Local safeguarding Practice Review

Sara, Edvina and Danuka

Jane Wiffin

1. Introduction

Reason for the Local Child Safeguarding Practice Review (LCSPR[1])

1.1 This independently led LCSPR was commissioned by Bradford Children's Safeguarding Partnership regarding three sisters, Sara (aged 11 months), Danuka (aged nearly two) and Edvina (aged 6). In December 2021 the children were living with their mother (aged 22) and her partner, Teo, in temporary accommodation. The family were subject to a Child in Need plan[2] and Mother had been found to have no settled status[3]. A referral was made by a voluntary sector organisation regarding concerns of Mother and what she described as her husband Teo's drug use, poor care of these young children and domestic abuse and violence. The initial response was not sufficiently urgent, but after two weeks at a home visit the two younger children were found to be living in significantly neglectful circumstances; mother and her partner were under the influence of illegal drugs. Child protection medicals were undertaken, and Danuka and Sara were both observed to be in significant pain due to injuries. Danuka had fractured ribs and bruising on different parts of her body, she also was found to have unexplained liver damage. Sara had some problems with her leg and such severe nappy rash that it had advanced down her legs. Edvina was not in the accommodation at the time and was found to be physically unharmed. The social worker who visited at this time is commended for her swift response, and in ensuring that Sara and Danuka were quickly taken to hospital for medical care and attention.

About the children and their Family.

1.2 Mother was born in Eastern Europe[4] and the maternal family heritage is Romani. Mother told professionals that she either did not know who the children's fathers were, or they were not involved, or different men's names were provided to different professionals. There remains a confused picture with a lack of clarity about the father of each child. The Mother moved to the UK when she was 11 with her parents and younger siblings, though little was known about them during the time under review. It has become clear that the children

[1] A Child Safeguarding Practice Review (previously known as a Serious Case Review (SCR)) is undertaken when a child dies or has been seriously harmed and there is cause for concern as to the way organisations worked together. The purpose of a child safeguarding practice review is for agencies and individuals to learn lessons that improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of children. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[2] why-do-i-have-a-child-in-need-plan.pdf (proceduresonline.com). The Child in Need Plan must identify the lead professional, any resources or services that will be needed to achieve the planned outcomes within the agreed timescales and who is responsible for which action and the timescale involved. Child in Need Planning Meetings will follow an assessment where the assessment has concluded that a package of family support is required to meet the child's needs under Section 17 of the Children Act 1989. The Planning Meeting provides an opportunity for a child and his or her parents/carers, together with key agencies, to identify and agree the package of services required and to develop the Child in Need Plan.

[3] Settled Status means that an individual has the right to live, work, and remain indefinitely in the UK, free of immigration control. It also means that the holder can access public funds (e.g., benefits), and after 12 months, apply for British citizenship.

[4] No country is given to provide confidentiality for the children.

lived itinerant lives, moving between at least five addresses, with a constant move back to mother's family home. Edvina lived for much of the time with maternal grandmother. Mother had at least six different adult men in her life, but the nature of the relationships in most situation is not known. The review does not refer to them all as partners because the nature of this involvement is unclear; there was known concerns about domestic abuse, but also indications of exploitation, but without any clarity about this. The following table in included to make clear who each adult male was so that readers can navigate the narrative which follows and what was known about their links with mother and the children. Although mother talks of some of these men as being the children's father, it is not clear if this is the case.

Person 1:	Bogdan: Eastern European	Mother and Edvina (as a baby) moved to live with him and his family when mother was 14 for some brief periods of time. Bogdan is referred to in 2020 as Danuka's father.
Person 2	Jarra: Eastern European	When mother was 17, she took Edvina to live with Jarra and this relationship lasted for around 3 years. She ended the relationship at around the time she was pregnant with Danuka.
Person 3	Karl: Eastern European	Mother was said to be in a relationship with Karl from early 2020, just when Danuka was born, but she always denied this, despite describing him as her boyfriend to some professionals and the extended family also saying this.
Person 4	Peta: Eastern European	Peta was reported to be Karl's brother and mother said she was in

		a relationship with him. There is no evidence whether this was the case. Mother lived with both Karl and Peta's parents outside Bradford during COVID public health requirements and before Sara was born.
Person 5	Paul: White/British and aged 52 (he is the only male who was older than mother).	There is no information about Paul, how he knew mother or what their relationship was. He was at times referred to as Danuka's father by mother and there was a couple of call outs to the police for harassment in 2020.
Person 6	Teo: Eastern European	It is unclear when and how mother met Teo, but he was introduced by her to professionals as her husband in 2021. It is not known if this was accurate.

Process of the Review

1.3 This review has been led by Jane Wiffin, an independent person with no practice links to Bradford. The methodology used was the significant incident learning process (SILP[5]). This process is consistent with the requirements laid out with Working Together 2018 for the conduct of an LCSPR.

1.4 The review process was overseen by a panel of senior managers/safeguarding professionals representing all the agencies who had contact with mother, Edvina, Danuka and Sara. They have acted as a critical friend to the independent reviewer, and helped with local knowledge, analysis of data and considering key lines of enquiry which form the themes at the end of this report. The independent reviewer would like to thank them for their hard work,

[5] SILP Reviews – Review Consulting

reflections and responses to the many questions asked in seeking to understand the children's world.

1.5 Individual agency reports were commissioned, which provided an analysis of the services provided to the siblings and their family and within these there are single agency recommendations.

1.6 It was unfortunate that many of the frontline professionals who worked with the family had left and so only two were able to come together with other representative professionals as a group to reflect on the emerging learning and to review the draft report. It is not always easy to review your own practice response to a family, but these two professionals have done this with openness, intelligence, and most of all as a commitment to wanting the best for these children and children in their circumstances. The independent reviewer would like to thank them for their time and help.

Family Involvement

1.7 Mother and her partner remain subject to criminal proceedings and the wider extended family have ongoing involvement with children's services which means that meeting with them at this time would not be appropriate.

2. Timeline of Edvina, Danuka and Sara's journey through services

Background information.

2.1 When Mother arrived in the UK she lived with her parents and five siblings. There were concerns about neglect of all the children, poor school attendance and concerns that mother was being sexually exploited which were assessed and support provided.

2.2 When Mother was 13/14, she spent some months in her country of origin. When she returned aged 14, she was 5 months pregnant. She reported that she did not remember how she got pregnant due to 'being drunk'. A pre-birth assessment[6] was completed, specialist support was provided by the specialist teenage midwife and a Child in Need plan put in place for a short period of time to support Mother and Edvina. Mother did not return in any meaningful way to school from this point.

2.3 When Mother was still 14 and Edvina a few months old they moved in with a man called Bogdan who Mother said was Edvina's father. There were concerns about his problematic alcohol use and domestic abuse. Mother and Edvina returned to live with the family. The whole family's engagement with health services was intermittent and between April 2016 and October 2018 they were held on the 'missing' caseload as their whereabouts were unknown.

2.4 When Edvina was 3, mother 17, they moved to live with Jarra (22) about whom there were concerns of sexual abuse and exploitation. Mother was persuaded to return home because of child protection enquiries. They quickly moved back to live with Jarra and there were two police call outs due to verbal disputes and threats of violence by Jarra.

Professional Involvement with the family. June 2019 to December 2021

2.5 At the age of 19 Mother was pregnant with her second child (June 2019). She and Edvina were still living with Jarra. Mother initially sought to have the pregnancy terminated but did not attend the appointments. During the first four months of the pregnancy there were three police call out's due to verbal arguments and Jarra's theft of some of mother's property. Sara was present and described as upset. Bradford Children's Social Care (BCSC) were informed.

2.6 Mother sought midwifery care when she was 5 months pregnant (September 2019), and an interpreter was used. This was the first indication that Mother was not proficient in English as her second language, something that was

[6] The purpose of a pre-birth assessment is to identify any potential risks to the new-born child, assess whether the parent(s) are capable of changing so that the identified risks can be reduced and if so, what support they will need. Assessments (proceduresonline.com)

inconsistently recognised in mother's future contact with practitioners. This is picked up in **Theme 1** about cultural competency.

2.7 The midwife asked about domestic abuse and use of drugs and alcohol; mother said that she did not know the father of the unborn baby well (called Martin) and he would not be involved in the future; this was not further explored, and this is picked up in Theme 4. Mother said that she did not drink or take drugs, had good family support and was happy to be pregnant. Contact was made with BCSC because Mother reported earlier involvement as a child. BCSC confirmed this, but information about the police call outs in recent years, was not provided. This meant that the midwife did not have a full picture of the vulnerability of this young mother. BCSC should have given some thought to whether a pre-birth assessment was required. This is discussed in **Theme 2**. Mother failed to attend subsequent midwifery appointments, although she was seen in hospital with pregnancy related health concerns when 7 months pregnant.

2.8 There were two police calls outs regarding domestic abuse, and the second included threats to kill by Jarra when Mother was 7 months pregnant. Jarra was arrested and gave a no comment interview. BCSC were notified and it was agreed that Mother would move back to live with her mother (maternal grandmother).

2.9 There was an antenatal visit by HV1 in December 2019 when Mother was 8 months pregnant. This took place in maternal grandmother's home. The only concerns noted were overcrowding, a cluttered environment, and Mother raised worries about benefits. She did not have a bank account and she said her benefits went into her stepfather's account. There is no recorded information about any evidence regarding preparations for the new baby.

2.10 In the week before Danuka was born, Mother attended her second midwifery appointment. Mother's reasons for her non-attendance are not recorded and the meaning of this in terms of both her feelings and trust in services and her ability to think that the ante-natal care was equally about the baby's well-being, indicating possible early signs of not being able/not understanding the need to put her child's needs before her own was not explored.

2.11 Danuka was born at home in January 2020; routine postnatal visits were undertaken and there were no concerns. HV1 saw mother Danuka, and Edvina (aged nearly 6) at a new address (this was the flat she had previously lived with Jarra; address 2). This accommodation was described as untidy, cluttered, but clean. HV1 noted 'warm and caring' interactions between Mother and both children. Mother said Edvina lived mostly with maternal grandmother but was often at home with Mother and Danuka.

2.12 Over an eight-week period from February to April 2020 there were nine incidents of concern. Five were either shared with BCSC or police notifications received. Four further incidents were contacts with the police.

- The police were called by mother's landlord with concerns that she was using drugs. No evidence was established but the incident was shared with BCSC.
- BCSC received two anonymous referrals that Mother was in a relationship with a dangerous and violent man named Karl and there were concerns that mother was using drugs. The duty social worker (DSW) asked HV1 to discuss the concerns with Mother at her next visit, but no one was at home. HV1 was told Mother moved back to live with her family; this address was visited, and a family member said that Mother was out with her boyfriend, Karl. HV1 shared this information with BCSC.
- A week later BCSC received another anonymous referral about Mother taking crystal meth in the street with Danuka present. The DSW initially asked for a police welfare check to be completed, but this request was declined. HV1 was asked to complete a visit and Mother was not at home. The DSW concluded that the anonymous referral was malicious due to information that Mother had been in a dispute with her landlord.
- There was a referral to BCSC from a man who said he was Danuka's father (no name was given) reporting concerns about Mother not seeking medical advice for Danuka and that she was involved with a dangerous man called Karl. HV1 undertook a planned appointment and there was no one at home. Contact with the GP suggested there were no health concerns except missed immunisations. It was decided no further action was necessary.

2.13 There were four incidents involving the police that do not appear to have been shared with BCSC:

- Mother reported harassment by Paul (aged 52) to the police, caused by their breaking up; she refused to provide a statement. The police records show that Mother was now living at a new address (address 3). Danuka was present.
- The police were called to an incident where a neighbour reported that Mother and her partner Karl had made threats to kill him. There was a further reported incident a few weeks later where the police were called because the neighbour was said to have barricaded Mother in her flat after a party and further conflict. These were all at address 3.
- The police visited address 3 in connection with a third party suspected of involvement with drug crime. This person was not found, but Mother was there with a man named Jed who was described as her boyfriend, the brother of Karl and his parents were present and described as Danuka's grandparents. No drugs were found.

2.14 Mother was pregnant with her third child when she was 21, four months after giving birth to Danuka. She spoke to her GP via telephone[7] and said she did not know who the father was, and she was living back with her family. Midwifery contact was made via telephone, with an interpreter included. Midwifery contacted BCSC because of mother's previous history and they reported no current involvement with mother and her children; recent referrals were not shared. It seems that Edvina may again have been spending much of her time living with maternal grandmother, whilst mother moved between addresses. The exact details are not known.

2.15 Mother then sought to have the pregnancy terminated and informed midwifery of this. She failed to attend the termination appointment and sought midwifery care seven weeks later. She did not attend subsequent appointments and home visits were undertaken without success. She attended a midwifery appointment when she was seven months pregnant and reported that she had moved back to live with her family. The midwifery team had been visiting address 3 and so had no found her there.

2.16 Soon after this in October 2020 BCSC received a referral from school about Mother being in a relationship with Karl and being pregnant by him. It was agreed that a Child and Family assessment (known in Bradford as a 'single assessment[8]) would be completed. Mother said that she was in a relationship with Bogdan (partner 1 from when she was 17) not Karl. The assessment would be ongoing for the next ten weeks.

2.17 Mother failed to attend her next midwifery appointment, a home visit was undertaken, and the midwife was told that Mother had moved (address 5) to the home of Karl's parents. The midwife appropriately made an urgent referral of concern to BCSC and discovered that a Child and Family Assessment was underway. The midwife also liaised with HV1 and the GP surgery.

2.18 Mother attended two midwifery appointments in December 2020, a few weeks before Sara was born. There were no concerns about her health, but the issue of all the missed appointments and the reason for these do not appear to have been discussed.

2.19 The Child and Family Assessment was completed two weeks before Edvina was born in December. The conclusion was that Karl did pose a risk to children but there was no conclusive evidence that Mother was in a relationship with him. The plan was for a Child in Need process and plan[9] to be instigated and

[7] Due to COVID public health requirements
[8] A key aim of the Single Assessment is to set out clearly the assessment plan and will: Aid relationship building with children and their families. Consider the balance between managing and reducing risks and promoting resilience • Assist in explaining to children and families why social workers are involved in their lives.
[9] The Child in Need Plan must identify the lead professional, any resources or services that will be needed to achieve the planned outcomes within the agreed timescales and who is responsible for which action and the timescale involved.

for Mother to seek her own tenancy/accommodation. The issue of the lack of reflection on the recent history and the poor analysis within this assessment is discussed in Theme 5 alongside the poor-quality Child in Need plan which was proposed. The first Child in Need meeting[10] was held remotely via telephone in December; midwifery, the GP and HV1 were not invited. Mother did join the call and it was agreed that the social worker would do direct work with Edvina because she had not been seen as part of the assessment, Mother was asked to keep all health appointments for the children and engage with support without there being an analysis of why this had not happened previously; it was proposed that Mother would seek her own tenancy, but in the meantime she would move back to her family home away from Karl's parents at address 5. There was said to be a safety plan in place, but it is unclear what this consisted of beyond moving back to Bradford.

2.20 A community nursery nurse completed Danuka' 9–12-month developmental check over the telephone due to COVID requirements. Mother said there were no concerns about domestic abuse or substance misuse but said she still smoked outside. She said that she had not taken Danuka for her immunisations due to concerns about COVID public health requirements. Mother said she would be moving back to Bradford.

2.21 Sara was born at the end of December in a hospital outside Bradford. Hospital staff had no knowledge of Mother or her circumstances. Contact was made with Bradford Emergency Duty Team and a discharge plan was agreed. Midwifery follow up was provided by the Bradford team because Mother and the children were now back in Bradford. There were no concerns.

2.22 HV1 visited Mother and the children at her family home at the beginning of January. HV1 observed warm and caring interactions between Mother and the children. The house was described as very overcrowded with at least eight people living there. The extended family were noted to be supportive. Mother reported that's she was not currently in a relationship. She said she was concerned that her benefits had stopped, and information was provided about where to seek advice. HV1 tried to contact the new social worker to ask about the next Child in Need meeting but got no reply.

2.23 The next (and last) Child in Need meeting was held at the end of January 2021. This was a conference call, joined only by representatives from Edvina's school; no other professionals were invited. The minutes suggest there was some

[10] Child in Need Planning Meetings will follow an assessment where the assessment has concluded that a package of family support is required to meet the child's needs under Section 17 of the Children Act 1989. The Planning Meeting provides an opportunity for a child and his or her parents/carers, together with key agencies, to identify and agree the package of services required and to develop the Child in Need Plan.

confusion about where Edvina was living. There were no changes made to the plan and the minutes do not give an outline of the children's circumstances.

2.24 Mother was not at home for the next visit by HV1 but was seen at the beginning of February 2021. HV1 noted that Mother behaved in warm, caring ways to the children. A man left the home when HV1 arrived, and Mother said this was Bogdan, her partner. There is no further information or reflections about this man, given on the face of it he was a new relationship. This man was confirmed to be Karl by the social worker, who reported there were no ongoing concerns regarding him and consequently no role for BCSC.

2.25 Between February and March 2021 there were escalating concerns about Danuka and Sara 's unmet health needs including:

- HV1 was notified by the neonatal hearing team that Sara had not been brought for five appointments.
- The GP surgery shared that there were numerous outstanding immunisations for the children.
- Mother did bring Sara for her eight-week developmental check; the GP surgery telephoned her several times as a reminder, they also sent texts and offered for mother to attend without the need to make an appointment. This was good practice.
- There were concerns about Sara (aged 10 weeks) having an ear infection with an awful smelling discharge. Danuka (aged 13 months) had a scalp infection. Anti-biotics were prescribed and further follow up appointments were made. These follow up appointments were not kept. Mother brought Sara to see the GP at the end of March and such was the concern about her health needs, Mother was asked to take her to hospital the following morning. Mother attended but left before being seen. HV1 was informed.

2.26 HV1 attempted some home visits because of the health concerns without success but in March she was able to see Mother and the children. Mother said she would take the children to the GP, though this did not happen. The home environment was seen to be chaotic and overcrowded. Warm interactions were observed between mother and the children. HV1 was concerned that when she was parked outside the house, there were signs of drugs being bought from the house by young women. This was shared with the social worker. It led to no action.

2.27 HV1 and the Advanced Nurse Practitioner (ANP) from the GP surgery shared concerns and they completed a comprehensive chronology of all the missed health appointments, unattended developmental checks, lack of immunisations and they sent this to the social worker. This was followed up by phone calls and email, without any reply from the social worker.

2.28 In April 2021 the social worker discussed these health concerns with her manager. It was felt that the Child in Need process was not working, and a child protection plan[11] would also not work because Mother would be unlikely to engage with it. The plan was to end the Child in Need process.

2.29 HV1 undertook an unplanned visit to see the children in April 2021. Mother was at home, and the children were seen. Sara 's ear infection had healed, as had Danuka's 's scalp infection. Mother said her benefits had been stopped. HV1 suggested seeking advice from the benefits agency and provided contact details.

2.30 The Child and Family Assessment was updated at the end of May. A safety plan was said to be in place whereby the children were not to have unsupervised contact with Karl's family; described as paternal grandparents. The decision was made to step down to an early help plan, with HV1 being the lead professional. HV1 was not informed of this decision.

2.31 In June 2021, sexual health services visited mother at home. They were concerned at the state of the house, which was infested with cockroaches and a Stanley knife was on the floor in reach of the children. The sexual health team contacted early help who said they were not working with mother but that HV1 was the lead professional and was undertaking an assessment. HV1 was contacted by sexual health, the concerns about home conditions were shared and HV1 was told that mother had recently had a termination. HV1 agreed to visit to discuss the early help assessment.

2.32 HV1 visited two weeks later. She stayed on the doorstep due to COVID requirements; Danuka was in the garden and Sara was reported to be asleep in the house. Mother was asked if she wanted early help support and she declined this. HV1 moved the family to universal provision.

2.33 At the beginning of September 2021 a member of the public noticed mother, a man she described as her husband (Teo) and two young children sleeping in the park late at night; Danuka was now twenty months old and Sara nine months old. BCSC emergency team were contacted, and emergency housing provided. Mother was given the number for housing and using a member of the publics phone (she did not have one) she made an appointment for the next day.

2.34 The housing assessment concluded that because Mother did not have settled status, she had no entitlement to housing assistance. Mother reported that she

[11] Where social workers and professionals feel that a child is at risk of significant harm, the local authority will arrange a Child Protection Conference and the child may be made subject to a child protection plan. This plan will set out what decisions were made in the conference to keep your child safe, what needs to be done and what support will be provided.

had been living at address 6 with Teo, her partner and two young children. They had been evicted and she said she had lost contact with her family. They said they had been street homeless for the last three weeks. Mother reported living on £140.0 per month child benefit, and some cash in hand money earned by Teo for small jobs like gardening.

2.35 A social worker was allocated to complete a Child and Family assessment. The family were provided with temporary accommodation. This was two rooms in a hostel accommodation inhabited by single adult tenants who were also homeless caused by substance misuse and some were sex working. There was a shared bathroom and kitchen.

2.36 At the end of September Mother called the police because Teo had punched her in the face when she had woken him to ask for money to buy medicine for the children. The police attended and were very concerned about the state of the accommodation, which they considered was not suitable for young children. There were no cots for them, and Sara was asleep in a buggy. The electric sockets were uncovered, and Danuka was crawling around, attempting to put her fingers in them. BCSC emergency duty team were contacted but said this was a housing issue and suggested completing a Multi-Agency Referral Form (MARF[12]). This was done. Sara started to have breathing difficulties and an ambulance was called. The police called an ambulance, but because of the lack of availability the police took Sara and mother to hospital. The police left, and Mother then left before Sara was seen. The Accident and emergency staff contacted the social worker and health visiting service.

2.37 The social worker went to see mother, Teo and the children. Mother and Teo were seen together to discuss domestic abuse and Teo blamed Mother for starting a fight. A 'safety plan' which did not address the concerns was formulated. The children were seen and looked unclean and unkempt; Sara looked underweight. Edvina was noted to be living with them because maternal grandmother had started working. The family were provided with travel cots and other essential items. Mother requested a food parcel.

2.38 The social worker asked if HV1 could undertake a visit and complete a height and weight check. This was agreed, but HV1 was unable find the property. HV1 then handed over to the health visiting team in the area Mother and the children were now living. A general handover was provided which did not highlight the urgent need for Sara to be weighed; HV1 said that the mother and the children were receiving universal health visiting services[13]. This meant the receiving health visiting team could not see there was a need for an immediate visit and a new health visitor was not allocated until the end of October 2021. The lack

[12] The MARF is the local process for alerting professionals about concerns regarding a child.
[13] Under the Healthy Child Programme this level of support indicates there is no need for any further support that routine health visiting support. HCP - Pregnancy and the First Five Years of Life (publishing.service.gov.uk)

of Sara's weight being checked was not challenged by the social worker or followed up. HV2 tried to complete a home visit some weeks later but could not find the property. HV2 did not ever visit.

2.39 The child and family assessment was ongoing through October and November. Mother regularly sought financial support from the social work office. BCSC received a phone call from the Landlord of the temporary accommodation reporting that Mother was begging for food from other tenants. He also said that Mother and Teo had been allocated two rooms but had sublet to a couple (male and female) and so this room was taken away from them. They were now all living on one room.

2.40 The child and family assessment was completed on the 10th of November. The assessment focussed on the family's immigration status and housing. It was acknowledged that the children looked unkempt, that the housing conditions were inappropriate, that the children did not receive adequate food or milk, but the conclusion was that their needs were adequately met. The assessment describes, but does not analyse the domestic abuse incident, and there were no immediate plans to move the family, given the unsuitability of the housing. Recent concerns by the landlord were not mentioned, nor the impact of three children living in one room.

2.41 The first Child in Need meeting was held in November with a focus on housing. The second at the end of the month. This was attended by the social worker and HV2, Edvina's school and the Butterflies project worker (specialist immigration advice and support) sent their apologies. At this meeting it was reported that the social worker had been unable to meet with the family or contact them. The concerns from the landlord were discussed, alongside outstanding health needs. There were plans for a new social worker to be allocated.

2.42 At the beginning of December 2021, the social worker received an email from a worker from the local Project working with sex workers sharing information from one of her clients about mother and Teo using drugs, domestic abuse, the children being left home alone and several different men visiting the rooms. The social worker went to the hostel twice in the next two weeks and no one was at home. This was not a sufficiently robust response. Two weeks after the original concerns had been shared the children became the responsibility of a new team and there was an appropriate review of their circumstances. There was an immediate home visit where mother and Teo denied the concerns and there was no evidence of drug use. This was followed up by another visit the next day, where mother and Teo were found to be under the influence of drugs and there was evidence of drug paraphernalia. The police were called. Sara and Danuka were present and found to have unexplained injuries. Mother and Teo were arrested, and the children placed with foster carers.

3. Analysis and Key Findings

3.1 The purpose of any child safeguarding practice review (LSCPR) is to review the circumstances of one family and consider whether this suggests that there are improvements that need to be made locally and nationally to safeguard, promote the welfare of children more generally and to seek to prevent or reduce the risk of the recurrence of similar incidents[i]. There are several themes that emerge from a review of Sara, Danuka, and Edvina's circumstances.

Finding 1: The importance of professionals working in a culturally competent way.

3.2 All the professionals who had contact with mother and the extended family were aware that the family heritage was Romani and they had moved to the UK from Eastern Europe.

Understanding of language and literacy skills

3.3 Professionals were also aware that mother's first language was not English, but there was a lack of clarity or precision about how well mother, her family and more latterly her partner, Teo, communicated in English or what their literacy skills were.

3.4 The police and midwifery demonstrated good practice by providing an interpreter for mother, but the need for this was not recognised by others. mother often said she could converse in English comfortably. This was not the same as having important conversations about addressing the children's health needs, why mother did not engage with support or attend appointments, making enquiries about domestic abuse, understanding sensitive issues such as the reasons for the requests for termination of pregnancy and trying to make sense of issues of neglect and the quality of care provided to these young children. It has now become clear through the school that Sara attends that maternal grandmother and mother both have very limited understanding or use of English. It remains unclear Mother's level of literacy overall, but she did not have a good grasp of written English. Professionals should have asked about language and literacy skills and made the reasonable adjustments required by the Equalities Act 2010[ii].

Understanding the Families Cultural context

3.5 There is little information available from the records about the cultural context of mother or her family. There is no information about the family's reasons for immigration, what that journey was like, their experience of living in England,

whether they experienced discrimination and racism, and what was important to them in their own cultural context, including health beliefs and family norms.

3.6 The GP surgery did think about how the family's cultural context might impact on bringing children for health appointments and sought to provide support. There was a danger overall, however that professionals may have understood the poor engagement with services as being connected to a broad concept of their cultural context, as opposed to evidence of neglect or a family that was not fully coping or had other pressures. Talking to families about their cultural context is critical to understanding their circumstances, strengths, and pressures and to be able to target services appropriately.

Legal Status

3.7 In September 2021 it became apparent that mother had no settled status and was not entitled to public funds or housing. The family were living on child benefit because mother's universal credit had been stopped a year earlier. The first child and family assessments recorded that the immigration status for mother was unknown. HV1 did ask about benefits and sought to provide advice, but no one professional had asked about this crucial issue. It appears that assumptions made that because Mother has been living in the UK since she was aged eleven that her immigration status was established. All professionals involved in this review process have reflected on the importance of establishing the immigration status of those children and adults they work with as part of establishing support and need, but also in recognition of understanding the cultural context of the family.

3.8 During the second Child in Need planning process in 2022 a specialist third sector support organisation services was asked to help mother and Teo sort out their immigration status. This was good practice, but their involvement was not seen as an opportunity to gain insight into cultural issues that the family might face.

Why is this important

3.9 The Romani and traveller community in the UK experience the same level of personal and institutional racism and discrimination as any other Black and minoritized groups. There is evidence of poor health outcomes, inequality in the labour and housing market, poor education outcomes and low literacy rates, an overrepresentation of referrals to children's social care and other institutions. Bradfords own report refers to the discrimination that Romani communities face in Bradford (European Roma Communities: A Strategy for Bradford District 2021 – 2025[iii]). There is also a community support organisation that mother could have been linked into[iv].

3.10 Legislation[v], Guidance[vi] and research[vii] highlight the importance of identifying a child and their families' cultural context and heritage, as well as their experiences of racism and discrimination alongside family strategies to address this. In other words, to be culturally competent professionals.

3.11 Cultural competence is defined as the ability and confidence of all professionals to explore and ask questions about the cultural context and practices of the different children and families that they work with. This includes understanding and addressing racism and discrimination and recognising that cultural identity will be treated with understanding and respect. It does not mean that professionals can fall back on simplistic notions of culture to avoid making difficult decisions about when and whether to intervene with families or to allow stereotypes and discriminatory attitudes to influence practice. Culturally competent workers recognise every individual as unique and equally worthwhile. The culturagram tool can be a helpful tool in exploring these issues.

3.12 Cultural competence needs to be supported by an organisational framework, which demonstrates a value to professionals working in this way, providing guidance, training, and support. A handful of Safeguarding partnerships have practice guides or frameworks for culturally competent practice. Bradford have done work in this area in the past, but the toolkit/framework no longer seems to be available.

What can be done about it?

Recommendation 1: The Bradford Safeguarding Children's Partnership should seek reassurance from partner agencies that they are ensuring that their workforce are being equipped and required to work in a culturally competent way.

Recommendation 2: The Bradford Safeguarding Children's Partnership should produce guidance on working in a Culturally competent way including information about the structured framework the Culturagram and implement its use across the workforce.

Finding 2. The importance of a robust consideration of the need for a pre-birth assessment and pre-birth early help and support plan.

Considering Pre-birth assessments

3.13 The safeguarding partnership has a pre-birth assessment policy which outlines the importance of undertaking a pre-birth assessment in the context of vulnerability and where the safety and wellbeing of parents and the unborn baby might be compromised.; this policy sets the criteria for a pre-birth assessment

and mother met the criteria for four out of 13 (if you include late booking/avoidance of ante-natal care alongside denied pregnancy – though this is not currently made clear in the guidance).

3.14 Mother was pregnant in April 2019 at age 19 with her second child. She had a child aged 4 to look after. She booked her ante-natal care late due to seeking a termination of pregnancy which she then did not go through with, something she explained to the midwifery service. Mother said that she had had previous children's services involvement and contact was made with them. They reported no current involvement; known concerns about domestic abuse spanning 2017 and more recently in June and August 2019 were not shared.

3.15 There should have been a consideration of the need for a pre-birth assessment by BCSC given this known information; the booking midwife would have been more able to evaluate Mother's circumstances if these risk factors had been shared with them. Mother denied any domestic abuse or drug/alcohol use. Mother only attended two midwifery appointments and one emergency attendance at hospital. There was an incident of domestic abuse including threats to kill in the 4 weeks before Danuka was born, and BCSC were informed; this was not shared with midwifery the health visitor. The lack of sharing of this information, providing the context for mother and the unborn baby's vulnerability meant no pre-birth or early help assessment was completed. Their needs were located at universal service provision.

3.16 Mother reported she was pregnant with her third child in April 2020 at the age of 21 and 4 months after Danuka was born. She attended the initial midwifery appointment and contact was again made with BCSC and they reported no current involvement. This was technically accurate; between February and March 2020 there had been five incidents of concern including domestic abuse, Mother's drug use, housing instability, association with a known dangerous individual with concerns about sexual exploitation and abuse and harassment. BSCS had been informed of these concerns through anonymous referrals, but again these did not lead to a discussion about whether a pre-birth assessment was required.

3.17 Without this information the midwifery team could not evaluate mother's, Danuka's and the unborn baby's vulnerability. Mother decided to have a termination of pregnancy which she did not go ahead with; she sought pregnancy care late and did not attend any appointments until October 2020, some six weeks before baby Sara was due. The midwifery service worked hard to contact her without success, and in November they made an appropriate urgent referral to BCSC. They found that there was already an ongoing assessment. Information was exchanged, but there was no assessment of the needs of the unborn baby.

3.18 There clearly needed to have been more consideration about the need for a pre-birth assessment for both Danuka and Sara. This would have been an opportunity to understand the chaos in Mother's and her children's lives, her constant moves between households and the many men who were domestically abusive to her. This information was never brought together.

Why is this important?

3.19 Pregnancy and the first year of life are an extremely important time because of the complete physical and emotional dependency that the unborn baby/ baby has on their parent and these early developmental stages lay the foundations for later life. There is an increasing body of evidence about the risk factors during pregnancy that are associated with likely developmental and emotional harm (particularly complex attachments) to the unborn baby lasting into adulthood and with possible future maltreatment of the baby in the early years of life by parents/adults. The factors during and after pregnancy include mothers and fathers with complex childhood histories, poor adult mental health, substance misuse, poor parental emotional and behavioural regulation, stress, anxiety, domestic abuse and living with the pressures of poverty. These risk factors are evident in the number of critical incident notifications involving serious harm to very young babies and the growth of care proceedings for babies in the first few days and weeks of life. This is a critical issue[viii].

3.20 Pregnancy is the opportune time to identify these risks, support parents to take action to address factors that will impair a baby's development during pregnancy, promote an understanding that this is baby's first home "the womb" which needs to be safe and secure and to start the process of building attachments; poor attachment in pregnancy is a predictor of poor attachments in babyhood and beyond. It is an opportunity to assess parental behaviours and factors which put the baby at risk of significant harm following birth. Part of this process is considering 'reflective functioning' or the ability of parents to understand and respond to all their baby's needs, and their ability, motivation, and capacity to make changes in their behaviour in the best interests of their baby. Pre-birth assessments provide an opportunity to consider factors which will impact on safety and wellbeing[ix].

What can be done about it?

3.21 The review by the Child Safeguarding Practice Panel of Star Hobson in Bradford[x] highlighted the importance of consideration of pre-birth assessments and a recommendation has already been made regarding this. **This Recommendation is**: *A review of the Partnership's Pre-Birth Procedures to ensure that the assessment of parental and family risk factors are explored, and decisions are appropriately documented. Any barriers to implementation should be identified.*

Finding 3: The importance of a proactive, holistic, and robust response to domestic abuse to increase safety for survivors and their children.

3.22 There is a long history of mother being subject to domestic abuse, incidents described as disputes, threats to kill or harassment and being sexually exploited from when she was 14 years to the date of the critical incident, a period of seven years, involving six different men. Except for Karl, nothing is known about the circumstances of these men. The information about domestic abuse and disputes was known to the police who were called out on many occasions, and they shared many of the incidents with BCSC in the form of a domestic abuse notification; mother was often pregnant or had just given birth. This information was noted by BCSC, but it was agreed on most occasions that no further action needed to be taken. Each incident was treated in isolation, and no cumulative picture was developed. This meant that those other agencies working with mother were not aware of these concerns.

3.23 The one place this history of concerns about domestic abuse was held was in the two child and family assessments completed by BCSC in December 2020, just before Sara was born and November 2021. These assessments were not shared with any other agency. There remains confusion about when and in what circumstances the child and family assessments should be shared with agencies working with the children about whom they are about. There is no legal or procedural impediment, but custom and practice has grown up locally (and nationally) that this is a children's services document; these assessments were intended (see Assessment Framework 2000 Guidance[xi]) to be led by children's services, but to be multi-agency in approach and their outcomes was to help build a multi-agency support plan to address unmet needs of children.

3.24 The midwifery and health visiting services routinely asked mother about domestic abuse in line with national and local expectations which was good practice. Mother mostly said she was not in a current relationship. The midwifery appropriately contacted BCSC on the two occasions when Mother was pregnant. The information about domestic abuse concerns was not shared.

3.25 The first Child and Family assessment took place in October 2020. This provided a summary of the domestic abuse notifications, but the assessment itself did not analyse this information; there is no evidence that Mother was asked about domestic abuse in the context of the known history. Those notifications would have shown that mother was being harmed by several different men, at different addresses, when she was pregnant and when Edvina was present. The impact on the unborn baby and real likelihood of harm was not considered. The Child in Need plan did not mention domestic abuse and the likely impact on the safety of the children and mother not mentioned.

3.26 Over the period under review mother sought to have a termination of pregnancy on four occasions. Although women have the right to make choices about

pregnancy, if the midwifery and health visiting team had known about the domestic abuse, they might have been able to reflect on whether mother was subject to sexual violence in the context of domestic abuse. There is good evidence that forced pregnancy is a feature of domestic abuse, coercion, and control.

3.27 In February and March 2020, when Danuka was four/eight weeks old, there were two anonymous referrals about mother being in a relationship with a dangerous and violent man, Karl. At this time the focus was on the risk he might pose to children. The possibility that he might be domestically abusive and coercive and controlling of mother was not considered. There was said to be uncertainty about whether mother was in a relationship with this man. Mother denied this was the case, she said that she was in a relationship with his brother, Peta and it became known in the period before Sara was born, she was living in Karl and Peta's parents' home, referring to them as paternal grandparents and this was the description of them in the completed assessment. HV1 saw Karl leaving Mother's home and shared this with the allocated social worker. The completed child and family assessment describes mother as 'not being open', but the possibility that she was being coerced and controlled by any members of Karl and Peta's family was not considered. Although the subsequent Child in Need plan talked about the need for the children to be supervised when with the Karl and Peta's family, there is no actual written plan and there does not appear to have been any action to address this issue of safety. There was said to be a safety plan in place, but there is no information regarding what this focussed on.

3.28 In September 2021 Mother was living with her new partner of 5 months, Teo. Mother called the police to report that Teo had punched her three times in the face. The police were called, sought a prosecution, but mother would not support this.

3.29 BCSC were already in the process of completing a child and family assessment and this continued. Mother and Teo were seen together to discuss the domestic abuse incident. This was inappropriate and falls outside of best practice; it does not take account of coercion and control and increases the risk for the victim. Mother was not given an opportunity to talk about the domestic abuse without the perpetrator present and Teo was not held responsible for his behaviour. Teo disputed the detail and alleged that Mother had started the fight, and this explanation is included in the assessment, alongside Mother's original statement to the police which gave a different story. There is no subsequent analysis or conclusion about domestic abuse, the risk to Mother or the impact on the three children who were present. The children were not identified as victims. This was seen as a one-off incident of conflict and there were no onward actions to address these concerns. The domestic abuse was not addressed, the impact on Mother as an adult and parent not considered, the

impact in the short term and long term on the children as victims of domestic abuse as outlined in the Domestic Abuse Act 2021 was not considered and Teo was not held responsible as a perpetrator.

3.30 Across the records where the domestic abuse incidents are described, such as in the historical chronology of the child and family assessment, they are referred to as 'domestic abuse between Mother and another person suggesting that both were equally involved. The information tells us this was not the case. Mother and her children were the victims of domestic abuse. This obscuring of the victims of domestic abuse by using phrases such as 'domestic abuse within the family', 'domestic abuse relationship' 'domestic abuse between the couple' leaves victims feeling unsupported and perpetrators without responsibility.

3.31 Across the period under review the domestic abuse of Mother was responded to by the police, it was not addressed by BCSC, despite the many notifications, two assessments and two Child in Need plans; other agencies were unaware of the specific concerns and were not included in multi-agency meetings, so Mother and the children's circumstances were never fully considered.

Why does it matter?

3.32 Each year over 2.3 million people in the UK suffer some form of domestic abuse[xii], and two thirds of these are women. Women are more likely to experience repeated and severe forms of violence (including sexual violence), and are also more likely to experience sustained physical, psychological, and emotional abuse. Research suggests that the victims/survivors of domestic abuse sought help from professionals on average 5 times in the year before they received effective help to stop the abuse[xiii]. 40% of victims report difficulties with their mental health because of domestic abuse[xiv]. Multiple studies describe how babies and children who are exposed to domestic violence experience greater levels of trauma, anxiety, and depression, as well as increased behavioural and cognitive problems which can last through childhood and into adulthood[xv]. They are also at risk of physical harm which can be fatal.

3.33 Given this reality it is essential that there are systems and processes in place to address domestic abuse effectively for children, victims and perpetrators. Research[xvi] has shown that this is a complex area of practice which requires professionals to enable survivors to **safely** talk about the abuse they experience, recognition of the needs of babies and children alongside support and interventions and processes to enable perpetrators to be held responsible for their behaviour and to be enabled to change and stop the abuse (Ofsted Joint Targeted Area Inspections of Domestic abuse (2016 [xvii]).

3.34 The Triennial analysis of serious care reviews published in 2016 noted: '*The impact of all domestic abuse is harmful to children and a step-change is required in how we understand and respond to domestic abuse. There is a need*

to move away from incident-based models of intervention with domestic abuse to a deeper understanding of the ongoing nature of coercive control and its impact on women and children[xviii]*'*.

3.35 The recent Child Safeguarding Practice Panel's review of domestic abuse[xix] found professionals often use the term 'domestic abuse' without full exploration, assessment or understanding of the nature of the abuse and its impact on the child and family. This was evident within multi agency meetings, plans and case records. There appeared to be an assumption that simply naming 'domestic abuse' as a concern for a child is enough for all practitioners to understand the situation and respond appropriately. This is an overly simplistic, optimistic and, at times, dangerous assumption that leads to potentially avoidable harm to children and non-abusing parents.

What can be done about it?

The National Panel review of the death of Star Hobson in Bradford raised concerns about the response to domestic abuse and made recommendations about the action to be taken. This recommendation is: to Jointly review and commission domestic abuse services to guide the response of practitioners and ensure there is a robust understanding of what the domestic abuse support offer is in Bradford. This should lead towards a coordinated community response by providing a bridge between services. Immediate action should be taken to provide multi-agency practitioners with guidance and/or training, supported within supervision, to enquire about domestic violence. There is no need to make further recommendations given this work is under way.

Finding 4: Professional recognition and response to the early signs of neglect of young children by their primary caregivers.

3.36 There was evidence across the timeline of both the early signs of neglectful care provided to these babies/children by mother and possibly other adults and that this neglect became more serious over time. The sporadic nature of mother's engagement with professionals, the difficulties over time of working out where she, Sara, Danuka and Edvina were living and with whom, meant that there was a lack of a clear picture of 'what life was like' for the children and what their experience of being parented was like. Edvina was said to be largely cared for by her maternal grandmother and no professional during the period under review spoke to maternal grandmother about this, despite two child and family assessments being completed, and there was minimal contact with the school Edvina attended. Speaking to the school during this review process has highlighted that Edvina was a happy and well cared for child, but there were times when mother was due to have her for the weekend and was supposed to

collect her from school. Mother either did not arrive, or was late, and at these times maternal grandmother would come and collect her. This evidence of a lack of attention by mother to Edvina's needs was not know because no one spoke to maternal grandmother.

Neglect of unborn babies; the womb as babies first home

3.37 Mother's poor engagement with ante-natal care was an early indicator of neglect. Ante-natal care is as much about meeting the needs of the baby, ensuring they are safe and well as it is about the well-being of mother's and parents. The reasons for mother's poor engagement were not explored (there was little opportunity to do so) and without a pre-birth assessment process, either under early help or the pre-birth procedures, it was not known if this was evidence of mother struggling to put the needs of the unborn babies before her own or there were other pressures such as the impact of domestic abuse, financial problems, lack of awareness of the need for these appointments etc. That is why exploration of these issues mattered.

3.38 The perinatal period is a crucial time for human development and provides a good opportunity to engender a love for the unborn baby for parents facing multiple adversities. The national and local policy entitled "The best start for life: a vision for the 1,001 critical days"[xx] recognises that pregnancy, and a baby's first 2 years, are a critical phase during which the foundations of a child's development are laid. If a child's body and brain develop well then, their life chances are improved. Exposure to stresses, parental mental ill health, domestic abuse, substances, such as illegal drugs, alcohol and tobacco during this period can result in impaired development and significant harm. For babies, because of their complete dependency on care givers, the risks of living with neglect can be fatal[xxi].

Instability as a form of neglect

3.39 The next period of professional involvement was when a further referral was made regarding Mother's contact with Karl who was said to be a drug dealer, a sex trafficker, and a risk to children. A Child and Family assessment was completed and led to a Child in Need plan. There was a lack of focus on whether the children's needs were being neglected in the context of constant changes of housing, and possibly living in circumstances where drugs maybe be being used and dealt. Sara was born and the family circumstances were perceived to be more settled, with mother back at maternal grandmother's home. There was a lack of reflection that there was a pattern of calm, and then periods of chaos. During the times of calm, professionals who had contact with mother (HV1 and social workers) thought the children were looked after appropriately, and warm and caring interactions were noted. During times when mother moved accommodation (and the reasons for this remain unknown) professionals were

not able to see the children because they either went to the wrong house, such was the confusion about where the family was living, or no one was at home. There was not a very clear picture of this instability held by any one agency.

Neglect of health needs

3.40 Mother did not bring Danuka and Sara to routine health appointments; this was not the same for Edvina, who was largely being parented by maternal grandmother. Health professionals worked hard to support mother by recognising her cultural context through reminders, texts, and phone calls. In the period between February and March 2021, there were considerable concerns about mother not taking Danuka and Sara for appointments to treat their health conditions leaving them both in likely pain; on one occasion mother was asked to take Sara (a small baby) to hospital and mother attended but left without being seen. Health professionals were concerned about this medical neglect, and as a consequence the GP surgery completed a chronology which they shared with BCSC. They followed this up with phone calls and emails but received no response. They were informed that HV1 had seen the children, whose health needs were addressed, and they were well, and BCSC also contacted them to say they were ceasing the child in need planning process. The GP surgery and HV1 worked well together to ensure that professionals were made aware of children's health needs and sought to address concerns through active support for Mother and alerting professionals of concerns.

3.41 At this time the children were all subject to Child in Need plans which highlighted the importance of Mother prioritising the children's health needs. However, health professionals were not part of the Child in Need process and their view that this was a serious issue was not heard. It was decided by BCSC that because mother was not engaging with the plan it would end, without any other support in place. HV1 was said to be the lead professional but no one told her this. HV1 visited the family and found that both children's infections had cleared up. At this point the chronic concerns and crisis were seen as resolved and professionals stepped back without any action being taken to understand the root cause of these children's health needs not being met and to consider the overall pattern of care they were receiving. The Child in Need process did not take this lack of engagement by mother with health appointments seriously, did not identify this as neglect which was having a negative developmental impact on these very young children, and which needed responding to robustly.

Unsafe housing and lack of attention to children's needs

3.42 The sexual health team visited mother in June 2021. They were concerned about the physical state of the home and the lack of safety for the children. This information was shared with HV1 via the early help team; it was agreed that a home visit would be undertaken to see if mother need any support and whether

she would agree to an early help assessment. Mother and Danuka were seen in the garden and due to COVID public health requirements the accommodation was not viewed; Sara was said to be asleep and so was not seen. This meant that the safety hazards raised were not addressed and worries about neglect not addressed. Mother said she did not need an early help assessment or another support. HV1 had seen Danuka and Sara at address 1 and although there were concerns about overcrowding, HV1 always noted that mother had a warm and caring relationship with the babies/children when she was present. This demonstration of warmth and care in the moment clearly influenced HV1's analysis of the family circumstances. However, she needed to have reflected on all the known available information, such as Mother's poor engagement with health services which risked serious harm, anonymous concerns about adult men of concern and known worries about drug use, housing instability and avoiding contact with professionals. This represented a picture of child neglect which needed responding to.

Parenting or mothering in the context of neglect: where are the men?

3.43 Up until September 2021 mother was viewed as a single parent who was parenting Danuka and then Sara alone. Mother told midwifery she was no longer in a relationship with the father of any of the children and provided no names or details. If midwifery had been told of the domestic abuse concerns when they contacted BCSC this would have provided a different picture.

3.44 Mother also told HV1 that she had no contact with the fathers of any of the children. Over time it became known that Mother was in a relationship with either Karl or his brother Peta, leading to an assessment and a period of Child in Need planning but there was no discussion about the role either of these men played in the children's lives, despite living for some of the time with these men's extended families. These men made themselves 'invisible', and no professional challenged this or asked questions about it beyond a discussion about who mother was in a relationship with. What this meant for the children, their parenting, their attachment relationships and their stability was not considered.

3.45 Edvina lived with her maternal grandmother for most of the period under review, until around October 2021. There is no information about how she was being parented or progressing or her relationship with mother. This was despite there being an assessment and Child in Need process which included her. The role of the extended family, who were ever present when professionals visited, was not considered in the context of parenting, and meeting these children's needs. Their views were never sought.

3.46 This chimes with the Child Safeguarding Practice Panel review 'The Myth of Invisible Men[xxii]' which highlighted that professionals continue to hold engrained

stereotypes and expectations about men, women, and parenthood. Women continue to be regarded as the prime and sometimes only carer for their children and men are not always engaged with meaning men are marginalised or enabled to be absent. The review suggests a cultural shift is needed including an '*organisation-wide approach to including fathers and working with other agencies and joining up principles; it means starting with a belief that fathers matter too, and engaging them in the early years sector, schools, children's services and health services*. This also needs to include recognition of the wider extended family who were absent in professionals thinking about Sara, Danuka and Edvina.

3.47 In September 2021 mother, her new partner Teo, Danuka and Sara were homeless and living on the street; it remains unclear why neither of the adults sought professional help, rather than sleeping in the park with these young children, because no one directly seems to have asked this question; mother did say she had lost contact with her family, something that was inaccurate. It was noted at this time that the family were living on a low income and had no settled status and therefore no entitlement to hosing. They were housed in temporary accommodation through the local authority's responsibilities to children and families without recourse to public funds and a child and family assessment was started.

3.48 Three weeks later the police were called by mother because she was assaulted by Teo. The police found the accommodation to be completely unsuitable for the children. They had no beds to sleep in, there were safety hazards and a poor physical environment; the police made an appropriate referral to BCSC. It remains unclear why this situation had gone on for so long without being addressed as part of the early contact with the social worker. The lack of bedding was addressed over the next few days, but there was no action taken to address the inappropriateness of this housing for three young children (Edvina (aged 6) had moved back to live with mother and Teo.

3.49 The police also found Sara was very unwell, and they transported her to hospital. The police left and mother did not wait to be seen. This was shared with HV1 and the social worker but led to a no action to address this lack of focus on Sara 's health needs. It was not linked to previous concerns or identified as a neglect of health needs.

3.50 The assessment was ongoing, and over time the family were provided with food parcels and one-off payments. This was not at this stage parental neglect, but a family who needed help. This was provided in a piecemeal and uncoordinated way which provided the parents with no dignity and the children with no safety and lacked a focus on their physical and emotional wellbeing. At the same time there were emerging concerns about parental behaviours that put the children at risk of harm, such as mother and Teo subletting one of the two rooms they

had been given. This was not challenged or addressed. Sara was noted to be underweight and the health visiting service was asked to complete a developmental check. This did not happen, and the child and family assessment was completed without clarity about Sara's physical wellbeing This was caused by an unclear handover from one health visiting team to another, highlighting the importance of these handover processes, and a lack of follow up by the social worker or challenge regarding why it had not been completed. The conclusion of this assessment was that there were no concerns about the children's wellbeing and safety. A conclusion that was out of step with the available evidence. The focus was entirely on the adults. This meant that the emerging concerns about neglect were not acknowledged, so were left unaddressed.

3.51 In December there was a further referral of concern about mother and Teo's drug use, Teo's domestic abuse and the children being left with inappropriate adults. More evidence of growing concerns about the neglect of these three children which was not responded to in a timely way, until a new team took over. The possibility that the growing evidence of neglect might indicate the possibility that these children were being harmed in other ways was not considered. It is critical that professionals consider in the assessment and analysis 'what other abuse does neglect enable'. Sara and Danuka were found to have a number of unexplained injuries which were causing them significant distress.

Understanding the child's lived experience as opposed to being adult focussed.

3.52 Child neglect is defined as the failure of parents/caregivers to meet a child's physical, emotional, educational, supervisory, stability and educational needs; this failure can be intentional or unintentional. Regardless of this intentionality, there is clear evidence of the short and long-term impact on babies and children's development and wellbeing. Identifying the neglect of children by their primary carers requires a focus on the child's lived experience, thinking about a parent's attitude towards their child and their ability to respond to their needs in an appropriate and timely way.

3.53 There is little information about the lived experience of any of the children. HV1 did write her records with a focus on what Danuka and Sara needed from their mother, in the context of their health needs. This was good practice. Overall, though, there was little evidence of discussion between professionals of what the younger two babies, who were pre-verbal might be feeling about the constant moving from place to place, having untreated infections which will have caused pain and the impact of different adults, often described as dangerous, in their life. What the implications were of the concerns about drug use by mother and evidence of drug dealing from one of the houses she lived

in. The implications for them were not recorded. There is no indication of what the day-to-day life for the children was like or that their lived experience at the time had the potential for physical harm due to lack of supervision and domestic abuse. The neglect they experienced was clearly linked to the significant physical harm that they were subject to (the perpetrator of this, mother or Teo is not known). When thinking about the neglect of any child, the link to physical harm and abuse must be considered.

Why does it matter?

3.54 The neglect of children by their parent(s) (primary caregivers) is a serious issue which has a significant and long-lasting negative effect on children's developmental outcomes, their safety, their emotional wellbeing, and the impact often lasts into adulthood[xxiii]. Child neglect is a complex area of practice[xxiv] which requires a structured and analytical approach with a focus on persistence and pervasiveness, how likely, capable, and willing are parents to change the circumstances for their children, the type of neglect and its impact across the developmental spectrum of children's needs, and then what has caused the neglect to establish the most suitable interventions. These elements were not evident in the professional response to Sara, Danuka and Edvina. When the early signs of neglect are not identified and responded to unhelpful patterns of negative parenting strategies can develop, the neglect worsens over time and the harm cumulative and corrosive in nature.

3.55 Research and the national reviews of SCR's and LCSPR's has highlighted that when working to address the neglect of children and adolescents, one of the barriers is multi-agency working, differences of opinion and the lack of respectful challenge between professionals. In this case there were times when challenge was necessary. HV1 became aware that she had been named as the lead professional without her knowledge. This should have been challenged. Professionals were not invited to Child in Need meetings, did not receive assessments, and did not receive minutes of meetings. When those professionals became aware of the various Child in Need processes, they needed to challenge, and to use the Partnership escalation process if they were unsuccessful.

What can be done about it?

Recommendation 3: Bradford Children's Partnership has noted that there have been a number of LCSPR's locally where there was an ineffective professional response to addressing and responding to the neglect of children, despite a strategy and neglect framework being in place. The Partnership Neglect subgroup group is reviewing why this is and what action needs to be taken. This working group will need to take the findings of this review into account.

Recommendation 4: This is one of many LCSPR's nationally that have been completed or are in the process of completion where there has been an ineffective professional response to addressing and responding to the neglect of children and adolescents, despite local neglect strategies and neglect framework being in place. This suggests this is a widespread national systemic issue which requires a specific look by the National Panel on why the neglect tools that have been developed over the last ten years are not having an impact on practice.

The Bradford Children's safeguarding Partnership has published an LCSPR recently a recommendation from that report is relevant here and means no further recommendation is needed. **Recommendation:** All agencies should review their existing training programmes to ensure that it is clear to practitioners that all children should have a voice, including those who are pre- or non-verbal.

Finding 5: Response to referrals, completion of assessments, Child in Need processes and multi-agency working.

Response to referrals

3.56 Over the period from June 2019 to December 2021 there were fourteen different contacts with BCSC expressing concerns about mother and the children. Five were from the police, three from anonymous sources, one from a family member and the rest from organisations/professionals.

Police call outs.

3.57 When mother was pregnant with Danuka in 2019 and Sara was sometimes in her care the police were called to three incidents where there were concerns that mother had been subject to domestic abuse and on at least one occasion Edvina was present and upset. There were several different addresses, involving at least three different men. Prosecutions were sought on two occasions, but mother was not willing to support a prosecution. There was a fourth notification in March 2020 when Danuka was two months old. In line with local protocols (is that right) these incidents were shared with BCSC front door. They led to no further action, though the police were told that the March 2020 incident had been allocated to a social worker to make some further enquiries; this was not the case. This meant that beyond the incident itself, neither the children's welfare were assured.

Response to anonymous/family calls

3.58 In the period between February and April 2020 there were five contacts with BSCS. These all related to similar issues. One from the police who had been told by mother's landlord that she was misusing drugs, two anonymous calls that she was associating with a known drug dealer and dangerous adult who was involved in sex trafficking, one concern from a family member about associations with this man and one further anonymous referral about Mother

being seen taking drugs on the street with baby Danuka present. There were different responses to these concerns, and no coordinated picture was formed about both the drug use and the associations with dangerous adults. Further information was sought by the front door, and for some of these referrals they were noted to be 'malicious' and so not requiring a response. This strategy lost sight of the fact that the referrals could have had a malicious intent, but that did not mean they were untrue.

3.59 On other occasions HV1 was asked to complete her routine home visit and establish whether the concerns about Mother's drug use and links with a dangerous adult were accurate. This was not appropriate and HV1 made this clear. It would have been reasonable to ask a health visitor to share any concerns that emerged from her routine visits as part of multi-agency enquiries, but nothing else. HV1 attempted to visit, without success although she became aware that mother was said to be in a relationship with Karl, because the family told her this. Health enquiries were undertaken in response to the family members concerns, and because Danuka had been seen recently at the GP surgery the concerns were said to be unsubstantiated. The children were never seen, and mother was never asked about drug use or whether she was being coerced and controlled by other men (the link with the police notifications was not made). The impact of this was those concerns about drugs use, the subject of four of the referrals, were never established, and wrongly seen as unsubstantiated on this basis. This lack of focus remained when a year later HV1 spoke about witnessing young people buying drugs from the house, this was simply disregarded.

3.60 The first referral by a professional was in October 2020 when mother was pregnant with Sara. This was from the school attended by Karl's children; there were concerns that Karl was the father of the unborn baby and that he was involved in sex trafficking, sexual abuse and drug dealing. Like the concerns given by the anonymous referrers. This was responded to by a child and family assessment; given the connection to recent concerns a strategy discussion should have been convened. The lack of this meant that no one professional really understood what the concerns about Karl were, and once again there was no focus on the issue of drug use/dealing or likely domestic abuse.

3.61 A referral was made to the out of hours service in September 2021 when mother, Teo and the children were found to be homeless. This appropriately led to a child and family assessment. Whilst this was ongoing the police raised concerns about neglect which were incorporated into the assessment process.

3.62 The final referral of concern was from a specialist voluntary sector organisation sharing concerns about drug use, domestic abuse, and inappropriate adults in contact with the three children. They were all subject to Child in Need plans, but much like the earlier concerns, home visits were undertaken, and no one was present. There was a lack of urgency in establishing the safety and

wellbeing of the children. This was resolved when a new team was allocated to work with the family. Prompt action was taken and the concerns about the children taken seriously.

3.63 Each of these notifications/referrals of concern were responded to in isolation, despite the consistency in what was being reported. The label of maliciousness served to minimise concerns, without sufficient enquiries being completed and without the children being seen. This echoes with the findings of the National Panel's Review into the death of Star Hobson and the recommendations from that review reflect the issues raised here.

Child and Family Assessments

3.64 There were two Child and Family assessments regarding the three children. The first was in response to the referral from school and took place between October and December 2020. This was completed by two different teams due to the pressures on BCSC at this time. The completed assessment takes no account of the recent history of concerns, does not build a picture of the family's circumstances, and focusses exclusively on the narrow information in the referral translated as 'concern about Karl'. There is a lack of reflection on the needs of the unborn Sara, little information about Edvina who was not living with mother, but there was no contact with the extended family. The issue became about mother's assertion that she was not in a relationship with Karl and the social work view that this could not be proven either way; an entirely adult focussed response. Concerns about domestic abuse, instability and drug use/dealing were not addressed. A Child in Need plan was agreed but focussed on mother keeping the children safe from the Karl and Peta's family, without a clear outline of what the risks were or how they were to be managed.

3.65 The second Child and Family assessment started in September 2021, and this also focussed on the narrow terms of the referral, which was about housing and immigration status. These were important issues, but there were known concerns about domestic abuse, growing concerns about neglect, children's presentation and weight, non-attendance at routine health appointments and not attending health appointments for acute child health symptoms, and known worries about previous possible drug use. These were not included or analysed in the assessment, and issues of neglect underplayed, despite the clear available evidence.

3.66 There was little multi-agency input to the assessments, and crucially they were not shared with any agency providing a service to the family. Good assessments matter. They are the way in which the multi-agency network can understand the needs of children and their families and the risks they face to address these.

Child in Need Processes.

3.67 As a result of the two completed child and family assessments in 2020 and 2021 there were two periods of child protection planning.

3.68 The first period took place over an eight-week period. The plan was narrowly focussed on undefined issues of safety from Karl's family. The health visitor, GP or midwife were not told about the Child in Need plan, and not invited to the Child in Need meetings. They were therefore unable to share their concerns about poor attendance at health appointments and their worries about what that meant for the children, including GP concerns about neglect. Edvina's school was involved in one meeting but did not know about the reason for the original assessment or the Child in Need plan. They were invited purely as information providers to one virtual meeting. The Child in Need plan was closed without any consultation with the multi-agency network, despite known concerns form the GP surgery and HV1 through the sent missed health appointments chronology. It was agreed that there would be a stepdown to early help support with HV1 as the lead professional who would undertake an early help assessment. She was never informed of this, and so unsurprisingly this only happened because of a further referral of concern to the early help team.

3.69 The second Child in Need process started in 2021 and would be ongoing until the critical incident. The focus of the plan was housing and immigration status. Appropriately a voluntary sector organisation was asked to support mother in her applying for settled status. Housing were not included in the plan or process despite the emerging concerns about the suitability of the accommodation for young children. The plan did not change with emerging concerns about domestic abuse, no specialist service was asked to provide support or interventions. The issues of Sari's low weight were left with the health vising service and were not addressed due to a change in teams because the family had moved areas. Edvina's school were unaware of the concerns and were not invited to the meetings.

3.70 Overall, both periods of Child in Need planning lacked a multi-agency approach and a poor focus on the real needs of the children.

Multi-agency working and information sharing.

3.71 Section 3.55 above covers some of the gaps in multi-agency working which impacted on the response to this family. There was some good practice:

- The GP, AP and HV1 liaised well when there were concerns about Danuka's and Edvina's health needs not being met.
- The midwife liaised well with HV1 and BCSC.
- The police made a good referral to BCSC outlining their concerns.

3.72 There was a significant gap in multiagency inclusion in the Child in Need process, which undermined both assessments and child protection planning.

This was during the time when BCSC were under significant pressures, as outlined within the Star Hobson national review.

Why does it matter?

3.73 It is critical that these routine processes, of identifying the risks facing children and their families, understanding their needs and establishing what the key issues are as to intervene effectively. This did not happen for Edvina, Danuka, and Sara, for whom there was an unclear picture formed of their circumstances and needs; despite the available evidence.

What can be done about it?

There is a recommendation within the Star Hobson national review which addresses some of these concerns:

Partners should work together to ensure that:

• Decisions not to proceed following a referral are based on a review of previous history, background checks and a chronology of prior concerns

• No referral is deemed malicious without a full and thorough multi-agency assessment, including talking with the referrer, and agreement with the appropriate manager

• All staff are compliant with information sharing protocols

• Risk assessments are always informed by multi agency information gathering which includes listening to family and friends and an assessment that goes beyond self-reporting

• Supervision is always used to test assumptions and alternative hypotheses

Recommendation 5: This recommendation from the Child Safeguarding Panel Review does not address the issue that although members of the public, children, family and friends are encouraged to see '*safeguarding as everyone's business*es and alert public authorities about concerns they have about children, there remains a lack of clarity about how they can receive feedback about the actions to be taken, whether their concerns have been heard and what they can do if they are unhappy with the response. It is recommended that The Bradford Children's Safeguarding Partnership to enhance the existing advice to family members, community members and anonymous referrals.

Recommendation 6: The Bradford Children's Safeguarding Partnership should seek information from the national panel about what work is underway to address this lack of guidance about the appropriate response to referrals and information from family, the public and anonymous sources which remains a national issue of concern.

Recommendation 7. There needs to be clarity about when and in what circumstances child and family assessments will be shared with those agencies who will be supporting children who are subject to Child in Need plans.

The Bradford Children's safeguarding Partnership has published an LCSPR recently and a recommendation from that report is relevant here and means no further recommendation is needed. Recommendation: The Bradford Partnership should undertake a systems review to ensure a robust approach to Child in Need arrangements.

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