Child Safeguarding Practice Review

Smith Family

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Introduction

1. The Stockport Safeguarding Children Partnership (the Partnership) agreed to undertake a Local Child Safeguarding Practice Review (CSPR) to consider the learning that can be identified by considering the professional involvement with a large family with concerns about neglect and sexual abuse[1]. It was agreed that a focused CSPR would be undertaken, using details of the professional involvement with the family, to provide an insight into local systems and practice with families where long-term neglect features and concerns about sexual abuse emerge later.

[1] The family are white British and there is no learning identified in respect of race or culture. Learning in respect of the impact on professionals of working in the community where the family live is included in the analysis of this report.

Process

2. An independent lead reviewer was commissioned[2] in February 2024 to work alongside a panel of local professionals. The process was outlined in a Terms of Reference. The panel met on a regular basis while the review was in progress.
3. The detailed information provided for the Rapid Review was used to provide the single agency information and reflection, with additional learning and single agency action plans being submitted by each agency towards the end the review.
4. A meeting was held with the professionals who had been involved directly with the Smith family prior to concerns about sexual abuse emerging in November 2023. This was well attended and provided the review with the opportunity to reflect on both the case and wider systems and practice in Stockport. Following the practitioner event, a meeting was held with managers and safeguarding leads to build on the learning identified and to understand the wider context within and between agencies, and any developments underway.
5. The lead reviewer and a representative of the partnership met with two of the older children. This was to provide information about the review and to identify any additional learning from their perspective. The eldest child struggled with the meeting and decided she did not wish to be involved, which was accepted. The other child spoke about her experience of services, and her words will be included in the review below. Each parent was also met with individually. They shared their views and provided additional information which was helpful to the CSPR and is included below. The children and the parents will be spoken to at the conclusion of the review to share the learning and improvement actions.

Information about the family[3]

6. In November 2023 a relative of a 13-year-old girl told health professionals that he had sexually abused the child in the past, and that this abuse was known about by her parents. The police visited the family and identified significant concerns about the state of the home. The police officers removed the children using their powers, reporting that the conditions were 'horrific' and 'the worst they had seen in a very long time'.
7. The family have been known to Children's Social Care (CSC) for around ten years. Information provided by CSC to the rapid review meeting prior to this CSPR included the following summary of concerns that had been evident over time; *'bruising, physical chastisement, poor home conditions, lack of adult supervision, poor school attendance, domestic abuse[4], and the emotional wellbeing of the children. A common theme over the last 10 years has been*

[2] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of Serious Case Reviews and LCSPRs and is entirely independent of the Stockport Partnership
[3] This report has been written with the intention that it will be published and only contains information about Child B and their family that is required to identify learning.
[4] The father received a caution in 2013.

professionals raising concerns regarding home conditions including the police, employment and benefit workers, housing, education and trades people completing repairs in the home'. Sexual abuse had not been considered. As well as engaging in the rapid review process and this review, CSC also undertook a practice improvement process shortly after the concerns about sexual abuse emerged. This has led to planning for co-allocation of large families to two social workers, peer multi-agency supervision in neglect child protection cases, and when there is repeat child protection planning there will be a case audit and care planning meeting chaired by a service lead. There is also an ongoing conversation about the need to include unannounced visits in step down plans in cases where neglect has been a concern. The CSPR supports these improvements.

8. The children had been subjects of team around the child (TAC) plans, having been assessed as children in need, on five occasions between 2014 – 2023, and on child protection plans (CPP) under the category of neglect twice: From July 2017 to June 2018 and from February to September 2022. A third initial child protection conference (ICPC) was planned and was due to be held a matter of days after the member of the extended family shared the information about sexual abuse.

9. The family member and both parents have been arrested and there is an on-going police investigation. The children have been safeguarded but it has been hard for them to settle due to their loyalty and affection for their parents and feeling conflicted because of the obvious benefits to children who have been physically neglected of being in foster care. One of the children told the review that she wanted to go home and that as far as she was concerned there was no reason for her to have been removed. This insistence is likely to have been due to her misunderstanding of the CSPR process and her belief that what she said would be fed back to her parents and to the court.

Analysis and identification of learning

10. In 2023 a CSPR was undertaken in Stockport (Dylan) and there was learning identified about the response to children living in families where there are significant parental vulnerabilities that may pose a risk to children, and the challenges professionals face in keeping a focus on children in such families. To some degree this learning was also relevant to the children in the Smith family, as will be shown. Additional learning was also identified about working with families where there are long term concerns about neglect, and about identifying risk of sexual abuse in the family environment.

Learning:
There is a need to consider the lived experience of children who are living in conditions that are detrimental to their health and development.

11. Neglect can cause serious harm to a child and is known to have a long-lasting impact. In the short-term it can cause developmental, social and health issues. In the longer-term children who have experienced neglect are at increased risk of poor outcomes, including in respect of their mental and physical health, their relationships, and their behaviours. Older children who have experienced neglect throughout their childhood are more likely to become known to services later due to exploitation, criminality, and substance misuse. Neglect is considered the most common form of child abuse in the UK, and it features in over 60% of Child Safeguarding Practice Reviews, although they were predominantly completed for other reasons. Responding to neglect and making enough of a difference for children who have experienced neglect is one of the biggest challenges for professionals with responsibly for safeguarding children in the UK. Considering involvement with the children in the Smith family shows how complex and difficult the work can be for professionals, and how serious the impact of long-term and cumulative neglect is on children. The CSPR, having heard (and to an extent witnessed) how devastated the children are about not living with their parents, recognises the difficulty in balancing the right for children to have adequate care with their need for a family life.[5]
12. The children's home conditions in November 2023 were described by the police officers who attended as 'horrific'. The police report stated the following: we *could not move easily around the home due to masses of rubbish and hoarded materials. There was a bowl of old sick and urine, dogs were running around eating soiled nappies and a dog crate was full of faeces. There was no heat, light or water, so no appliances could be used and there was no functioning bath or shower. The toilet only partially flushed, and the kitchen sink was connected to a hose which ran into the bathroom. There was no food in the cupboards, fridge or freezer. The upstairs floorboards were saturated with faeces and urine. There was no bedding and faeces all over the children's beds.* The police view was that these poor conditions had not accumulated over a short period but showed long term neglect. Social workers who had visited a few weeks before, in October 2023, confirmed their shock at the poor state of the home. When they saw the photographs taken by the police during the CSPR, they reflected that the conditions had improved slightly since their visit and them sharing with the parents that the state of the home was unacceptable and that a child protection conference was to be held[6]. Those involved in the review reflected on the likely lived experience of the children at the time, with them having to live in a home where they did not have adequate beds or bedding, where there was little to no food, where electricity, heating, and running water was limited, where there was excrement and urine on floors and mattresses, and where there was no space to sit or play. The environment was harmful to their physical health, development, emotional and mental health. There was a request, when the social workers visited, for the police to attend.

[5] As posed by Research in Practice in their report 'neglect in a context of poverty and austerity' published in 2019.
[6] The social workers sought consent from the parents to take pictures in the absence of the Police

They did not do so. The social workers reported that they requested attendance via 101 and then spoke to the MASSH police representative due to the significant concerns about the state of the home. The police records, however, state that the social worker said there was no need for police to attend. As there was likely evidence of criminal neglect at the time there is a need to consider how detailed and assertive the requests for police attendance were.

13. The children in the Smith family had lived in a dirty and cluttered home for most of their childhood, with many of their basic needs not always being met by their parents. There was little understanding over the years of the parent's ability to recognise the damage being inflicted on their children or to empathise with their experience, although they would improve the home conditions when helped and pressurised. When spoken to as part of the review the parents said they often needed 'a kick up the arse' to clean and tidy, but that the home conditions were never as bad as the professionals were stating and that the children knew they were loved and cared for. Indeed, agency records note a degree of physical affection from the parents to the children, but this was arguably given too much merit, and assumptions were made that this was therefore a family where the children were 'dirty but happy'.

14. Agency records shared with the review show that the first concerns about the home conditions emerged when the eldest of the children were aged four and three. The parents had received the support of the Family Nurse Partnership (FNP) for over two years, starting during their pregnancy with their oldest child. This included the pregnancy and birth of their second child, who was born 18 months after the first. In Stockport the FNP offer intensive and structured home visiting by Family Nurses who are experienced and specially trained midwives or health visitors to parents aged under 19 and believed to be vulnerable. The parents told the review that this support had been helpful to them. This intensive FNP support was likely to have been significant as the young couple adjusted to parenthood, and no safeguarding concerns were identified at the time.

15. It is the aim of the FNP was to *'tackle intergenerational disadvantage by the provision of early intervention and support to the most vulnerable parents, and 'improve pregnancy outcomes, child health and development and future school readiness and achievement, and parents' economic self-sufficiency.'* The programme has been discontinued in many areas of the UK but continues in Stockport. A 2021 study[7] shows that the children whose parents were supported by the FNP had improved development, school readiness and early education outcomes compared to randomly selected peers. However, it also states that having had FNP involvement does not necessarily reduce child abuse and neglect.[8] This case confirms this long-term finding.

[7] The Building Blocks Trial. National Institute of Health Research. Cardiff University 2021.
[8] There was also a finding that a longer-term evaluation is required.

16. The agency records from the TAC and child protection support provided to the growing family evidence regular poor home conditions and concerns about the children's hygiene and school attendance, these followed a pattern of improvements when professionals were involved and there was pressure on the parents to improve, and a decline when they were not. There was a sense, even at the time, that the family only cooperated to alleviate concerns and reduce professional interventions, rather than acknowledging and having a commitment to improving their children's lives. Professionals reflected in the practitioner events, that the family were often reported to be ill with common illnesses such as stomach bugs, which were thought to be due to the unsanitary kitchen.

17. The children also all had exceptionally poor dental health, and the review found good information sharing by the dentist with the GP. There needed to be a rigorous consideration of whether the children's health needs were being met, including ensuring that there was effective reporting and sharing when the children are not being brought to appointments or seen by health professionals. The family tended to access health care through emergency departments but didn't then attend follow-up appointments. The review was told that at least 30 health appointments for the children had been missed. This showed the difficulty the parents had in making prearranged appointments and ensuring preventative care. There was also evidence of non-engagement by the parents in respect of their own health needs. While Did Not Attend/Was Not Bought processes were followed, it did not result in an improvement for the children. This learning has been identified in another CSPR where the NHS Foundation Trust Stockport have reviewed was not brought to processes and reiterated the importance of following these with practitioners.

18. The children often presented as hungry in school and appeared tired and lacking in sleep. Their clothing was regularly dirty or inadequate, with the school providing coats in cold weather. The primary school shared that the parents have never attended parent's evening or SEND (special educational need and disabilities) meetings about one of their children and have not engaged with the school phone 'app' which is used for communication between teachers and parents. The children's supervision in the community was another cause for concern. Local people reported to teachers that the children were often out late, would act unsafely on/around roads, and were seen away from the family home without supervision. On one occasion the police were involved because one of the young (pre-school) children was reported missing by the parents. He was later found asleep in a dog crate in the kitchen. At the time the police officer contacted out of hours CSC and discussed removing the children using police powers due to the concerns they had about lack of supervision, the state of the home, and the discrepancy in accounts of the incident. It was agreed that the children would remain at home, partly due to the difficulty there would be in finding appropriate placements for 7 siblings. There was limited challenge in relation to this, and the police informed the review that

they are working with officers about the need to be more questioning. They are also reviewing the data on the use of police powers. CSC are also working on strengthening contingency planning in cases of on-going neglect. A recent Ofsted focused visit said that CSC were missing opportunities to crystalise support from families.

19. The primary school shared with the review that while the children were often late, dirty, unkempt, and odorous, in the months prior to their removal by the police the situation had clearly deteriorated further. They spoke to the children's mother about their concerns and made a referral to the MASSH. They liaised with other professionals, including housing, about the family. The primary school reflected during the review that they can see that they should have been more assertive about how serious they felt things were and pushed for a timelier home visit and robust assessment. There could have been an opportunity at this juncture for the school to use the early help assessment process and team around the child processes if parents gave their consent.

20. Professional contact with children, seeing them in their home environment, with their siblings and with their parents, helps to develop an understanding of the child's lived experience. Professionals should aim to capture this by talking to them about their day-to-day life and by observing their presentation, behaviour, and relationships. Observing their world is important, as children, particularly older children, can be silenced by concerns that their parents will get into trouble if they share anything concerning, and from fear of the repercussions. The CSPR was told that it now appears that the children often spent time with members of the wider family. A social worker told the review that at the time they regularly tried to complete genograms and explore the involvement of the wider family, but the parents would not provide details. The children themselves never mentioned any members of their wider family when they were seen by the social worker. The national CSPR into the murder of Arthur Labinjo-Hughes and Star Hobson, published in June 2022, found that agencies did not talk with and listen to the views of wider family members, including those who had raised concerns about potential abuse and despite the family members knowing the children well. The difficulties in gaining information from the Smith family parents led to this part of the children's lives being largely unknown.

21. The family was not open to Children's Social Care during the period of Covid-19 related lockdowns and will have been seen less often by school and other agencies consequently. It is very likely that the pandemic impacted on the children negatively as there may have been prolonged periods of time where they were not 'seen' by any safeguarding agencies. It is also noted that a new baby was born in 2020, and while there was some contact with professionals in respect of that baby, it would have been extremely limited. CSPRS undertaken in the last few years have reflected that Covid-19 allowed the avoidance of professional contact and

provided families who are hard to reach and who wish to avoid professionals with the opportunity to do so.

22. The birth of the youngest child needed to be considered from the point of view of whether their needs would be met in the family, as there was evidence that the parents had difficulties meeting the needs of the older children, and a new baby coming into the home would be particularly vulnerable. There was also a need to consider the needs of the older children of a new baby joining the family, as this would potentially have an impact on their care. Despite previous child protection planning, there was no consideration given by midwives or the health visitor to a pre-birth referral to the MASSH. This is despite expectations that one is always undertaken if there has previously been a child protection plan, as there was here. A growing family is an increased risk in a family where there have been safeguarding concerns, as it can mean that a situation that was just good enough for the existing children can become more concerning. There is a need to undertake a pre-birth assessment that focuses on this.

Learning:
If a child is not attending school and this indicates neglect, a multi-agency response is required. For children where an older sibling is vulnerable and persistently absent from school, the younger children in the family require support and a robust and clear plan for transition from Year 6 to Year 7, and when they are due to start reception class, to prevent a similar situation occurring.

23. For the younger children, their lateness and absences from school were a clear indicator of neglect. The children had a long-term pattern of arriving significantly late for school, which impacted on their education and their emotional and social needs. While the children's attendance was around 90%, the school reflected that on average the time missed due to persistent lateness as well as absence was the equivalent of the children being absent for over a day's schooling a week. This means that they were all significantly below their age-related expectations for learning. On occasion the children and their mother would arrive at school in a distressed state in the morning, due to the challenge of getting to school. This would leave the children feeling very upset for much of the day and requiring a lot of adult support to engage in any learning activities. The children were often collected late from school at the end of the day, which could leave them feeling anxious.

24. One of the primary school age children has an EHCP[9] due to learning difficulties. School absence meant that their development was further impacted. The school stated during meetings at the time that it was their belief that the child's home life and poor attendance affected their behaviour and learning in school and isolated them from their peers. Children

[9] Education Health and Care Plan.

with special needs are at greater risk of abuse or neglect. The barriers to identifying and intervening also tend to be higher, as their special needs can be seen as the reason for any delay or emotional issues, without the coexistence of abuse and neglect also being rigorously considered. The school described the child as active and engaging, but they have severe language and cognitive delay, and they are performing academically at levels expected from a reception or year one child, while they are in year 6.

25. Single agency learning was identified during the review in respect of children who have been open to CSC but who are closed at the time that an EHCP is being considered. This was the case here. Because children suffering from neglect are often open then closed then open again to services like early help and CSC, there needs to be an understanding of this when an EHCP is being considered, to ensure the history is known. If they are not open to CSC at the time of the assessment, it does not mean that there has not been a significant and important history of involvement with them and/or their siblings that requires consideration.

26. For the older children, who were of secondary school age at the time of their removal, their education needs had not been consistently met by their parents when they were in primary school, and this pattern continued in secondary school. Both were known to have cognition and learning needs, as well as emotional needs. The transition to Year 7 had not been straightforward for either child. The eldest child was impacted by the COVID lockdowns. The school invited her into school, but she refused. They provided a laptop, but she did not engage in on-line learning at all. The school reflected that some of their pupils (not the child in this case) had no Wi-Fi access, no quiet place to join lessons and could not always charge their laptops. This reinforces the knowledge that the most disadvantaged children were disproportionately impacted by the COVID lockdowns, which was undoubtedly the case for the children in the Smith family. The child's mother said she encouraged her to engage with the offsite learning, however she refused to do so.

27. Both of the eldest children have spent a significant amount of time in the school learning hub, which means that they did not access a full learning curriculum at any time. This impacted their education, their social integration, and their wider learning.[11] The eldest child had not attended school for much of her time at secondary school and was identified as a 'severe school refuser'. The Education Welfare Service (EWS) was involved, and she was allocated a place in an alternative provision to try and reengage her in education, but she also refused to attend there. As part of the review the school spoke about their wider difficulties in regard to attendance problems, stating that the EWS were 'cut to the bone' and 'a toothless tiger'. School resources had been committed to providing an attendance outreach service, who were

[11] Another issue with not attending classes when in school, or when absent from school, is that both children have likely missed out on vital PSHE, sex education and classes about relationships, which are designed to help keep children safe.

involved with both the children in the Smith family. The CSPR questioned the use of education supervision orders and were told that they are being introduced.

28. The younger of the two children in secondary school was refusing to attend school much of the time around the time that the sexual abuse allegations were made in respect of her by the family member. She had missed her secondary school transition day due to being absent and did not have a further opportunity to visit the new school prior to the 6-week holiday. She told the review she was really worried about starting there in the September and that she did not know what to expect. She was aware that her sibling did not enjoy attending the school and that she was refusing to attend, which increased her anxiety. In her first term at secondary school her attendance was 44%. She had been placed into a small nurture form group at the start of the day but was not benefitting even when she attended school that day as she was usually late. The review felt that it was important, in a family where an older sibling had poor school attendance, to have a particular focus on the younger siblings at transition and when they start secondary school to ensure their improved attendance. Transition meetings for children who are known to be particularly vulnerable are now being held in Stockport, but this was not the case for either of the children being considered. The school said that the pattern of the second child following the attendance example of the first child is common. A transition meeting should always be held for the younger siblings when they are in Year 6. The school attempted morning home visits in the hope of getting the second child to attend school, and to have ‘eyes on the child’ as she had not been attending school. While the eldest child was felt to have a school anxiety, the second child appeared to enjoy school when she was there, and her absence was seen to be about lack of motivation and organisation at home. Whilst this review process was ongoing, a group of multi agency professionals have reviewed school attendance data for children approaching transition age between primary school and secondary school. This process has included case practice reviews to identify common themes and learning that can be used to support children with similar vulnerabilities to have a successful transition to secondary school and improve attendance.

29. The attendance issues were discussed in March 2023 as part of the TAC process, but CSC closed the case as the home conditions had improved to ‘good enough’. The increase in attendance issues for a child in Year 7 were not seen as a reason to continue involvement of a social worker, with the TAC meeting recommending that the school and EWS to start prosecution of the parents. It is important that all professionals working with children where neglect is a concern recognise that children not attending school, when part of a wider pattern of chronic and reoccurring neglect, is a child protection issue. This was also an issue where ongoing early help, in respect of attendance, via a Team Around the School discussion would have been helpful.

30. Neglect should always be considered when a child is absent from education. For these children, not being in school increased the known safeguarding risks and indicated their vulnerability to disadvantage and isolation. Children who are absent from education are among the most vulnerable, as they are at risk of underachieving, of being victims of harm or exploitation, and of having mental health issues as adults. They may also be invisible to professionals. It is important that all professionals consider the child's lived experience when they are not in school, establish how they spend their days and work together to ensure that the child returns to education. In Stockport there around 900[12] children where school attendance is a significant concern (where attendance is close to or below 50%) which has an impact on how services can intervene in a meaningful way. All schools are apparently having to provide more interventions themselves due to the limited capacity of the EWS. The EWS told the review that they were involved due to poor parental engagement and on-going issues with non-school attendance, and that the matter progressed quite quickly to enforcement actions. They were keen to use this review as a way of reinforcing that poor school attendance is the responsibility of all agencies and that it is strongly correlated with wider parenting issues. There is a plan to develop a multi-agency tool to support improved planning in relation to attendance issues.

31. From September 2022 new government guidance, working together to improve school attendance,[13] was implemented to help schools and local authorities to 'maintain high levels of school attendance'. It states that 'for the most vulnerable pupils, regular attendance is an important protective factor and the best opportunity for needs to be identified and support provided. Research has shown associations between regular absence from school and extra-familial harm. This includes crime (90% of young offenders had been persistently absent) and serious violence (83% of knife possession offenders had been persistently absent in at least 1 of the 5 years of study).' The guidance includes examples of positive practice in improving a child's school attendance, which include 'robust day to day processes to track and follow up absence and poor punctuality which are rigorously applied across the school.' Locally, there are changes being made to ensure that EWS focus is on the harder to reach children and for there to be a more strategic approach to those children. There is also a move to holding schools to account to ensure their improved focus on children where attendance is an issue, as expected in the guidance.

32. A thematic CSPR was undertaken in 2023 and issues were identified about the need for more aspirational and strengths-based approaches for older children in schools. Secondary heads and school improvement partners are investigating an offer for a nurture-based provision for

[12] Data from April 2024

[13] https://assets.publishing.service.gov.uk/media/63049617e90e0729e63d3953/Working_together_to_improve_school_attendance.pdf

those who are identified as at risk of struggling with the transition to secondary, using a primary based teacher to provide this. The plan is for a very focused transition for around 25 children per secondary school. The partnership should ask for an update on this initiative.

33. The meeting with managers reinforced the need to have a clear system-wide understanding in Stockport about educational neglect, and a clear statement about what multi-agency support is available to improve attendance for children where there are indicators that the attendance issues are due to neglect. There is also a need to consider the children who are being electively home educated and where neglect may feature. There is a commitment to improve in this area and a recommendation has been made.

Learning:
Professionals must always be alert to the possibility of sexual abuse in the family environment and be aware of the particular vulnerability of children who are known to have been neglected.

34. The existence of child sexual abuse (CSA) was not obvious to the professionals working with this family, although there was evidence of sexual abuse in previous generations, which is a risk factor. Although this was identified during the review period, this was not know by social workers at the time due to historical records not being accessed. There was however no known sexual abuse concerns about the male who harmed the 13 year old girl in this review.

35. It is known that children are more likely to be sexually abused if they are vulnerable. This includes children who are disabled, who witness domestic abuse at home, who have a history of neglect or physical abuse, who have a parent who was sexually abused in childhood, and/or who has mental health issues or learning needs. There is evidence that perpetrators often target vulnerable children because they believe they are less likely to disclose the abuse or be believed if they do. Professionals need to be aware of this, and to identify contexts where children may be more vulnerable to CSA. In the case of the children in the Smith family, a number of these vulnerabilities were evident and therefore there was increased risk of them being groomed and abused. While domestic abuse was not considered to be an issue at the time, the children's mother has since disclosed violence and coercion and control in the parental relationship.

36. Children who have been neglected are particularly vulnerable to sexual abuse, as are those who are often being cared for outside of their immediate family. In the Smith family the children had a history of chronic neglect. It is now known that they often spent time staying with wider family members and neighbours. They also had behaviours that were of concern to professionals, including emotional outbursts, anxiety, and refusing to go to school when they were in secondary school. The NSPCC report Child Sexual Abuse: Learning from Case

Reviews[14] states that 'if professionals are not continually challenging and curious about the source of children's distress, this can lead to missed opportunities to recognise and stop sexual abuse'. At the time the known neglect was seen as the reason for the children's behaviour, along with the acknowledgement that the parents often struggled to manage many children with emotional needs. What happened in this family shows the need to also consider if anything else may be an issue. The NSPCC report states that 'between a half to four fifths of children and young people who report sexual abuse have some symptoms of post-traumatic stress disorder (PTSD), anxiety or depression, and many exhibit self-destructive behaviours.' Professionals need to be alert to this and have an open mind to the cause of these behaviours. Professional curiosity and the ability to 'think the unthinkable' are key when working with the most vulnerable children.

37. There were other potential indicators of potential CSA for the children in the Smith family that are of concern to this review. Two of the girls had injuries to their genitals that were thought to be accidental 'straddle injuries' at the time. They were identified in 2013 and in 2016. The children were seen by medical professionals, but neither incident was shared with the police or children's social care at the time. In 2017 the British Society for Paediatric & Adolescent Gynaecology published a report looking at genital trauma in girls and states that sexual abuse should always be considered as a differential diagnosis. This is particularly the case when the child is more vulnerable to such abuse, including those with a history of other safeguarding concerns, and where the child has special needs. In the Smith family these were both relevant. As stated in the report, '*an assessment must be made in any injured child as to the aetiology of the injury, building up a picture of the whole situation'*. It also states that the child should be seen by a senior paediatrician, '*who will be best placed to consider all aspects of care, including child protection procedures.'* It is impossible to say whether the injuries in the two children were indicators of sexual abuse, as this was either not considered or was considered and dismissed at the time.[15]

38. When she was in year 6, the child who has been sexually abused was said to be wetting during the day and night. The school nurse undertook a continence assessment and gave advice to the child and her mother. Information on this was shared at the core groups (the children were on a CPP at the time). No consideration was given to this as a possible indicator of sexual abuse[16]. There were also concerns about the home environment that could have led to a discussion about lack of privacy, as some children were sharing beds and there were few internal doors. There was also reflection that professionals rarely had the opportunity to speak to Mother alone, and that having this kind of discussion with just Mother may have led to her

[14] NSPCC. Published January 2020
[15] A crib sheet is now available to the emergency departments, and there is an expectation of such injuries being flagged.
[16] https://www.nhs.uk/live-well/spotting-signs-of-child-sexual-abuse/

reflecting on her relationship with the children's Father and the impact on the children. It was also noted that the younger children were often overly friendly with strangers.

39. If the perpetrator had not made the disclosures of his abusive behaviour himself, it is possible that professionals would still not know about the sexual abuse, as the child has still not yet made a clear disclosure. In 2015, the Children's Commissioner carried out an inquiry into CSA in the family environment which states that only one in eight children who are sexually abused come to the attention of statutory authorities, and that children often do not recognise that they have been abused until they are older. Some children recognise their experiences as abusive only when they receive relationship and sex education classes in secondary school. For children who miss large portions of their schooling, this means abuse may not being identified or disclosed by the child until later.
40. In this case, the disclosure made by the perpetrator shows that the wider family may have been groomed to not share information about the abuse to professionals, apparently because of the financial support being provided to them by him. Perpetrators of child sexual abuse are known to groom children, their families, and professionals. They can work hard to gain the trust of children and their parents, and their presentation needs to be seen through a lens of whether they are showing grooming behaviours.[17] In this case the perpetrator stated that at least one of the other children and one of the parents knew about his sexual abuse of the child. While there is an on-going police investigation it is not possible to consider with the child or parent why they did not share the information, and why the parent did not safeguard her child and allowed on-going contact. It is possible that this is because financial support was being provided, because sexual abuse was accepted in the wider family, or because of the fear of repercussions from professionals in a family where there were already known concerns and a history of keeping professionals at bay. The family member was not known to agencies working with the children. The previously allocated social worker met him on one occasion when he was at the home at the time of their visit. He criticised the involvement of social workers, stating that there was nothing wrong with the home conditions. He was not seen or mentioned again.
41. It is noted that the focus on training in recent years has been on contextual sexual harm to children and not on sexual abuse in the family environment. Professionals told the review that they do not feel confident about identifying the risk of or signs of intrafamilial sexual abuse. There is a move to ensuring staff are trained to build confidence. Learning from this review about the links between neglect and sexual abuse also need to be reinforced with the

[17] They may work hard to gain the trust of children and practitioners by being charming, they can be intimidating, they can avoid engagement, they can create diversions, they can make fun of the process, they can encourage people to feel sorry for them, they can try to convince people that everyone is against them, and they can blame the child/victim.

workforce. The planned national CSPR[18] terms of reference states that it is being undertaken due to specific challenges in the identification, assessment, and response to this type of abuse, and their aim to ensure that multi-agency local and national safeguarding practice can change to better reflect evidence about how to protect children from sexual abuse in the family environment. It is expected that the review will be published shortly after this local CSPR is completed, and a recommendation has been made for the Partnership to consider the national review and it recommendations at that stage, in order to consider if the right conditions exist in Stockport to ensure effective and confident practice when a child is at risk from or has suffered sexual abuse within the family environment.

Learning:
There is a need for those working with a family where neglect reoccurs to understand and consider the impact on a child/ren of the parenting they are receiving, and to seek to understand why improvements are not maintained.

42. When a child is the subject of a child protection plan for neglect for a second or subsequent time, it is important that sufficient chronological context is given to their experiences, over time the Dylan CSPR published by the SSCP in 2023 recognised that the processes for supporting children and their families can lead to 'episodic or issue-based responses which limit the understanding of and support to families with more chronic needs'. There is an expectation that support provided to a family via early help or TAC is short term, and when a child is the subject of a child protection plan it is considered good practice for this to end as soon as improvements are seen. For the Smith family this led to incident led practice which saw the removal of support when things improved and as found in the Dylan case, opportunities were not taken to step back and look at patterns of parenting' over time to see the buildup of harm with each incident of concern. Both reviews show the need for support to be longer-term than is currently common practice, and for there to be more decisive consideration of whether the parents are able to care for and protect their children. Professionals working with the family recognised that there was a pattern of improvement followed by a deterioration in the care of the children and the state of the home, but this did not result in any positive long-term benefits for the children. This is a common issue nationally and was described as one of the biggest challenges for those wishing to safeguard children.
43. On two occasions when CSC involvement concluded there was a clear record made by the managers that should neglect concerns reemerge, 'the Public Law Outline (PLO) should be invoked'. In other words, there should be a serious consideration of care proceedings. This

[18] https://assets.publishing.service.gov.uk/media/656df31d1104cf0013fa74a7/Terms_of_reference_-_national_review_into_child_sexual_abuse_within_the_family_environment.pdf

was understandable and shows a recognition of the long-term harm caused by care that dips well below 'good enough' on a regular basis. When the first child protection plan was stepped down to Team Around the Child (TAC) in June 2018, the review child protection conference chair recorded that 'if the matter were to return to a child protection conference in the future, then the Local Authority would seek legal advice.' Concerns emerged again in 2019, when a housing worker shared their concerns about the poor state of the home. This resulted in a further period of TAC planning and improvements in the home conditions. It Is not known how long the home was in an acceptable condition, as there was limited professional involvement in 2020, possibly due to Covid 19. A further period of TAC planning occurred in 2021 after housing again shared concerns about the conditions in the family home. The review was told that even if the PLO had been started, it is likely that the matter would not have met the threshold for an application for care proceedings, due to difficulties in reaching threshold in cases of chronic neglect. This is a finding often made in reviews of this type.

44. By January 2022 an initial child protection conference was convened due to the lack of improvement from the TAC process. The concerns at the time were again about poor home conditions, lack of routines and boundaries, and poor school attendance. The conference concluded that there had been a general neglect of the children's basic needs, so they were placed onto CP plans under the category of neglect. In March 2023 the TAC plan ended as the home conditions were considered 'good enough'. It was clearly recorded however that 'any safeguarding referral into the MASSH re housing/conditions or other safeguarding issues will result in case going straight to pre-proceedings'. In July of the same year, there was a joint visit by the education welfare officer and a High School teacher. They were concerned about the state of the home as observed from the doorstep and that Mother did not appear to be coping. The High School made a referral to the MASSH in September 2023 after the children did not return to school after the holidays and they had been unable to contact the family. It is not known what the children's experience of the six-week holiday had been. Due to the learning identified in relation to the long term history of CSC involvement with the family in this review, and multiple episodes of child protection; the partners have undertaken a review of children who have been subject to child protection plans more than once.

45. There was evidence that the parents were avoiding professionals following this referral and a decision was made for an Initial Child Protection Conference to be held in November 2023. There again does not appear to have been any legal advice sought, although it is possible it would have been if the sexual abuse concerns had not surfaced. However, this was the third occasion where there was drift and delay and further assessment and support while deferring decision making about taking legal advice. All professionals involved in the children's plans, including the chair of the child protection conferences, has a responsibly to refer to previous plans and decision making, and to challenge drift and/or delay.

46. Understanding why the parents did not manage to maintain improvements was key in this case. Professionals needed to understand more about the parent's and how they spent their time and what was going on for them in their relationship and lives. Mother told the review that her mental health has always been poor, and that she struggled with motivation. She said that she now recognises that her relationship with the children's father was difficult, that he was controlling, that he went out a lot, and that he had traditional ideas about a woman's place and gender roles. She said that she was also ashamed about her home, but that she has an issue with hoarding that she was unable to control. The focus of work with her, and to a lesser degree with father, was on tasks and practical improvements, rather than trying to help her understand what, psychologically, got in the way of her managing.

47. Father told the review that he knew that the state of the home was not always good enough for the children, and that as he went out to work, he did not always have the energy or motivation to clean. He suffers with a physical health condition and has regular steroid injections. He said that this impacted on what he could contribute to maintaining the home. He did not think this was acknowledged by professionals. He didn't feel he was involved enough in meetings to be able to properly recognise the impact on his children of the poor home conditions. Father told the review that he found the conferences particularly difficult, as he felt there was never time to share his views or challenge what was being said. Although he did have a pre-meet with the conference chair, this would be about ten minutes which, again, was not long enough to share his views and to discuss each child. He said this led to him feeling frustrated, particularly because when professionals visited them, they did not always share the extent of their concerns. During the conference they would be much clearer.

48. Those involved reflected on the need to consider how usual processes may need to be changed when there is a need for a child protection conference to be held with a family like the Smith family, where there are a lot of children with different vulnerabilities and needs, and where there is a significant history. The standard conference format of a 90-minute meeting to hear about assessments and consider whether the children have suffered or are likely to suffer significant harm needs to be reviewed in cases where there is a big family and a history of previous CP planning, to ensure the individual experiences and needs of the children and fully considered and heard. When there are concerns about neglect, there is a need for the conference to robustly consider the chronology of concerns over time, what has been tried before, and why it did not work. This takes time. A recommendation has been made.

49. Professionals and families need to be aware of the impact of cumulative harm on children. This was highlighted in the CSPR undertaken in Stockport in 2023. As was the case with 'Dylan',

the cumulative[19] nature of neglect and emotional harm needs to be understood when working with a family where there is evidence of persistent neglect. Each new concern that emerges must be considered alongside what the child has experienced before, to assess whether a multitude of factors, when considered together, constitutes significant cumulative harm. In the case of the children in the Smith family, the older children's behaviour and difficulties, and the younger children's unhappiness were clearly indicating this.

50. When spoken to during the review, both parents stated they had happy childhoods and that they did not consider that they had any adverse childhood experiences. In Mother's case there was evidence that she did, as she had been on a child protection plan as a young child. Records show that she lived in a household where there was domestic abuse, and concerns that she was a victim of physical and sexual exploitation. When seen during the CSPR, Mother genuinely did not seem to remember this and stated that no professional had explained to her what the agency records included. If this is the case, this was a missed opportunity to consider with Mother the impact of her own unresolved childhood trauma on her ability to safeguard and care for her own children. Research and practice experience shows that adults who struggle to meet their children's needs often have poor mental health, and that this can be linked to ongoing or past trauma. If her own attachment with her care givers was compromised, this was likely to have an impact on her parenting. It is therefore essential to speak to parents about their own history to avoid relying on self-report, and to ensure that agency records are checked in order to be open and honest with parents about what might be impacting on them and their children.

51. In cases where long term neglect features, agencies tend to help the family with short term practical support, for example providing a skip, undertaking clearing and cleaning, referrals to charities and foodbanks, and buying beds, bedding and so on, Yet, when the improvements are not maintained and the parents are unable to continue to meet their children's needs over time, this indicates a need to consider *why* the children are being neglected, then work with a parent to improve their insight and their own wellbeing. Compiling and updating a chronology which includes agency information on the parent's childhood is important to any professional working with children where neglect is a feature. It is helpful and important to then go through the chronology with the parents to ensure there is a shared understanding of the history and a transparent conversation about the likely impact of the history on their parenting and ultimately on their children. The review found a lack of clarity about when a social work chronology is required, even though this is expected for every case. This requires further exploration. In a case like this it is important to complete one as part of an assessment to consider harm over

[19] Bromfield and Higgins in Australia first introduced the terms 'cumulative risk' and 'cumulative harm' in 2005 when they point out that 'the effects of patterns of circumstances and events in a child's life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.'

time, not as an admin task but as a meaningful part of an assessment. The review was told that responding to crises and the amount of work needed to keep up to date with the current issues with a family like this means that there is limited time to compile and consider chronologies. The social worker did complete a single agency chronology however, just prior to the allegations, and found this helpful when preparing for the ICPC that had been agreed. A recommendation in relation to chronologies was made in the Dylan CSPR, there has been ongoing work to progress this across the partnership.

52. The review could see the benefit of ensuring that multi-agency chronologies are completed in cases where there have been previous child protection plans and concerns reemerge, in order to allow those involved to interpret the history and understand the ongoing and cumulative risk to the child/ren. Those involved in the review spoke about the difficulty, with evolving IT systems in agencies, of accessing the history. A chronology which is kept up to date and remains on a child's record will ensure the history is always readily available. Using the chronology when working directly with parents is also helpful, as it should enable them to understand the concerns.

53. It is known that sometimes the children stayed with various family members. This was to support the parent's and provide some respite from the overcrowded conditions at home. Those involved in TAC or child protection plans for the children need to understand to extent and limitations for family or community support. They must engage with family members and potentially assess them when they are playing a key role in supporting or safeguarding a child, as even if it appears the children's physical care improves when they are staying with relatives, there may also be risks. Early Help and TAC planning can be enhanced by the use of family or community help, and understanding what this support involves is important when working with a family. Assumptions, either of protection or of risk, can't be made without meaningful engagement with those providing support. The parents told the review that they had supportive families, however they were not keen for professionals to engage with the wider family, due to being embarrassed by the involvement of professionals, and their perceived deficits in the care of their children. The social worker tried to seek the contact details of family members, but the lack of information provided by the parent's means there was no opportunity to ensure that family members who knew the children and may be supportive were engaged with. When the children were the subjects of child protection planning this could have been raised in the child protection conference setting as a necessary part of improving the children's lived experience**.**

54. In Stockport the Graded Care Profile 2 (GCP2) [20] is used as a way of objectively benchmarking neglect in families where they are reoccurring concerns about the children. It is acknowledged

[20] An assessment tool that helps practitioners take a strengths-based approach to measuring the quality of care a child is receiving and supports them to identify neglect.

that it is not used consistently, although it was twice with the Smith family, with each child being assessed individually, which is good practice. The GCP2 is not always recognised and used system wide, as is the expectation. The social worker reflected that it was difficult to undertake, as the parents were dismissive and sometimes angry. The Dylan review undertaken in 2023 reflected on the GCP2 and it was felt that, while only used sporadically, it did allow for evidenced based practice and successfully identified neglect at an early stage. For children where there is known neglect and the issue is not with the identification of concerns but with how improvements are made and maintained, there is a need for a clear model of practice. The need to refresh the current neglect strategy has been identified and forms a key recommendation in Stockport's CSC improvement plan. This should include how to work with families when neglect has been identified.

Learning:
The impact on children of poverty and poor housing conditions needs to be considered alongside concerns about neglect. Professionals in communities with high levels of poverty need support in differentiating between the two, but also to be able to challenge themselves and others about their thresholds for neglect in poorer communities. This should include agencies robustly considering if their essential support is masking child neglect.

55. The review was told that there is evidence that inequality and poverty is growing in the Borough, and that poverty awareness across all agencies is important to the system. There is a strong association between poverty and a child's chance of suffering child abuse or neglect. As stated by Bywaters et al[21] in 2016, 'the greater the economic hardship, the greater the likelihood and severity of child abuse or neglect.' The review considered, with the professionals involved, their expectations about families who live in certain communities or areas of Stockport. Including whether expectations about care of children are lower for these families, and if there is over optimistic celebration of even small improvements, with the potential that neglected children are not then being adequately safeguarded. The experience of working with this family shows that there is a need for professionals to consider and challenge themselves and others, during supervision and when meeting with colleagues also involved with a child, about whether there is any evidence of tolerance or desensitisation about neglect in certain families and in certain communities. In the case of the Smith family there was commitment to improving the situation for the children without resorting to child protection or legal interventions, and understanding about the difficulties the family faced, including with overcrowded housing. The system ensured that the children received practical support to negate some of the impact of their situation, such as breakfast at school and winter coats.

[21]The relationship between poverty, child abuse and neglect: an evidence review. Bywaters et al, 2016

While the review considered if such support masked neglect (also known as 'scaffolding') it was agreed that many children benefitted from such support, and that professionals were mostly aware of those where neglect featured alongside poverty. It was concluded that best practice is for schools to support the children in practical ways but also to consider assessing and making a referral for neglect.

56. The review was told that work is being done with schools regarding improving the quality of referrals.[22] This should include detailed information sharing about the support provided. There was appropriate recognition of overcrowded housing and the impact of poverty. The Smith family lived in a relatively small home and had clear difficulties managing on a limited income. Hindsight shows the significance of this, as the extended family member told the police that the reason the parents did not inform anyone of the sexual abuse was because he was providing a degree of financial support to them. The family support worker who knew the family well tried to discuss budgeting with the parents, as she had been concerned about where their money went. She said they found this very hard and were extremely defensive and avoidant of this work. Mother told the review that she was ashamed and embarrassed by the state of her home and not being able to afford to look after her children properly.

57. There was evidence of involvement from the housing provider and communication with and from them. The need of the family to be rehoused was acknowledged by all, but without extensive and expensive repairs being done (to damage that was assessed to have been due to the tenant's lack of care or maintenance) they could not be rehoused. The poor home conditions meant that it was hard to differentiate what was due to the size and condition of the home and what was neglect. What was clear, was the amount of time most of the professionals involved spent trying to resolve the housing issue. CSC agreed to provide a percentage of the costs of the repairs, but the family were unlikely to be able to raise the funds for the balance, which was thousands of pounds, and were not able to organise and plan for the work to be undertaken. When the housing provider did agree to undertaken repairs, access was not always provided. There was no solution in sight when the children were removed.

58. Research in Practice published a briefing in 2019 called 'neglect in a context of poverty and austerity.' They quote Morris, who reflected on the fact that when almost all the families being worked with are experiencing financial hardship, it can become 'the wallpaper of practice - so familiar that it is not discussed as a factor affecting parents' ability to care for their children'. The briefing explores the complex interaction between poverty and concerns about neglect of children by their caregivers. It encourages practitioners to reflect on; the impact of poverty on

[22] Schools in Stockport are also working on 'poverty proofing'. This includes an awareness of the need to make it hard for the general school population to identify children with free school meals or receiving cost-related support and being sensitive to costs associated with curriculum and after school clubs and so on.

families and their ability to meet their children's needs, including experience of discrimination and stigma; the types of support that can help mitigate the impact of poverty on parenting and children's outcomes; and the way that practitioner interactions with families can re-enforce or relieve some of that feeling of blame and disempowerment. They also consider the indirect effects of poverty, including the stress of managing day-to-day life in poverty, which can reduce the capacity to provide nurturing care. This resonated with professionals in Stockport, who recognised that families having to use food banks and choosing between 'eating or heating' has become normalised in recent years.

59. The Children's Society[23] reflect on this issue, and the danger of practice in poorer communities being different to practice elsewhere. 'When practitioners experience the sights, sounds and smells that result from poor living conditions, emotional responses of disgust, anger and fear are common and understandable. These responses can become associated with particular streets or localities, leading practitioners to have pre-conceptions about the families that live there and may well get in the way of forming a working relationship. They make suggestions about what can make a difference, that should be considered by professionals and agencies. This includes the importance of supervision, how to focus on what can be done when feeling powerless and exhausted, the need to challenge discriminatory language and stereotyping, exploring a family's history of involvement with services, and recognising the danger of bias.

60. The review acknowledges that this issue was a factor with the Smith family and that it is a wider issue that requires consideration by partner agencies. Professionals need support in working in a non-discriminatory way with families where poverty is their norm, and in developing practice that differentiates between poverty and neglect, and challenges normalisation of both. The learning briefing being produced from this review will stress this issue.

Conclusions and recommendations

61. There are several similarities between this review and the CSPR completed in 2023 regarding Dylan. Both reviews should be considered when considering learning for the system in respect of neglect, as much of the learning in respect of Dylan and his siblings is relevant to the Smith family. The exception is the learning about child sexual abuse in the family environment and the links between school attendance and neglect.

62. Recommendations were made in the Dylan review that are relevant to what has been found when considering the professional involvement with the Smith family. They include; the use of chronologies[24] within and across agencies, which incorporate the history of siblings and parents, to inform safeguarding work; the need for professional understanding and assessment

[23] The Children's Society, Understanding childhoods: Growing up in hard times. (2017)

[24] It should be noted that chronologies should also include positive information in respect of the family. They can be used as a tool for engaging the family and can include their comments and views.

of the impact of mental health and trauma on parenting; the need to monitor the professional use of the multi-agency practice model (restorative practice) in respect of the need to balance high support with high challenge; and the need for the increased use of the GCP by professionals who have been trained, and for this to be monitored and appropriately challenged.

63. It is recognised that actions have already been taken in relation to some of the multi-agency and individual agency learning, and that changes have been made. Having considered further learning identified during the review, and recognising the need to check that the reported changes are effective, the following recommendations are made:

Recommendation 1

The Partnership should refresh its neglect strategy, and this should include agreed identification and assessment tools. The strategy should make provision for a training programme that ensures that partners are equipped to identify and respond to neglect where and when it occurs; that the impact of cumulative harm is well understood and that the relationship between sexual abuse and neglect is clear. This work should be reviewed following publication of the National Panel's review of neglect in 2025.

Recommendation 2

The Partnership should seek assurance about the delivery and progress of existing plans to improve system-wide understanding and response to educational neglect. This should be explicit in any revised neglect strategy.

Recommendation 3

The Partnership should publish and deliver a strategy that outlines an agreed approach to child sexual abuse. This should include a clear training offer to strengthen and support confident practice in identifying and responding to this issue. The findings from the national CSPR on sexual abuse in the family environment should be considered when completing this recommendation.

Recommendation 4

The Partnership should continue to promote the use of chronologies and genograms across agencies so that families' stories are known and understood. This should include consideration of parents' own childhood histories and exploration of the involvement and contribution of wider family members. Assurance activity to ensure that this learning is embedded in practice is recommended.

Recommendation 5

A clear pathway should be put in place to encourage increased use of partnership supervision. This recommendation is made with a view to enabling the provision of safe multi-agency spaces where curious systemic conversations can take place and partnership chronologies be developed.

Recommendation 6

The relevant statutory partners should provide assurance to the Partnership in relation to the following:

- That Police Powers of Protection are being used appropriately, and that decision making is focused on the needs of the child.
- That NICE guidelines are being followed in medical settings when genital injuries are present.

Recommendation 7

Child protection conference practice should be reviewed to ensure that:

- Full single agency chronologies are required for all initial child protection conferences and time is available for robust and detailed consideration of these
- time is available for each child to be considered appropriately when there is a large sibling group
- A procedure is in place that provides additional rigour to thinking and decision making for children who become subject to a child protection plan for a second or subsequent time.