Local Child Safeguarding Practice Review (LCSPR)

Child Y

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Date published: 2nd February 2022

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Learning identified from considering Child Y[1]

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1 Introduction

1.1 The DSPP agreed to undertake a CSPR by considering a case to be referred to as Child Y. They recognised that lessons could be learned from reviewing the practice in the case, with the aim of better safeguarding the children of Dudley.

1.2 Child Y was nearly seven years old when they first started school and was significantly developmentally delayed due to neglect. The child lived with their parents who had managed to avoid professionals for a number of years. The review considered the professional involvement with this family in order to identify learning for the wider systems and practice in cases where neglect and lack of engagement features.

1.3 Learning has been identified in the following areas:

- The link between child neglect and missing school
- Information sharing with health visitors if there are concerns about a young child's development
- The importance of seeing a child and meaningfully considering their lived experience
- The impact of working in difficult and exceptional circumstances[2], particularly when working with families who are hard to engage
- Ensuring child protection procedures are followed when neglect is a concern
- The importance of professional challenge
- Meaningfully considering fathers

2 The Process

2.1 An independent lead reviewer was commissioned[3] to work alongside local professionals to undertake the review. Information provided to the rapid review meeting was considered and individual agency chronologies including analysis were requested from all involved. These identified important single agency learning.

[1] The child is to be referred to as Child Y initially; this may be subject to change following consultation with the safeguarding partners and the family.
[2] Covid 19 in this case.

[3] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is a lead reviewer undertaking Serious Case Reviews and now Child Safeguarding Practice Reviews and is entirely independent of the DSPP.

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, a practitioner participation session[4] was held in July 2021 using video technology.

2.3 The lead reviewer met with Child Y's mother and spoke to his father on the telephone in order to identify any learning from their perspective.

3 The Learning

3.1 The learning identified for the safeguarding system and partnership is as follows:

<u>Learning point 1</u>: When a young child is 'missing from education', while it is a priority to ensure that the child starts or returns to school, the possibility of parental neglect should also be considered.

3.2 'Children missing from education' (CME) refers to children of compulsory school age who are not on a school roll or being educated otherwise, such as in alternative provision or by home schooling. The Dudley Metropolitan Borough website states clearly that 'these children can be amongst the most vulnerable in the country, and it is essential that all services work together to identify and re-engage these children back into appropriate education provision as quickly as possible.' The West Midlands regional child protection procedures identify this as a potential safeguarding concern. They quote the 2016 guidance[5] which states that children missing education are 'at significant risk of underachieving, being victims of harm, exploitation or radicalisation, and becoming NEET (not in education, employment or training) later in life'. As a young child these were not immediate issues for Child Y, however they should have been in receipt of an education and have had the safeguard of being regularly seen in an educational setting. Indications of Child Y's significant developmental delay and neglect were not identified due to them being missing from education and because they had no contact with any professional for a number of years. At no stage prior to Child Y starting school in October 2020 was neglect identified. A recommendation has been made that the procedures are reviewed as this case shows the impact that not being in education can have on younger children.

3.3 In Dudley children start primary school the September after their 4th birthday. The law states all children must start school by the latest the beginning of the term after their 5th birthday. Child Y was due to start school in September 2018, and there was a legal requirement that they start school by the latest January 2019. The process of gaining a school place for a child involves a parent or carer taking the initiative and putting in an application either on-line or using a written form delivered to the council prior to 15th January of the year that they are due to start. Child Y's parents did not complete an application form and this was not identified by the council or any other agency at the time. If a child is registered in early year's provision in the borough, information is shared by the providers and applications are sent directly. If parents still fail to apply, the case is referred to the CME team who work with the family as the child approaches compulsory school age. Child Y was not part of this process as they were not in registered early-years provision. There is currently has no other mechanism of getting data on children approaching school age. The admissions service is in the process of establishing links with school health to establish if they can access data from GP records to track pupils in Dudley who are due to start school. A recommendation is made in respect of this.

3.4 Local authorities have a duty under section 436a of the Education Act 1996 to make arrangements to establish the identities of children in their area who are not registered pupils at a school and are not receiving suitable 'education otherwise'[6]. It was in June 2019, a year after they should have started school, that it was established that Child Y was living in Dudley, was not attending school and had no school place in the borough or in any other area, due to a housing issue. It became apparent that the parents had probably been avoiding professionals since Child Y was three years old. Action was then taken by the CME team to enable Child Y to access an education, but it took another 16 months

[4] Four groups were organised chronologically. Each group considered a period of professional involvement with the Child J and her family. Some professionals attended more than one session.
[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/550416/Children_Missing_Education_-_statutory_guidance.pdf
[6] For example formally being home schooled.

for Child Y to start school. By then Child Y was nearly seven years old. Child Y's mother told the review that she had no contact with any friends or family members with young children and that she genuinely was not aware of the need to put in a school application. There is a need to consider how to improve awareness of the application process and timescales.

3.5 Between June 2019 and June 2020 the council's CME team took responsibility for ensuring that there was a satisfactory conclusion to this matter. There was significant drift and delay in the response, despite the involvement of the CME team and the consideration of the child at the Fair Access Panel[7], the weekly CME meetings and the monthly CME Board. Statutory Guidance states that 'prompt action and early intervention are crucial in ensuring that children are safe and receiving suitable education. The CME officer explained to the review that they sought to develop and use a relationship with the parents to encourage them to accept a school place and ensure the child started school. While this may work with some families, it was not effective in this case. A school was identified and asked to offer Child Y a place, using the Fair Access process, in January 2020. It was ten months before Child Y started there. This further delay had an impact on Child Y's health and well-being as it was not until they were attending school that the neglect they had experienced was recognised.

3.6 There was an appropriate request for a School Attendance Order (SAO) to be considered in this case, and Child Y was referred to the Education Investigation Service by the CME team, as once the school place was offered Child Y's lack of attendance then became the issue. No SAO was sought however despite the threshold for an order being met. The review was told that at the time there was a review of the standard operating procedures which had an impact on this case, and others. There was also a Covid-19 impact as the council[8] agreed that no prosecutions should be pursued during the pandemic. The review has established that not all of those involved at the time were aware of what was happening in this regard however, and assumptions were made that this matter was being progressed, when it wasn't. Those who were aware did not communicate that the SAO referral had been put on hold whilst the SAO procedures were being reviewed and that the previous procedures should have been in place until the review was completed. However SAOs were not being used at the time due to COVID 19. A recommendation has been made regarding this.

3.7 The allocated school began pursuing the parents to ensure that the child started school following the fair access panel in January 2020. This included asking a school attendance consultant to conduct a home visit. All attempts to contact the family were unsuccessful. The school have a procedure that they do not place a child on roll until a start date is agreed. This is because they have experience of children who are no longer living in the area and not actually requiring the place. This did not impact on their attempts to ensure that Child Y was welcomed to the school. A wider issue has been identified in Dudley about inconsistencies across schools regarding when a child is placed on the school roll. For example, some schools do not add the child to the roll until their first day at the school, others place them on roll right after the Fair Access Panel has made a decision or a parent has applied for the child to transfer to the school. The Department of Education September 2016 Children Missing Education Statutory guidance for local authorities states that schools must enter pupils on the admission register at the beginning of the first day on which the school has agreed, or been notified, that the pupil will attend the school. If a pupil fails to attend on the agreed or notified date, the school should then undertake reasonable enquiries to establish the child's whereabouts and consider notifying the local authority at the earliest opportunity. The local education authority is currently undertaking a consultation in the hope of agreeing a consistent approach across all schools in Dudley. The review was told that is likely that a child will be put on a school roll when a start date is agreed with the parents, which was what happened but did not resolve the issues in this case.

3.8 The CME team policy at the time was to close a case when a child is placed on the roll at a school. In the case of Child Y the decision was made to close the case in June 2020 when the mother told the officer she was in contact with the school and planning for Child Y to start. No start date had been

[7] It is the role of the Fair Access Panel (FAP) is to agree a Fair Access Protocol, oversee the process and ensure that the amount of time any child is out of school is kept to a minimum.
[8] This was common across the country at this time.

agreed with the school and Child Y was therefore not on roll. This was an issue as when the CME team close the case, it is the responsibility of the school if the child does not then attend. It is positive that the policy has since changed so that cases are not closed until it has been confirmed that the child has started at the school. This case shows that when there is a history of lack of engagement and avoidance of school, there is a need for on-going CME team oversight until the child starts or returns to school. In this case the CME team were aware that the school were working hard to engage the family and ensure the child attended. The school undertook home visits and attempted communication by telephone, text message and email. They were not permitted access to the home and did not meet Child Y, although they tried to do so on a number of occasions.

3.9 The CME team identified learning when compiling their contribution to the review. This included the need to ensure that records are kept up to date and that management oversight is robust, the need for closer working with health services and housing to ensure that all children approaching school age are identified, and the need for more regular 'safe and well' checks to be undertaken on children who are not on a school roll and are not being seen by professionals in other services. Changes that have been made already and their on-going action plan should make a difference to the system and practice.

<u>Learning point 2</u>: Systems need to support optimum information sharing between health professionals to ensure that a child's needs are met if there is any indication that there may be issues with the child's development or if appointments are missed.

3.10 When Child Y was three years old the parents approached the GP sharing concerns about their child's delayed speech, and the GP referred the child to a consultant paediatrician. Neither had been able to examine the child or undertake any assessment due to the child's distress during the consultations. The paediatrician also appeared to have been reassured by the family's statement that they were no longer concerned, and that Child Y was 'now fine'. Rather than making another appointment or speaking to the child's health visitor, whose role it is to monitor a child's health and development, the paediatrician referred the child back to the GP. When the GP saw the child for a health issue a few months later, there is no evidence that the previous concerns about their development were discussed. The review has identified the need for information sharing with the child's health visitor when there are identified issues or a need for assessment of the development of any child under 5.

3.11 Child Y was not then seen by any other professional for over two and a half years. The health visitor had contacted the family to undertake a standard universal offer developmental check but the family did not respond. The health visitor followed agreed processes, instigated the No Access Policy and asked the GP to place a flag on the system that the health visitor needed to be contacted if and when they came to the GP's notice. The flag was put in place but the request does not appear to have been discussed with the family on the one occasion the child was seen shortly afterwards. The learning identified for the heath visiting service from this review is the need to always follow up if a child is requested to attend but then not bought to the healthy child clinic, and the need to include housing in checks for the no-access process. There is also a need to ensure when a child who has missed a key developmental check is transferred to the school nursing service, they need specifically identified to school nursing via a formal hand over.

3.12 Child Y's mother told the review that they understood both that Child Y should be in school and that he was behind developmentally, but that the longer they left it to seek help, the harder it became. She said she was avoiding professionals because she felt worried about getting into trouble and losing her child. Her partner's immigration status was also a concern and she did not want to draw attention to him. She described being ashamed of her home and her own presentation and that she was worried what people would think. She said all of this stopped her asking for help. The professionals involved with families who are avoiding services need to consider what might be stopping engagement, and consider which professional is best places to provide initial support and reassurance to improve engagement and assess the child and families needs.

3.13 Once Child Y was seen at school, developmental delay was swiftly identified. The areas of delay included speech and language, mobility, wearing nappies and being unable to drink from a cup or use cutlery. There were also concerns about hygiene. Building on the school's good working relationship with the school nurse, she was contacted and undertook an assessment the same day, identifying neglect as a reason for Child Y's delay. The school, along with the school nurse and the family support worker showed persistence and respectful challenge when their referrals to the MASH were not accepted as child protection concerns that required an investigation and assessment. The School Nursing service will be using this case as an example of positive practice.

<u>Learning point 3</u>: When any professional has concerns that a child is not in education, there needs to be timely information sharing and early consideration of the child's lived experience, which includes the child being seen.

3.14 The housing fraud team first identified that Child Y was not attending school. They were able to provide this information to the CME team, including where in Dudley the family were living, that they had established that the child was not attending school in any neighbouring authority, and that they had also spoken to the mother who had confirmed the child was not yet attending school. Their extensive enquiries meant that the education authority could work quickly to engage the family and ensure the child was enrolled at a school. The housing professional involved liaised promptly with both the CME team and the MASH in respect of Child Y.

3.15 The MASH considered the information provided by the housing professional and forwarded the information to Early Help, although the housing officer had not completed a multi-agency referral form (MARF) as would be expected. This was not challenged and there was no record made of the contact by the MASH. The analysis from children's social care (CSC) provided for this review found a need for email information on closed cases to be available on the information system so that they can be seen if further information is shared, and the need to ensure that MARFs are used consistently when referrals are being made to the MASH. An action plan has been devised to ensure improvements in this area of practice. Learning has also been identified about the need for 'professional curiosity' in the MASH about children who are not in school, and an improved awareness that this may be a safeguarding issue. In this case a note to early help that they should consider referring back to the MASH if they were unable to engage the family could also have been considered, bearing in mind the link between children missing education and neglect.

3.16 Early Help involvement remained an appropriate plan at this stage, as there was a need for a sensitive assessment to understand why the child was not yet attending school. Other than the child not being in school, no other concerns about the child had been identified or shared at this stage. The fact that the child had not been seen by any professional for a number of years, therefore not allowing for any concerns to be identified, needed to be considered. An early help worker contacted the family in writing and attempted two home visits to the known addresses in an attempt to meet the family during June 2019. As there was no response, the case was closed. In order for any early help work with a family and information sharing about a child, parental consent is required. This was not available in Child Y's case due to the lack of engagement. The early help worker had confirmed that the CME team were still pursuing the family before closing the case. This was reassuring, but they did not consider consulting the MASH about the lack of contact and the fact that the child had not been seen. The connection between neglect and children missing from education had not yet been made.

3.17 Once the address where the family were staying was confirmed, the CME Team requested that the school admissions team send a school application form to the address where they had been told the family were living. The form had not been returned a month later so the CME team were informed, and they requested that a second form be sent. During this review the LEA (local authority education service) has identified that there is an issue with their IT system that can result in a child's home address being altered[9] during data collection exercises, and in this case it appears that the forms

[9] Addresses that include a number then an a, b, c, etc were automatically changed to number only. This is being rectified as a priority.

were being sent to the wrong address. This led to a review of the system and there is a plan to solve the glitch in the next software update.

3.18 The review has identified that as well as a need for improvements in the I.T system, there also needs to be professional curiosity about why a child is not in school and why the family have not returned the application form, and a more proactive and timely response to ensure that children do not miss too much education. The Child Safeguarding Practice Review Panel stated in their annual report 2018-19 that 'whilst technological solutions are a critical component, we also need to think in terms of human factors. Complexity of practice requires sophisticated conversation, hard wired into the DNA of our child protection practitioners. How do we help people talk to each other within a context of high-risk, high-volume and limited resource?' This is a pertinent and valid question that needs to be considered by the partner agencies in Dudley, as is the case nationally.

3.19 While the process of trying to engage the parents was on-going, the child was not seen by any professional until seen June 2020. This sighting was brief, with the CME team officer confirming to the review that they had only seen the child for a few minutes, that they were in their father's arms and that they did not engage with them at all. They were not able therefore to consider the well-being of the child during the visit, other than that they were present and 'seemed fine'. The fact that they were in nappies and had limited speech and delayed mobility was not identified. The poor quality of the accommodation was noted however, and there was an awareness that the parents were consistently trying to avoid the child going to school. The fact that the child had been seen and there were no obvious concerns about Child Y's safety led to a degree of professional optimism about how Child Y was, and this contributed to a further delay in identifying the neglect. The CME officer was contacted by the school and they too were prematurely reassured that the child had been seen and was well. Covid-19 had an impact as the resulting restrictions meant that the visit completed by the CME officer had to be a doorstep visit and therefore limited the opportunity to grasp a fuller awareness of the child's lived experience. The CME team went on to close the case without informing the school.

3.20 In order for young children to be the focus of any contacts with a family, they need to be seen, spoken to and observed with their parents. All professionals require the time and opportunity to ensure they see the child and that this contact is meaningful. Reviews of cases in which children have died or been seriously harmed have shown that abused children have often been seen but that workers either were unable or were prevented from identifying abuse[10]. There are examples of serious cases where professionals have been in the same room as a child but did not engage with them. The type of home visits that were undertaken in this case are very difficult for professionals. They were largely kept on the doorstep (or had to be on the doorstep due to Covid-19) and they had to negotiate with parents who did not want to engage. Being able to see the child in a meaningful way was almost impossible, yet this was the only way of identifying how the child was. The parents were not sharing any concerns and getting Child Y to school was the focus of the work at the time.

3.21 There was limited consideration at the time of why the parent's may be avoiding services and what was stopping them sending their child to school. The CME worker was told by the mother that she was worried about Child Y attending school and that she had a tendency to 'baby' the child. Mother also told the lead reviewer this. It is now known that financial difficulties, poor and overcrowded housing and the wish to avoid professionals due to the father's insecure immigration status probably had an impact on the lack of engagement and then on Child Y's development. The stress the family must have been under at the time needed to be considered and acknowledged with them, including consideration of the father's race and culture. These predisposing stressors were not entirely established prior to October 2020. After Child Y started school consideration was given to the impact of poverty and poor housing on his development and support is being provided. Child Y's mother told the review how overwhelming their financial insecurity and debt was at the time and that this had an impact on her mental health and ability to focus on her child and their needs. She was estranged from

[10] Ferguson H. (2009) Performing child protection: Home visiting, movement and the struggle to reach the abused child' Child and Family Social Work.

her family because they did not approve of her relationship, and this added further stress and isolation. The third national CSPR[11] published in September 2021 found that cases considered in reviews often involve families living with additional pressures such as poverty, mounting debts, deprivation, worklessness, racism.

3.22 Good practice was shown by the Family Solutions early help worker who became involved in September 2020 following a MAAM (multi-agency action meeting) also attended by the school. She was persistent in trying to get the child to visit the school with the parents, in the hope that they would then be reassured about the child starting there. They also saw the child briefly when visiting the family in September, just the second professional to do so after the fact that they were missing from education was identified. As was usual, the mother ensured the visit was on the doorstep and blocked a view into the home. The child was seen briefly in a coat and again there was no meaningful engagement or the opportunity to identify any concerns about their development. They were curious about the mother's mental health and whether there was domestic abuse through control as the mother stated she could not take the child to visit the school as her one and only pair of trousers had split.

3.23 There was confusion about whether the police saw Child Y in September 2020, as had been recorded by some agencies. A police officer had been in attendance at the September MAAM where Child Y had been discussed, and had said they could visit if there was no success in seeing Child Y. The officer in attendance does not always make a record of the discussion on a case which led to a gap in the police chronology submitted for this review. It has since been confirmed that as the FSW had then seen Child Y, the police did not visit.

3.24 There was very limited communication with Child Y's father, and the focus was on the child's mother to get Child Y into school. Services are often 'mother focused' rather than seeing both parents as equally responsible for the child and the need to be equally involved in any plans made. There was very little information available about Child Y's father. He was not registered with a GP for example, and it is now known that his precarious immigration status had an impact on his willingness to engage with professionals. It was in fact the father that first took Child Y to the school, along with the family support worker who took the initiative to ensure that the visit took place when Child Y's mother would not attend the appointment. This was a turning point in being able to assess Child Y's health and development. The review was told that the need for professionals to consider fathers more rigorously is a reoccurring issue in Dudley. In the 2015 NSPCC report, 'Hidden Men - Learning from Serious Case Reviews'[12] it is pointed out that men can be 'ignored by professionals who sometimes focus almost exclusively on the quality-of-care children receive from their mothers and female carer.' Other research[13] also confirms that professionals do not always engage with fathers, that they have limited expectations of them, and that when plans are made to support or protect children, it is often assumed by professionals and the parents themselves, that 'parent' really means 'mother'. This was found in regard to Child Y, particularly in the early attempts to engage with the family. Child Y's father spoke to the lead reviewer and it was evident that his spoken English is limited and that he did not appear to understand all that was discussed. He said that he does not always understand what is being discussed and that an interpreter would be helpful. There was no evidence that this was considered by those involved at the time, and may have been another reason why Child Y's mother rather than father was the main focus of professional engagement. Child Y is dual heritage as his mother is white British.

<u>Learning Point 4:</u> The response to COVID 19 has allowed parents who are hard to engage with to avoid professional contact. Professional rigor and persistence are required so that the needs of children continue to be met despite the challenges of working during a pandemic.

[11] The myth of invisible men: safeguarding children under one from non-accidental injury caused by male carers. 2021
[12] https://learning.nspcc.org.uk/media/1341/learning-from-case-reviews_hidden-men.pdf
[13] Family Rights Group, Fatherhood Institute, Daryl Dugdale (Bristol university), Professor Brigid Featherstone (Open University) 2012

3.25 Attempts to ensure that Child Y's parents took up the school place that was allocated in March 2020 were hindered by the decision to close schools for all children except those who were vulnerable or the children of key workers on 20 March due to the COVID-19 pandemic. It is impossible to say whether Child Y would have started school sooner without the lockdown, but there is evidence that the child's mother stated that the family were 'shielding' when the issue of school attendance was raised with her, and it provided another reason for the parents to avoid sending their child to school. There were attempts by the school over the months following the first lockdown to engage the family in home schooling for Child Y, to no avail. The school had not yet met Child Y, did not know what level of work to provide (although age-appropriate resources were delivered to the home address, partly due to assurance from the CME worker that the child had been seen) and it is acknowledged that all professionals were working during unprecedented times. The annual report from the national Child Safeguarding Practice Review Panel published in May 2021 stated that the first national lockdown reinforced the crucial role that schools play in safeguarding children.

3.26 School attendance for vulnerable pupils was recommended but not compulsory during the government imposed lockdowns. At the time of the lockdown in March 2020 no professional was aware of how vulnerable Child Y was and they were still not on the roll at the school, so their attendance was not considered. (They continued to attend school during the later lockdown in January 2021 as they were on a child protection plan at that stage.) Child Y was seen very briefly by professionals in June and September 2020 but none were able to meaningfully identify or consider Child Y's vulnerabilities. Child Y was effectively invisible to all services from October 2017 to October 2020 and both parents kept their child away from the scrutiny that professionals would bring.

3.27 There had been challenge about the child not having been seen from a School Improvement Director from the Academy Trust who was working at the school during February 2020 to increase leadership capacity. They contacted the CME team for information and to challenge them about why the child had not been seen yet. The following day the matter was again raised at the Fair Access Panel and the chair suggested that the CME team visit the home within the next two days. The CME officer was in text and email contact with Child Y's mother at the time and had attempted home visits, but Child Y was still not seen until June 2020, when they were very briefly observed. The national lockdown which started in March would have had an impact on CME attempts to see the child. The review was told that there were debates about whether it was safe and appropriate to undertake home visits and whether PPE was required for example. Schools were given PPE in order for the attendance officers to visit children's homes shortly after the start of the first national lockdown. The CME Officer was also provided with PPE but initial guidance to staff was to complete virtual or doorstep visits.

3.28 Covid-19 has provided families who are hard to reach and who wish to avoid professionals with the opportunity to do so. A number of reviews nationally are finding that families have been using 'shielding' as an excuse for children to remain at home, which in some cases increases risk and limits support for vulnerable children. To a degree this was the case for Child Y. With or without the pandemic, the parents ensured that professionals were not able to establish what impact their non engagement with services may be having on the life of the child. The neglect of Child Y's educational and developmental needs was not identified due to the parent's long-term avoidance of the agencies trying to assist them, and while Covid 19 added to the difficulties in engaging the family, the review has shown that their avoidance and drift in the plan to get Child Y into school was a feature prior to March 2020.

<u>Learning point 5:</u> When there are concerns about a child, all agencies need to be clear about the child's place in the system and to challenge if there is a disagreement or delay.

3.29 Good practice was evident within the system when challenge was required due to concerns about Child Y and differences of opinion regarding whether they required a safeguarding response. There was individual agency challenge to the MASH from the school, from Family Solutions and from the school nurse regarding the MASH decision that family support was the appropriate response for Child Y after they started school. There was good communication between these professionals about the

need to challenge and a number of attempts to show evidence that Child Y had suffered neglect and was at risk of ongoing neglect. While this debate was on-going, appropriate support was provided by the school and the school nurse, and the child was referred for assistance from speech and language therapy and the continence service. Practical support was also provided including nappies, food bank vouchers and school uniform.

3.30 This challenge and the persistence of those involved led to a change in the plan for Child Y, and a social worker was allocated to undertake an assessment two days after they started school. The child's current social worker, who became involved later, told the review that the extensive knowledge of the child's needs and the experience of those involved, regarding the behaviour of the parents and their reluctance to engage with professionals, particularly the school, allowed her to have an understanding of the case quickly which enabled an informed response. Child Y's mother also spoke about the non-judgemental approach of the social worker and how this has helped her to engage and consider and understand the concerns about Child Y.

3.31 There was some confusion regarding the nature of the CSC and police involvement, which was not identified at the time. Following the agreement from CSC that they would undertake an assessment, a social worker visited with the police. They met the parents and the child. During the visit the police officer issued a Community Resolution Order (CRO) stating that the parents must work with CSC, and the parents consented to an assessment. The use of this order would have involved the police officer acknowledging that an offense of some kind had been committed. CROs are an 'opportunity for the police to deal with appropriate low-level offences and offenders without recourse to formal criminal justice sanctions.'[14] Without a full investigation of the impact on Child Y of the neglect they had suffered, and without giving the parents the opportunity to work with a social worker (this was the first contact CSC had with the family) this initially appeared to be a premature decision. Further discussions with West Midlands Police show that this was a pragmatic response to ensure compliance from the parents. The CRO was not necessarily a final decision and the police assured the review that this decision could be reviewed at any time and alternatives such as a criminal investigation would be considered if further evidence of neglect was identified. What was not clear is whether there was in fact a review and whether other professionals involved were aware that this was a possibility which they could request.

3.32 The status of the case at this stage was not clarified. Police records state that it was a single agency S47 investigation had been agreed, however CSC decided to pursue the assessment under S17. Procedures are clear that a S47 investigation is usually undertaken following a decision made at a strategy discussion. There was no strategy discussion / meeting in this case until 4th November, nearly a month after Child Y started school and the serious concerns were identified. This led to a delay in a child protection medical being considered and no opportunity for debate about whether a criminal investigation was required. While it was unlikely to be appropriate in the case of Child Y, in other cases it may be. This has highlighted a need in Dudley to consider if this is a wider issue and a recommendation has been made in regard to this.

3.33 Around a week after the visit from the police and CSC, the social worker had a discussion with the Child Protection Chair service regarding whether the child should be subject to an initial child protection conference (ICPC). Discussion with the CP chairs in Dudley is common when considering thresholds and is largely good practice. In this case the chair was spoken to and the fact that the parents had been cooperating with the assessment, that Child Y would remain a child in need with an allocated social worker and coordinated multi-agency support would continue, it was felt that an ICPC was not required. It was noted that if this was not sustained, the need for a conference should be reconsidered. The decision did not take into consideration the extensive history of lack of engagement with all professionals, that the cooperation from the family may have been due, at least in part, to the police CRO and the fact that Child Y had already suffered significant harm from neglect.

[14] https://www.west-midlands.police.uk/your-options/community-resolution

3.34 As outlined above, there was appropriate earlier challenge when the Academy Trust that manages the school contacted the LEA in February 2020 asking why the child had not been seen. The school have identified single agency learning, recognising the need to develop confidence in escalating using the DSPP process if they have concerns about partner agencies not completing agreed actions. The review reflected on the use of the restorative practice model in Dudley when working with families and how in this case the clear neglect of Child Y was not the primary focus. The aim of CSC to work with the family to meet the child's needs in the medium to long term was a good one, however the investigation of the abuse and a clear focus on the risk to Child Y needed to receive equal focus. There was evidence of reflection within CSC that focused on the mother rather than Child Y, and an optimistic view of both the past and the plan for working with the family.

3.35 A medical was undertaken on Child Y a month after concerns about neglect were identified. The West Midlands child protection procedures[15] state that a child protection medical should be undertaken where there are indicators of neglect, as there were for Child Y. The procedures state that the need an assessment in the context of S47 enquiries should be discussed with the doctor due to undertake the medical assessment 'to ensure they are aware of its strategic significance' and that the 'doctor should demonstrate a holistic approach to the child and assess the child's well-being, including mental health, development and cognitive ability.' In this case the medical concluded that Child Y's educational, developmental and possibly medical needs had not been met in the family environment by the parents and may indicate neglect.

3.36 The decision to have an ICPC was made the same day as the medical, and while the conference was then held within 15 days of the strategy discussion, it was seven weeks after the first visit by the police and CSC. No agency challenged the delay in either the medical or the decision to hold an ICPC. This was because they were relieved that CSC were now involved, because Child Y was now attending school, because there had been a referral to a paediatrician via the school, and because of a more general lack of knowledge of the required timescales within child protection procedures.

4 Conclusion and recommendations

4.1 When Child Y started school it was identified by experienced and skilled professionals that they had been neglected and that they were delayed in their physical and cognitive development. This CSPR has considered the learning from Child Y's case and identified learning that will be helpful for the wider system. It shows that good information sharing, open communication between professionals and embedded relationships between the professionals working with a child can make a positive difference, but it also exposes the vulnerabilities, particularly when a child and their family are effectively invisible to the services that safeguard children.

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 partner agencies, which was essential in establishing the learning from this case.

4.3 Having considered the learning from this review that has not been addressed in the single agency actions, the following additional recommendations are made to ensure improvement actions are taken.

Recommendation 1:

The DSPP should request that the West Midlands procedures in relation to children missing education are reviewed to ensure that reference is also made to younger children missing education and the links with neglect.

Recommendation 2:

[15] https://westmidlands.procedures.org.uk/ykpzl/statutory-child-protection-procedures/additional-guidance/#s536

That the DSPP seeks assurance and an update from the LEA regarding the effectiveness of their service when a child missing education meets the criteria for a school attendance order, and requests that the Education Investigation Service undertakes a review to ensure that all children who require a SAO are receiving timely consideration and that any other children missed during 2019/20 have been considered.

Recommendation 3:

The DSPP should ask the relevant partner agencies to ensure that Working Together compliant strategy meetings are being held to plan investigations and visits and there is consideration of a child protection medical in neglect cases. Assurance should then be provided in relation to this.

Recommendation 4:

The DSPP to request that the LEA Admissions Team provide assurance about what processes are in place to ensure that all children living in Dudley who are due to start school are known about and receive timely support if an application has not been received. All partner agencies may be required to provide information to the Admissions Team if a fool proof system is to be in place.