_Time_Guidance_V4_Feb_2020.pdf

[6] http://www.lscpbirmingham.org.uk/images/BSCP/BSCP_Home_Page_/Birmingham_Neglect_Strategy_2019_22.pdf

[7] https://www.actionforchildren.org.uk/media/3368/neglectc_research_evidence_to_inform_practice.pdf

bed and breakfast for children to be in and Child One had to move schools because of the distance.

3.7.3 School One had a process called Spotlight which was for supporting parents when the child's attendance was poor. They did not implement it for Child One because Early Help was already working with the family – Think Family – but the Think Family worker was not working on attendance.

3.7.4 There was a significant delay in Child One moving to a new school due to a misunderstanding between School One and School Two, with consequences for Child One missing education.

3.7.5 Teachers should have considered the impact on Child One no longer wearing glasses. Child One became self-conscious and stopped wearing the glasses, which were then lost. The Paediatric Eye Service closed the case because Child One was not brought to appointments by his parents.

3.7.6 When Child One was fighting at school, which was out of character, the reason for the altercation was not ascertained. This was shortly after their father had been attacked with a baseball bat and then was arrested in front of Child One. It was known that Child One was frightened to go to sleep.

3.7.7 School Two painted a clear picture for the review of what Child One was like but the review team has no sense as to the character of Child Two. The only word used to describe Child Two was "unruly".

Learning Point Seven

All professionals working with children and their families need to keep the child at the centre of everything they do.

- All professionals need to be given the time to build relationships with children, as well as the adults, and time to get to know each child in the family individually.
- Professionals need time to reflect on the work they are doing and time to research and implement effective resources to assist their work.
- Professionals must constantly question the effectiveness of any plan, asking themselves "So what? What is getting better for the child?".

3.8 Appropriate temporary accommodation for families

3.8.1 When the family fled their property, because of antisocial behaviour directed at them, they were placed in temporary accommodation by the Council. The bed and breakfast they were placed in was described by professionals who

contributed to the review as extremely well known in the city. Many of the people were placed there in challenging circumstances; individuals in the criminal justice system; drug users and adults with mental health issues. This accommodation which is no longer used was reported to be known for violence and drugs, and when the family was placed there, it was also infested with bedbugs. Birmingham City Council stopped placing families there in May 2019, because they deemed it as inappropriate for families. Birmingham City Council acknowledge that the level of demand for accommodation in the city far exceeds supply requiring the use of temporary accommodation, the majority of which are self-contained family homes, bed and breakfast and homeless centres. Bed and breakfast equates to 14% of the temporary accommodation being used in the city, which is used for time limited periods only.

3.8.2 The mother described staying up all night killing the bedbugs that were trying to bite her baby. The father told the review he and his partner could not understand how the baby was being bitten and it was not until they tore back the plastic lining on the travel cot the hotel provided that they found 'nests and nests and thousands of bed bugs'.

3.8.3 Professionals working with the family expressed surprise that they had been placed in such a notorious bed and breakfast but said it was not something they could have had any say over. Professionals were reluctant to visit the family at the property because of the bedbugs and on one occasion a meeting was arranged in a local coffee shop for that very reason.

3.8.4 Regarding complaints raised about the bedbugs in the property, on each occasion the complaint was forwarded to an environmental health officer to address. The City's Pest Control Service advises that in such situations rather than moving families which could spread the bugs, the infestation is managed through treatment on site. The proprietor was very cooperative in addressing issues highlighted, however the infestation was not resolved prior to the family moving to a subsequent address, where the child later died.

Learning Point Eight

Children and their families must be a priority for housing providers

It must be acknowledged that the level of demand for accommodation far exceeds supply and until that changes, children will continue to be placed in temporary accommodation. What is important is for housing providers to consider, on a case-by-case basis, the quality of the provision and its suitability for specific children and their family.

4. Summary

4.1 On the surface this was a family that seemed to be doing well enough. The fact that the parents, when they chose to see professionals, were cheerful and chatty and warm and friendly and the home seemed fine, and the children seemed fine, and the parents were not showing signs of drug use, meant no concerns or suspicions were aroused. What this case has shown is how very difficult it is working with drug users and identifying neglect when there are few of the outward signs often associated with parents who are on a low income and using Class A drugs, even when there is a considerable amount of other evidence.

4.2 This case highlights how vital multi-agency working is. How vital it is to understand family history, context and children's lived experience. Each agency held a piece of the puzzle, but they were not put together to form a holistic picture of the children's day-to-day lives. If that had been done, and professionals had had a comprehensive understanding of the children's day-to-day lives, professionals should have been able to recognise how vulnerable these children were.

Appendices

Appendix One – Methodology and limitations

Appendix Two – About the author

Appendix Three – Relevant national research

Appendix Four – Acronyms used

Appendix One

Methodology and Limitations

The review was conducted under *Working Together to Safeguard Children, 2018,* which clearly sets out what is required in CSPRs: *"*Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose. The purpose of serious child safeguarding cases is to identify improvements to be made to safeguard and promote the welfare of children. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving".

This is therefore a systems review. I, as the lead reviewer, have worked closely with a review team – a team made up of senior managers from each of the agencies involved. Although the report is published in my name it is the work of the review team as a whole. We as a review team have also worked closely with frontline professionals who worked with the family who are at the centre of this review. This group of professionals is referred to as the case group.

It is essential that agencies, wherever possible, learn from families and their experiences of services, and therefore involving family members in a child safeguarding practice review is an essential component. Regrettably the parents chose not to be involved in this review.

The smooth running of the review was enabled by the support of BSCP.

Review Team

Designated Nurse Safeguarding Children and Adults	Birmingham and Solihull Clinical Commissioning Group
Head of Service for Safeguarding Children	Birmingham Community Healthcare NHS Foundation Trust
Head of Service, Child Protection & Review then replaced by Assistant Head of Service, Child Protection & Review	Birmingham Children's Trust
Safeguarding Lead	Change Grow Live
Head of Housing Management	Birmingham City Council
Named Midwife Safeguarding Children	Heartlands Hospital, University Hospitals Birmingham NHS Foundation Trust
School Advisor Safeguarding Education	Birmingham City Council
Detective Inspector	West Midlands Police
Deputy Regional Manager then replaced by Deputy Head of Service	Staffordshire and West Midlands Community Rehabilitation Company
Safeguarding Manager and Prevent Lead	West Midlands Ambulance Service
Assistant Director, Early Help & Prevention	Birmingham Children's Trust

Case Group

Case Manager One	Community Rehabilitation Company
Case Manager Two	Community Rehabilitation Company
Health Visitor One	Birmingham Community Healthcare
Health Visitor Two	Birmingham Community Healthcare
Health Visitor Three	Birmingham Community Healthcare
Student Health Visitor	Birmingham Community Healthcare
Community Midwife	Birmingham Women's & Children's Hospitals Trust
Orthoptist	Birmingham Community Healthcare
Social Worker	Birmingham Children's Trust

Team Manager, Children's Advice and Support Service	Birmingham Children's Trust
Designated Safeguarding Lead, School One	Primary School
Head School Two	Primary School
GP	GP Practice
Think Family Worker	Birmingham City Council

Timeframe

The timeframe for the CSPR was agreed as being from 24th March 2017, which is when an anonymous referral was made to the NSPCC who then referred to Children's Social Care (CSC), to the date the baby's death in May 2019. Systems review are not historical reviews because systems change over the years. There is no value in reviewing systems that are no longer in place. Family history is vital but what matters is that the professionals working with the family are aware of the family history, not the team reviewing the case. It should be noted that Birmingham Children's Trust (BCT) only formally existed from April 2018. Prior to that it was CSC.

Appendix Two

About the Author

I have worked in child protection/safeguarding for 27 years, the last fourteen of those as an independent safeguarding consultant, case/practice review author and trainer.

I am an accredited systems lead reviewer having undertaken the Social Care Institute of Excellence's Learning Together systems methodology training in 2011. I have been leading systems reviews since then.

For more information, please see my website https://joannanicolas.co.uk

Appendix Three

Relevant National Research, at the time of undertaking the review:

In the words of Brandon et al in the Department for Education's analysis of serious case reviews "The need to understand more about neglect, which is present in more than 60% of serious case reviews, has been a constant theme across all the serious case reviews studies. This underlines the importance of neglect as a marker not only for long term damage to a child's development and wellbeing but also as a marker of

potential physical danger to the child. This means that neglect should be treated with as much urgency as any other category of maltreatment"[8].

In 2014 Ofsted published a report "In the child's time: professional responses to neglect".[9] It found that:

- One third of long-term cases were characterised by drift and delay, resulting in failure to protect children from continued neglect and poor planning in respect of their needs and future care.
- Almost half of assessments seen did not sufficiently convey or consider the impact of neglect on the child.
- The practice of engaging parents was found to be a significant challenge to professionals.
- In those cases where children were not making positive progress, a common feature was parental lack of engagement.
- The cumulative and pervasive impact of neglect on the development of children and their life chances has to be properly addressed if they are to be able to contribute to, and benefit from society as adults and future parents.

There are a number of hypotheses as to why professionals do not see the urgency of neglect as a form of abuse. One of the reasons may be that neglect is rarely the primary and immediate cause of death, even though it is so prevalent in serious case reviews. Another is the association between poverty and neglect. In 2016 the Joseph Rowntree Foundation published an evidence review into the links between poverty and childhood maltreatment. It concluded "There is a strong association between families' socio-economic circumstances and the chances that their children will experience maltreatment. There is a gradient in the relationship between family socio-economic circumstances and rates of maltreatment across the whole of society; it is not a straightforward divide between families in poverty and those which are not. This finding mirrors evidence about inequities in child health and education. The greater the economic hardship, the greater the likelihood and severity of maltreatment".

Evidence shows the people who neglect their children are very often facing adversities of their own. It is a common finding from serious case reviews that professionals have become too focussed on helping and supporting parents and have lost sight of the child and the impact of the maltreatment on the child.

A theory put forward in the Department for Education's analysis of serious case reviews is one of cultural normalisation and professional desensitisation, which they

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419072/In_the_child_s_time-professional_responses_to_neglect.pdf

talk about in the context of “needy families. The sheer volume of needy families in an area was a frequent feature in reviews. This can mean that there is little to distinguish at-risk families from other families in the area. A danger that can arise in such situations is that of cultural normalisation and professional desensitisation. This may be a very appropriate coping mechanism by professionals overwhelmed by the volume and complexity of their task but can result in vulnerable children being left without adequate assessment of their needs”.

It is a common finding from serious case reviews across the country that professionals have failed to recognise neglect and have underestimated the impact of neglect as a form of abuse. Professionals are much more likely to respond to alleged physical and sexual abuse of children rather than the neglect of children. Findings from serious case reviews show that the professionals’ perception is the threshold is much higher for neglect, whether that is a referral to CSC or an application to the court and that one has to wait for something worse to happen before making a referral or submitting an application because only then will it be accepted.

Appendix Four

Acronyms Used

BCHC	Birmingham Community Healthcare NHS Foundation Trust
BCT	Birmingham Children’s Trust
BSCP	Birmingham Safeguarding Childrens Partnership
CASS	Children’s Advice and Support Service, Birmingham Children’s Trust
CSC	Children’s Social Care
CSPR	Child Safeguarding Practice Review
HMP	Her Majesty’s Prison
MASH	Multi-Agency Safeguarding Hub
SWM CRC	Staffordshire and West Midlands Community Rehabilitation Company