Swindon Safeguarding Partnership

Local Child Safeguarding Practice Review

'Bella and Ben'

Jane Wiffin

1. INTRODUCTION

Reasons for the Local Review

1.1 This independently led Local Child Safeguarding Practice Review (will be called the review from this point on) is about Bella (aged nearly 4) and her brother Ben (aged nearly 6[1].). In November 2021 Bella was admitted to hospital after concerns were raised about her physical and emotional wellbeing by the pre-school she attended; at hospital she was found to have been severely neglected by her mother and the home circumstances were found to be hazardous for children; mother lacked support from either family or professionals at this time. Care proceedings were initiated and both children are now living in safe and appropriate homes; the plan is for them both to live permanently away from their parents, but with contact being maintained. The Hospital Consultant Paediatrician and Named Nurse for Safeguarding made a referral to the Swindon Practice Review Group (PRG[2]) because the significant neglect of Bella and Ben had not been picked up or addressed by professionals working with them and there had been delays in action when safeguarding concerns became known. Bella and Ben's circumstances were discussed at a meeting of the Swindon Statutory partners and the Swindon PRG. It was agreed that their circumstances did not meet the criteria for a Local Child Safeguarding Practice Review and notification to the National Panel. It was agreed a Local Review would be undertaken by Swindon Safeguarding Partnership and involving agencies from Wiltshire. This later changed and a LCSPR was initiated.

Methodology and approach

1.2 This review has been led by Jane Wiffin, who is independent of all agencies within Wiltshire and Swindon; she has a professional background in social work and has extensive experience of undertaking serious case and local child safeguarding practice reviews. She is responsible for the writing of this overview report. The review has been a collaborative process with support and critical analysis being provided by a panel of senior representatives from local agencies who provided services to Ben and Bella.

1.3 It was initially agreed that the review would focus on a relatively short period, March 2021 when an early help referral was made, to November 2021 when a strategy meeting was convened; however, this was extended to a review of the professional response from when Bella was born, and Ben was two-years old because information emerged about early concerns of neglect.

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[1] These are anonymised names.

[2] The role of the Swindon Practice Review Group (PRG) is to coordinate Rapid Reviews and consider referrals for child safeguarding practice reviews on behalf of the statutory partners.

1.4 The initial discussions within the PRG suggested that Bella and Ben's circumstances could shed a light on:

- The impact of handover process within universal services when family's move across boundaries. What are the implications of different policies being used across borders with two sets of custom, practice, policies and procedures that may be different?
- How did the Covid-19 pandemic impact on service delivery to Bella, Ben and family?
- Did professionals look beyond the descriptions of the children's disability as a reason for indicators of concern and consider neglect?
- What impacts on the ability of Universal Services & Early Help professionals to identify the early signs of child neglect and respond appropriately?
- Did professionals consider mother's background and her social circumstances?
- Did professionals consider the role of non-resident father and the extended family? What impact did this have for Bella and Ben?

Reflections on these issues have been incorporated into the practice learning section.

1.5 The data collection process built on the initial scion of agency information and the chronologies that each agency provided. Some additional agency records and reports signposted in the agency chronologies were sought and reviewed.

1.6 A meeting with professionals involved with Bella and Ben was held to consider the key terms of reference. It was unfortunate that many of the professionals that had worked with Bella and Ben had either retired or were working in a different area and were not contactable. So, although the review could establish a clear picture of the children's circumstances over time, it has not always been able to establish why professional responded as they did. It has been possible to see the practice gaps but hard to establish the cause of them.

Involvement of the Family

1.7 Mother and Father were both keen to contribute to the review and they were interviewed by the independent lead reviewer.

1.8 Mother said that she had struggled to parent both children from when Bella was born. She had little family support and had separated from father who no longer saw the children. On reflection she felt she had been feeling depressed; she described having no life, lacking sleep because the children did not sleep, and being unable to go out because she found looking after Ben and Bella so overwhelming. She was aware that over time she could not meet the needs of the children and asked for help from the pre-school and the health visitor. She said that the pre-school was very supportive, but she never got the help she needed around parenting the children. She was offered a group, and attended a few sessions, but this did not help. She said she was glad that the children were now being well looked after and that they would be living with loving and caring families. She has regular contact with both children.

1.9 Father said that when he and mother separated, he initially saw the children and provided financial and practical support. There was then some conflict about contact arrangements, involving legal action, and father did not see the children for an extended period of time; he thinks about two years. When he was seeing them, he was aware that mother was struggling, and he was worried about the home circumstances. He discussed this with mother, and this was also discussed at a meeting with the health visitor. He said that the health visitor was not concerned about how mother was coping, and so he said he raised no further concerns. From this point on he was no longer involved. He is now in regular contact with both children and is happy that the plans are for them to live with loving and caring families. He intendeds to continue regular contact. He has no close family who could have provided any early support.

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2. ABOUT BELLA, BEN AND THEIR FAMILY. THEY ARE ALL WHITE/BRITISH.

2.1 Ben was born in early 2016 and lived with his mother (aged 19) and father (aged 21) in cramped housing. By the time Bella was born in 2018, mother and father had separated. Little is known about why this was the case, but there is evidence that father continued to attend meetings until the end of 2019, and he continued to provide financial support. The family originally lived in Wiltshire but on the border with Swindon and where Swindon services were easier to access, but not always available to the family. They then moved to Swindon but remained registered with a Wiltshire GP surgery. This meant the family received a bewildering mix of Swindon and Wiltshire services over time, which impacted on the consistency and purposefulness of the services they received.

2.2 Ben and Bella were fortunate to attend a pre-school who knew them well, and it is through their records that we have a sense of the lives of these young children[3] when they were at pre-school. Ben was described as having a lovely laugh and smiling face; he loved being outdoors, looking at leaves and trees and climbing on the play equipment. He also loved music and the trampoline. He struggled to regulate his emotions, biting himself and others and head butting Bella; he was delayed in his development and was in the process of being supported to use augmented communication approaches. He also had difficulties with eating, toileting and sleeping. At the age of 2 years, he was seen by a community paediatrician who said that he presented with autism spectrum disorder associated with global developmental delay. When he started school in 2021, he still had communication difficulties, he struggled to regulate his emotions, ate a limited range of foods and his mother reported that he did not sleep well, waking several times in the night. At school he was initially settled, but over time mother was unable to ensure his consistent attendance or punctuality.

2.3 Bella is described as loving colouring, Peppa Pig, doing jigsaws, using building blocks, water play, playing with musical instruments and to have a lovely warm smile. She was noted to be clingy to her mother in pre-school, but this improved over time. She struggled with her emotions and was hard to soothe. She liked a limited range of foods and would pick things up off the floor to eat; she did not progress with toilet training and found communication difficult, and this did not improve over time. She was behind her peers in all areas, was faltering in her growth and was said to be globally developmentally delayed at age 2 years and 6 months.

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[3] Although several records highlighted the complex needs, disabilities and developmental concerns, the “My Plan” developed by the pre-school provided a picture of both children, their likes and dislikes and described their personal endearing characteristics. We thank them for this child centred approach.

2.4 Although the children were seen regularly at pre-school, and Ben more latterly at school, over time fewer and fewer professionals saw them regularly at home; in part due to COVID. This means that there is little information available about their home lives from April 2020 onwards. So, beyond descriptions of their faltering development as outlined above, there is no information about what they liked to do at home, what fun they had, whether they did things as a family, spent time with their father or relatives or accessed community facilities. Mother provided a picture of constant struggle with parenting the children and she asked for more help on a number of occasions, this was not provided.

3. TIMELINE OF PROFESSIONAL INVOLVEMENT WITH BEN AND BELLA

2018			
January	Bella born	She was born 2 week premature. She returned home with no concerns.	Agreed follow up every six months at the Swindon neonatal hospital clinic.
February Ben (2) Bella (1 month old)	Ben seen by Community paediatrician1.	Ben said to present with autism spectrum concerns[4] associated with global developmental delay.	Health visitor1 (HV1) informed and asked to link parents with autism groups.
July Bella (6 months)	Hospital neonatal follow up for Bella aged 6 months.	Slight concern about falling weight and growth. The plan was for a more structured feeding routine and HV1 to monitor Bella's weight.	Unclear if mother changed the feeding routine. There is no evidence that HV1 monitored Bella's weight.
December Bella (11 months) Ben (nearly 3)	Bella's routine 9-12 month developmental check	HV1 was concerned about unkempt state of the flat and the level of stimulation provided to Bella and Ben by mother.	CAF (common assessment framework) [5] was undertaken and Team around the Child plan (TAC) and meeting agreed [6]. There are no written records of any of these.
2019			
March Bella (12 months)	Planned hospital neonatal follow up did not take place due to administrative error.		

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[4] Autism spectrum concern (ASC) is a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave. Although autism can be diagnosed at any age, it is described as a "developmental disorder" because symptoms generally appear in the first two years of life.

[5] The CAF stands for 'Common Assessment Framework. ' This may also be called an EHA (Early Help Assessment). A CAF is a document which is completed by a professional who is working with the family to support a child with additional needs including physical, emotional, or learning needs.

[6] TAC is a model of multi-agency service provision. The TAC brings together a range of different practitioners from across the children and young people's workforce to support an individual child or young person and their family. The members of the TAC develop and deliver a package of solution-focused support to meet the needs identified through the common assessment.

May Bella (16 months) Ben (3)	TAC meeting said to have taken place	No record of agreed actions.	Outreach worker now involved.
July Bella (18 months)	Bella placed with a childminder	The childminder expressed concerns about Bella's delayed development with the duty health visitor.	Mother was asked to contact Wiltshire single point of access (SPA[7]); mother did not do this. There was no follow up.
	HV1 home visit	Bella's developmental progress was discussed; Mother concerned about Bella being autistic.	
	Neonatal follow up in the paediatric outpatient's clinic.	Hospital Paediatrician concerned about Bella's motor, social and emotional development	The hospital paediatrician made a referral to Swindon community health services 1. Speech and language therapy (SALT[8]): progressed to assessment. 2. Physiotherapy: Bella assessed developing appropriately and no need for any services. 3. Occupational therapy: was not processed due to an administrative error. 4. Referral to Community Paediatrician: redirected to SALT and proposed some more observation of needs required.
August Bella (19 months)	SALT assessment undertaken.	Considerable concerns about the state of the home. Bella seen to eat old	The SALT therapist liaised with HV1 about concerns for the home and mother's

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[7] Single Point of Access (SPA) is the key point of contact for children, young people, families, GPs and health and social care professionals to access advice and support from all Wiltshire Children's Community Services. The SPA coordinates community health care advice and support for all children and young people.

[8] Speech and language therapy provides treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing.

		food off the carpet. Concern about Bella's social development and communication abilities, caused by a lack of stimulation from mother.	ability to cope; invited to the planned TAC meeting.
September Bella (20 months)	TAC meeting	There are no minutes and no record of what was discussed. SALT therapist could not attend (recorded in her records).	
October	Ben started at pre-school	Pre-school started a My Support Plan (MSP)[9]	First meeting about MSP planned for November .
November Bella (22 months)	SALT therapist contacted child minder.	SALT therapist aware of child minder concerns about Bella.	Child minder unable to meet until January 2020. Never took place.
	SALT therapist	3 Appointments offered for Bella. Cancelled/forgotten by mother.	Next contact was in April 2020 when COVID public health requirement in place.
	MSP meeting at pre-school for Ben	Mother and father attended, alongside staff from pre-school, Wiltshire SALT, and the children's centre outreach worker[10]; HV1 sent apologies	Outcome: Education, Health and Care plan (EHCP[11]) assessment to start.
2020			
January Bella (2 years)	MSP meeting at pre-school for Ben	The EHCP was progressing for Ben, and he was on the waiting list for	1. Referral to Springboard[13] was made for Ben to address concern about

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[9] A My Support Plan (MSP) is Wiltshire's way of supporting young people who do not meet the criteria for a EHC Plan. At this level, a Lead Worker will not be involved, but a My Support Plan can be completed by an educational setting or another professional working with a young person and used to plan and co-ordinate their support.

[10] Funded by Wiltshire Council, the voluntary Children's Centres provide support to parents.

[11] An education, health and care (EHC) plan are for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs.

[13] Springboard is a charity that provides support for pre-school children (aged 0-5) with special needs and their families.

Ben (3 years 23 months)		community disability nurse support and was being helped by portage services[12]	his communication needs. 2. Referral to the community disability nurse around eating habits was made but did not progress.
	Bella started at same pre-school as Ben	MSP agreed for her.	
	HV1 visited the family	Mother said Ben was having problems with sleeping and eating food from the floor.	HV1 made a referral to: - Targeted mental health services (TaMHS[14]); this referral was not accepted. - 2.The Swindon community Paediatrician: this was not received. - 3. Continence service; did not lead to a service.
	Hospital Neonatal appointment.	Bella was not brought.	HV1 was informed and asked to complete a schedule of growing skills (SOGS[15]). This happened in April 2020.
March 2020: COVID public health requirements came into force and services stopped face to face contact with Mother, Bella and Ben. The exception was pre-school.			
April	Ben and Bella were not identified officially as a vulnerable children, but the pre-school decided that they felt it was in their best interests to attend. This was good practice.		
	Wiltshire portage	Started an assessment of Bella's needs.	HV1 informed.
	HV1 telephone contact with family	Mother asked for HV1 to seek paediatric appointment for an	HV1 suggested waiting until the next development review.

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[12] Portage is a home-visiting educational service for pre-school children with SEND and their families. https://www.portage.org.uk/about/what-portage

[14] TaMHS take referrals for 0–18-year age group with a defined mental health need such as anxiety, self-harm, or low mood.

[15] The Schedule of Growing Skills allows PROFESSIONALS to establish the developmental levels of children, including areas of strength and potential delay, and covers ages from birth to 5 years. https://www.datadictionary.nhs.uk/nhs_business_definitions/schedule_of_growing_skills.html

		assessment of Bella for autism.	
	Swindon SALT telephone contact with family	Mother remained concerned about Bella’s poor communication.	SALT team recommended intensive interaction[16], the curiosity programme[17] and some leaflets were sent to mother to help her with this
Mother registered with Wiltshire GP			
April	Swindon SALT	Transfer of services to Wiltshire SALT	Referrals made to - Wiltshire SALT who would see Bella in June. - Wiltshire Autism Assessment Service (WAAS). This led to no offer of a service.
May	Hospital neonatal follow up appointment by telephone.	Mother reported concerns about Bella’s poor development and not gaining weight/height.	Referral to Swindon community services; not accepted because the SALT service was involved.
June	First MSP meeting for Bella	Mother and pre-school staff/education representatives attended. HV1 sent apologies and Wiltshire SALT referral had not yet progressed.	Decided needed referral to community paediatrician. HV1 said she would review necessity after the next developmental assessment of Bella.
	HV1 completed Bella’s 24-30 month review	Bella was assessed as not meeting her developmental milestones; HV1 told	It was agreed that Bella would continue to receive universal plus support[18]

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[16] Intensive Interaction is an approach that can be used by everyone involved in supporting a child to interact with other people and develop.

[17] The Curiosity Programme is a strategy used to help teach individuals to develop the skill of curiosity, form positive relationships with others and to learn to engage with a wider range of stimuli.

[18] Universal plus offers rapid response from the local health visiting team when specific expert help is needed for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting

	over the telephone	mother this was not surprising given Ben's ASC diagnosis.	from the health visiting team.
June 2020: Mother and the children moved to a house in Swindon			
June	Verbal handover between HV1 and the health visiting service in Swindon.	Information was shared about the complexities of the children's developmental needs and environmental circumstances. It was reiterated that HV1 felt mother was doing well in difficult circumstances.	The TAC and previous CAF were not mentioned. HV2 was allocated to provide a service to Bella and Ben.
	HV2 contacted mother by telephone	Mother expressed concerns about Ben's aggressiveness and Bella's poor growth and development.	HV2 made referrals to: • Swindon continence service: did not lead to service. • TaMHS for Ben; referral declined due to other professionals involved. • Safe Families[19]; unclear if made and what the outcome was. • Specialist dental services. Unclear if made and what the outcome was. • The family were assessed needing a universal partnership plus level of support. [20].
	HV2 contacted the pre-school	The pre-school shared comprehensive information about the	HV2 went on unexpected leave and no health visitor was allocated to replace her.

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[19] Safe Families match volunteers from the local community to families that have requested a Family Friend.

[20] Universal partnership plus provides ongoing support from the health visiting team and a range of local services to deal with more complex issues over a period of time. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216459/dh_133022.pdf

		children including their significant developmental delay.	
	Wiltshire SALT start assessment.	SALT therapist sees Bella at pre-school	
July	Second MSP meeting	The work of the outreach worker had ceased, and it was agreed that a referral would be made to early help in Swindon.	Referral to early help not made, but others were. See below.
August	Pre-school referral for Bella	Requesting further SALT assessment, Paediatric assessment regarding possible ASC, Wiltshire Autistic Service (WAAS) and an OT assessment.	Bella was put on the waiting list for list for WAAS, but OT and SALT and Community Paediatrics referral declined.
September	Hospital Neonatal follow up	Bella was not brought.	Bella was discharged because she was 2 years 6 months old, but with the offer that mother could book a follow up appointment over the next 6 months. This did not happen.
October	Third MSP Meeting	Progress discussed.	No actions agreed.
	Mother called health visiting team.	Mother asked for some support	HV3 allocated. Tried to call mother without success.
2021			
January	Ben started at school	School had no concerns.	
February	Mother telephoned GP surgery 3 times.	Mother concerned about Bella’s weight and constipation.	Medication prescribed.

February	Fourth MSP meeting	Mother said she was struggling and needed support.	Referral made to Swindon early help who suggested two parent support groups. Mother did not attend.
April	Mother called GP surgery twice.	Mother concerned about Bella not eating and drinking. The GP was concerned about faltering growth.	The GP: • Spoke to HV3 who said mother had not engaged with her. There was no plan made to try again. • A referral a to the hospital paediatrician was made and an appointment agreed.
May	Fourth MSP meeting. HV3 invited, but said the team were not attending such meetings due to capacity concerns.	It was agreed that EHCP would be started.	Information sent to Swindon special educational needs resourcing and assessment panel **(**SENRAP[21]).
July	Bella seen by hospital paediatrician.	Bella's weight and height had fallen, and the conclusion of this appointment was that Bella had "*significant global developmental delay with severe social and communication problems, poor feeding behaviours and PICA resulting in faltering growth and urgently required multidisciplinary therapy input*".	Referrals made to: • Occupational therapy and physiotherapy; these were declined by the SPA. • Dietician service: referral to Wiltshire service and they reported back this needed to be sent to Swindon.
September		Acute paediatricians send letter to Wiltshire community paediatrics (SPA)	

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[21] Process for agreement for Complex and Additional Needs Special Resource Provision.

		that strongly disagrees with their decision to not accept referral	
September	Bella started at Special Tots Group[22]		
November	Mother brought Ben to school, and she seemed anxious and stressed.	The school offered support.	School made referral to the learning disability team and short breaks service
	Mother brought Bella to pre-school.	Pre-school had not seen her for four weeks. Bella was noticeably thinner and seemed ravenous. Mother said she had a fractured her left arm. Bella looked pale and thin.	The pre-school made a referral to Swindon MASH
	School concerned for Ben.	Mother reported giving Ben extra medication to get him to sleep.	The school made a referral to Swindon MASH.
	Strategy meeting held.	Agreed that child protection enquiries would be undertaken. A child protection medical was sought but declined. This was challenged, without success.	Plan from the strategy meeting: • Home visit to be undertaken. • GP information to be sought as appeared that GP was already monitoring Bella's weight. • Bella to be taken to the GP.
	Next day: Home visit by allocated social worker the day after the	Home was in a very poor state. Both children looked unwell. Mother	GP appointment made for Bella the next day.

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[22] Special Tots is a pre-school group for children with Special Educational Needs/Disabilities. Parents accompany their children to the weekly sessions, and the team work closely in partnership with them.

	strategy meeting.	provided confused picture about having sought medical advice for Bella regarding possible fractured arm. Mother said she was not coping and had given Ben extra medication.	
	Bella seen by GP two days after the strategy discussion.	GP very concerned about Bella's wellbeing, she appeared very pale, looked thin and malnourished, with very dry skin.	GP referred Bella to the hospital paediatric consultant
	Bella seen in hospital	The hospital paediatric consultant was concerned about Bella.	The paediatric consultant asked for an immediate assessment on the paediatric assessment unit and Bella was admitted to hospital as a place of safety. Information was shared with the social work out of hours emergency duty team manager because this was a Saturday.
	Out of hours social worker visited the family home.	Social worker found the house in a terrible state, assessed it was not suitable for the children to be living in.	Mother was asked to agree for children to be placed in foster care and a voluntary agreement under s.20 (Children Act 1989) was agreed.

4. LESSONS LEARNED FROM THIS REVIEW

4.1 The purpose of any practice review is to learn lessons about what supports effective practice, identify gaps in effective practice, consider what causes them and identify improvements that need to be made locally and nationally to safeguard and promote the welfare of children[i].

Lesson Learned 1: Professionals in universal and some specialist services are not routinely identifying and responding to the early signs of neglect , recognising parents seeking help and the need for early help support to stop neglect becoming pervasive.

4.2 This review was initiated because Bella (aged 3) and Ben (aged 5) were found to have been significantly physically and emotionally neglected such that they were immediately removed from their mother's care for their own safety and wellbeing. Mother had signalled her need for help from when Bella was very young; she had highlighted that she was not coping and was struggling to meet their needs. These requests for help were not responded to and early help support was not provided and plans not formulated; the children's wellbeing deteriorated over time. The purpose of this review is to look back and seek to understand why the requests for support by mother were not responded to and the early signs of neglect were not recognised.

4.3 There were early concerns from HV1 regarding the quality of care that Ben (aged 3) and Bella (aged 1 year) received from their mother and the unkempt physical circumstances in which they lived. At this stage, the lack of stimulation provided by mother was linked directly to both children's developmental delay, but this analysis was not acted upon and over time the cause of the delay became about Ben's autism and Bella's likely predisposition to autism (see lessons learned 3). There seems to have been a lack of focus on what the lived experience of these children was and what the support needs of mother were.

4.4 HV1 should have sought to understand what the cause of these circumstances was and what help was needed to improve Bella and Ben's circumstances and to support mother, both in terms of her parenting role, and self-esteem. Mother's immediate circumstances were that she was a single parent, looking after two children under three, with almost no support, living in unsuitable housing, and trying to understand the implications of the diagnosis of autism for Ben. Beyond this, HV1 could have asked about domestic abuse, considered an assessment of possible post-natal depression and whether mother had a mild learning disability or learning difficulties. Mother does not seem to have been asked about her own social history, the role that father played in providing support or the role of the extended family; were they helpful or not. Most importantly, to address neglect, mother also does not appear to have been asked about her feelings towards the children, how well she felt she had bonded with them and what might be getting in the way. This was all important information to make sense of the current circumstances, to think about how best to respond and provide support. Without understanding cause of mother's reported lack of coping in her parental role, and the early indicators of neglect, it is hard to create change and provide the right early response.

4.5 Some of this may have been discussed as part of the reported Common Assessment Framework (CAF) process, but the lack of a copy of this document means this information is not known. Although HV1 made a referral for outreach support, which focussed on housing, there was no other plan put in place and for the next 6 months this was the only additional support provided to mother. There were TAC meetings said to have taken place, but there are no records of these, and looking at health visiting records there are no actions that flow from the time they were meant to take place.

4.6 The specialist services such as portage for Ben, and the paediatric neonatal clinic who were monitoring Bella's development were unaware of any concerns about the children or that mother had reported that she was not coping. This meant they could not contextualise both children's delayed development with their home circumstances, parenting context and mother's need for support.

4.7 Six months later, when Bella was 18 months old, her childminder raised significant concerns with the health visiting team (and mother/father) about Bella's development with her belief this was cause by a lack of attention and stimulation at home. The records do not describe this as a worry about early signs of neglect and minimal support. Mother was advised to contact the single point of access in Wiltshire, which she did not do, and no one questioned whether she felt able to do this, given her previously reported low mood, and as she herself reported, her lack of understanding about what this service was. There was no support in place or plan to address the concerns raised about Bella's wellbeing. This new information did not inform the work of HV1, did not add to the analysis or understanding of the family's circumstances and there was no support in place or plan. HV1 would not see mother or the children for another year.

4.8 HV1 did not share the information with the hospital paediatric team who saw Bella at this time and were concerned about her overall delayed development. They were not able to contextualise the delayed development with information about the home circumstances because they did not know about it. Background information could have been sought by the hospital team from mother and HV1. There is no evidence that mother shared concerns with the hospital paediatric team. HV1 should have been spoken to. This did not happen, and onward referrals were made to address the developmental concerns, without sufficient attention being paid to potential differential causes such as the early signs of neglect.

4.9 The next time a professional visited the family home and was concerned about both the poor level of hygiene in the home, the limited attention paid to Bella and Ben by mother, the lack of stimulation for the children by mother, which was impacting on their speech and ability of mother to cope was SALT1 in August 2019. She shared her concerns with HV1 and was invited to attend a TAC; she sent apologies to this, and it remains unclear if this meeting took place. SALT1 did not seek an update of the TAC plan, ask about what support was being provided or highlight that she was not going to be seeing Bella again until November. The concerns were left unaddressed and not responded to. The SALT1 made three appointments in November to see Bella; two were cancelled by mother, and on one occasion no one was at home, mother said she had forgotten. This information was not shared with HV1 and was not contextualised alongside the concerns from 12 weeks earlier. SALT1 did not see the children again due to COVID and their move to a new GP surgery meaning a referral to Wiltshire SALT was required. She does not appear to have shared her concerns about Bella when handing over to the Wiltshire SALT team.

4.10 Ben started at pre-school in September 2019. The pre-school team were aware that he had developmental delay and was on the autistic spectrum. They did not have concerns about mother who brought Ben regularly. Their experience was that looking after Ben could be difficult. He was a picky eater who struggled to communicate.

4.11 The last time a professional went to the family home was HV1 in January 2020. Mother talked about Ben struggling to sleep and eating food off the floor. The children were not present as there are no observations regarding how they seemed or looked. HV1 made onward referrals regarding concerns about sleep, which did not meet the criteria for services.

4.12 Mother continued to have little support beyond advice about applying for housing; COVID public health requirements meant that professional contact was by telephone, and it was more difficult for professionals to form a picture of how mother was coping and the children’s circumstances. Ben continued to have portage help and to attend pre-school, who developed a My Support Plan (MSP). Bella started to attend the same pre-school in January and a My Support Plan (MSP) was developed. These plans focussed on educational needs and developmental concerns; HV1 did not attend the regular MSP meetings and the concerns about home circumstances and how mother was coping were not shared. The lack of attendance by HV1 meant there was no discussion about how my support plan should and would intersect with the CAF (now called an Early Support Assessment in Wiltshire).

4.13 Bella was not brought to the next paediatric neonatal appointment and HV1 was informed. This should have been considered as a possible further indicator of mother still not coping leading to the children's needs not being addressed. It is not clear why this did not happen because it has not been possible to speak to HV1 who has retired. This was at a time when the Graded Care Profile 2 was being used, and it would have been expected this would have been used to assess neglect.

4.14 The COVID public health requirements started in March 2020 and Ben, Bella's and mother's main support was now pre-school. Mother had telephone contact with Swindon SALT, HV1 and the neonatal paediatric team. Mother continued to report that the children were not developing well. The hospital paediatric team were also concerned about Bella's poor developmental progress and a referral was made to the Swindon Community Paediatricians; this was not accepted, and the reason given because the SALT service was involved and addressing the developmental concerns.

4.15 Mother then moved to Swindon in June 2020. She remained registered with a Wiltshire GP. There was a handover from HV1 to HV2 in Swindon; concerns were shared about the children's developmental progress and mother was described by HV1 as coping well in difficult circumstances. This was an inaccurate picture. Concerns about the earlier indicators of neglect were not mentioned. The handover process was conducted as would be expected, with written information shared and a discussion about the children. It was the analysis of need provided by HV1 that was incorrect. Mother was spoken to by HV2, but HV2 then went unexpectedly on extended leave. She was not replaced, and mother was not allocated a new health visitor; this fell below expected practice standards. It has not been possible to establish why this was the case, but Mother was left with no support except pre-school and portage for Ben.

4.16 Bella was not brought to the September 2020 hospital neonatal paediatric follow up and was discharged because she was 2 years 6 months old, but with the offer, that mother could book a follow up appointment over the next 6 months. Mother did not request further support.

4.17 In October 2020 mother asked for help from the health visiting team. HV3 was allocated and attempted to contact mother; when she did not reply, no further action was taken. The lack of handover information about concerns about the children, mother not coping and early indicators of neglect meant that this was seen as a non-urgent set of circumstances.

4.18 Ben started at pre-school in September 2019.There were no concerns about Ben at this time.

4.19 The preschool remained concerned about how mother was coping and in February 2021, they made a referral to early help; this led to the offer of support groups for the parents of neuro-diverse children.

4.20 In November 2021, the pre-school and school both responded promptly and appropriately by making a referral to Swindon Children's Social Care when it was clear there were concerns about how well mother was coping and the impact this was having on the quality of care Bella and Ben were receiving.

What is the practice issue?

4.21 The first 1,000 days of a child's life from pregnancy onwards is a critical moment[ii]; it is a time of rapid brain growth, which sets the foundations for future relationships, cognitive, emotional, physical and social development. These best develop when a baby has at least one stable and committed relationship with a reliable and attuned adult. It is this relationship that supports this rapid brain development and builds the emotional scaffolding to support all early development. The neglect of a baby's fundamental need for love, care, available attachment relationships lead to delayed development in all areas, which can cast a long shadow into adulthood if not addressed. Therefore, it is critical that the early signs of neglect by parents/caregivers are identified, named, understood, particularly about causal factors and addressed though agreed multi-agency plans, which set goals regarding children's progress, or lack of it, and which are regularly reviewed and updated.

4.22 For Bella and Ben, the neglect they were experiencing was not acknowledged or named. The evidence in this case and from research nationally, is that if early help is not provided, then the neglect by parents gets worse, unhelpful parenting approaches become entrenched, and parent-child relationships deteriorate making it harder and harder to address. Each incident of concern was dealt with individually, solutions sought without analysis, and there was no follow through to see if these solutions had made a difference to these children's lives. The individual responses, the lack of records and fragmented information sharing meant that the slow creep of neglect over time, ended up with significant cumulative harm at a very young age.

4.23 Throughout the professionals contact with Bella and Ben's there was very little discussion about the role that father played in their lives, what he thought about their circumstances or what support he could provide. He attended early meetings, but there is no mention of him from 2019. There is no evidence he was involved in the CAF undertaken in 2018 or whether he was invited to the planned TAC meetings in 2019. This is also true of maternal grandmother who was said to play a small role in supporting mother. The lack of any real plan across the whole of the period under review meant that no thought was given to how and when to include father and the extended family. Where there are early signs of neglect, fathers can either be a source of stress, which needs addressing or a source of support, which needs harnessing. The same is true of the extended family. Both were absent here.

4.24 It has been hard to establish exactly what caused the professional response outlined, partly because most of those involved no longer work locally. What we have found is that the professional response was impacted by COVID 19 public health requirements because the children were not seen at home, by poor record keeping, by fragmented and siloed working and information sharing and the lack of the use of neglect frameworks to make sense of a child's circumstances such as the Graded Care Profile 2[23], which has been implemented in Wiltshire and Swindon. Overall, though, the primary issue was that professionals did not respond to mother's continual requests for help and support; she knew she was not coping and was not able to meet the needs of the children. There was a reluctance, seen in many serious case reviews, local child safeguarding practice reviews, to name the early signs of neglect, analyse cause and put a clear and focussed plan in place.

Lessons Learned 2: Professional lack awareness of faltering growth, the guidance and how to respond in a timely and robust way.

4.25 When Bella was seen in hospital in November 2021 there were considerable concerns about her growth and evidence of 'faltering growth'. Faltering growth is a term used to describe a slower rate of expected weight gain in infants and children according to their expected growth trajectory for age and sex[iii]. Faltering growth has replaced the more negative term, 'failure to thrive'[iv]. Faltering growth, after the early days of life is identified in about 5% of infants and preschool children[v]. Without appropriate early identification, assessment and an appropriate response it can lead to serious growth failure and delayed psychomotor development[vi][vii] [viii].

4.26 There were early concerns about Bella's growth. When she was seen at the hospital neonatal clinic in May 2018, aged 5 months, her weight had fallen from 25/50th centile[24] to the 9th centile. This did not meet the NICE Faltering Growth guidance[ix] as the thresholds for concern is a fall across two or more weight centile spaces, if the birth weight was between the 9th and 91st centiles. The hospital paediatrician thought that when Bella's weight was adjusted for her slight prematurity it fell within an acceptable range; a clear feeding

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[23] An assessment tool to help identify and measure risk of neglect. https://learning.nspcc.org.uk/services-children-families/scale-up/graded-care-profile-2-gcp2

[24] UK-WHO Growth Charts - Fact Sheet 1 What are growth charts and why do we need them? https://www.rcpch.ac.uk/sites/default/files/What_are_growth_charts.pdf

programme was proposed and HV1 was asked to monitor Bella's height and weight over the next few weeks. At this stage this was an appropriate plan which was undermined by the absence of a feedback loop. There is no evidence that HV1 did monitor Bella's weight or talk to mother about how she was getting on with the proposed feeding programme. Due to administrative arrangements and an error in timetabling, Bella would not be seen at this clinic for the next 13 months.

4.27 In December 2019 HV1 completed Bella's 9-12 month developmental check. Mother expressed concern about Bella's overall development, but her growth was not mentioned. Mother reported that she was not coping with the children. HV1 was concerned that the children lacked attention and stimulation. HV1 undertook a CAF and organised TAC meetings; it is not known whether Bella's growth was discussed, because there are no records of these processes.

4.28 Bella was seen in the neonatal follow up clinic in July 2019. Her weight had returned to 25th to 50th centile and her height is recorded for the first time as on the 0.4th to 2nd centile. Mother and father attended, and they reported that Bella's childminder had expressed concern about Bella's growth and overall development. Mother said that Bella had a good appetite, but both parents shared their concern about her overall development. Bella was unhappy with being examined, and the paediatrician also felt concerned about Bella's overall development. Bella was not brought to the next neonatal follow up appointment in January 2020 and HV1 was asked to complete a schedule of growing skills (SOGS). This was an appropriate course of action, which did not happen; HV1 did visit mother and Bella in January 2020, but her weight was not discussed.

4.29 The next neonatal follow up appointment was in May 2020 when Bella was two years old. This appointment was by telephone due to COVID public health requirements. Mother said that she was worried about Bella's weight (calculated as having fallen to the 9th percentile from the 25th-50th centile); her height was not given. This fall in weight did not meet the criteria for concern in the NICE faltering growth guidance; but mother was concerned. The hospital paediatrician proposed a referral to a dietician (this was sent to the wrong email address and did not happen) a re-referral to Swindon Community Paediatrics was not accepted. The GP and health visiting team were made aware of the outcome of this hospital visit and the plan of action. Although the criteria for faltering growth had not been met, an early intervention approach would suggest that a robust plan with an inbuilt review process needed to be put in place. The hospital team were not going to see Bella for another six months (and she was not brought for this appointment). The neonatal team did not check that the developmental assessment and schedule of growing skills had been completed by HV1 or ask her to think about weight and growth at the next developmental assessment. Bella’s 24-30 month check was undertaken by HV1 in June 2020 over the phone. This assessment did not provide any detail about growth, but there was acknowledgement that Bella was globally developmentally delayed. From this point on there was no further health visiting contact with the children. This meant there was no one to make sense of the concerns that mother raised with the pre-school about Bella’s poor appetite and eating off the floor. No health representative attended the regular My Support Plan meetings; the pre-school was aware that Bella and Ben were both picky eaters and offered mother advice. The fall in weight had not been addressed or responded to.

4.30 In February 2021 mother sought advice by telephone from the GP about her concerns regarding Bella’s growth. She also sought advice in April 2021 and the GP identified that there were concerns about possible faltering growth and a referral was made to the hospital paediatrician. HV3 was also informed but said that mother had not engaged with her. The GP shared mother’s concerns but there was no plan agreed. It would have been expected that HV3 would have contacted mother given the concerns about Bella’s poor growth and development.

4.31 Bella was taken to see the hospital paediatrician in July 2021. Her weight had fallen to the 2nd centile having been on 9th - 25th centile at two years and the 25th - 50th centile at 18 months and her height was static on the 0.4th centile. Significant global developmental delay was noted, alongside severe social and communication needs. The hospital paediatrician considered there was no organic cause for the faltering growth and made an urgent referral to the Swindon Community Paediatric team regarding the overall developmental delay; this was declined. This was challenged by the hospital paediatrician, and again declined in October 2021. This meant that there was no action until Bella was taken to hospital in November 2021, another delay of three months.

4.32 This was not in line with national guidance regarding faltering growth in a child over two years. This requires the responsible clinician (and for Bella there was a lack of clarity about who this was) to measure the body mass index (BMI) centile using the UK-WHO centiles and BMI look up charts, or calculating BMI and plotting[x], see RCPCH for further details[xi]). If the BMI is below the 2nd centile, it may be due to undernutrition or small build, a BMI below 0.4th centile is more suggestive of undernutrition and requires further assessment and intervention. The NICE guidance makes clear there should be a clinical, developmental and social assessment. A detailed feeding or eating history should be taken, preferably including a direct observation of a mealtime and food diary[xii]. For older children mealtime behaviours, foods offered, intake, parent-child interaction and intake of fluids such as juice or milk should be considered. This guidance was not followed for Bella.

What is the practice issue?

4.33 There was no plan to establish the cause of Bella's faltering growth put in place, beyond the acute hospital team asking the community paediatric team to accept a referral. Bella fell between these two services, and this led to no action being agreed. Crucially there was no plan to understand why this was happening. Establishing the cause of weight faltering, just like establishing the cause of neglect, should be key to intervention. There is little national evidence about what causes faltering growth. Most children have no underlying health condition[xiii], and the cause is likely to be complex and multifactorial. Some evidence[xiv] suggests that faltering growth occurs in the overall context of emotional deprivation and neglect and the child not only fails to grow but also fails to develop intellectually and emotionally. This was the profile for Bella. Other factors that have been identified have been parental mental health problems, substance misuse and isolation[xv] [xvi],maternal postnatal depression and anxiety[xvii]. Other research points to attachment disorders and growth faltering occurring in the context of emotional deprivation and neglect; therefore, the child not only fails to grow but also fails to develop intellectually and emotionally[xviii].

4.34 Bella's faltering growth over time was clearly part of the developing pattern of neglectful parenting she received, which was not addressed with either mother or father. The lack of recognition of concerns about neglect meant mother was not provided with the right or timely support or help to establish more effective parenting responses. The lack of an analysis about this from professionals in the community meant that the hospital health team were viewing this concern from a narrow lens, based on mothers own self report regarding the nature of the problem. The poor links between acute hospital paediatric services and community paediatric services within Wiltshire and Swindon, evidence by constant request from one service for assessment from the other, which was declined, did not help and caused some delay in action. The fragmented information sharing between health professionals, including the GP and HV3, the neonatal clinic and HV1 meant that plans made were not followed through or followed up.

4.35 Finally, talking to health colleagues in both Swindon and Wiltshire there a lack of awareness of 'faltering growth' or 'failure to thrive' and the national guidance. This is replicated in both Swindon and Wiltshire; in Wiltshire, there is no local guidance and in Swindon, there is guidance focussed only on growth faltering in the context of breast-fed babies.

Lessons Learned 3: There is a tendency that professionals attribute developmental delay as an inevitable part of a child's disability, rather than either caused by, or exacerbated by neglect and poor parenting. This leads to a response, which focusses on the child and their need for services to bring about improvements, rather than focusses on parenting, positive attachments the child's environment and the parents need for support.

4.36 Ben was seen by the community paediatric consultant in Wiltshire when he was 2 years old. He was assessed as presenting with autism spectrum disorder associated with global developmental delay. Mother and father were told that he met the criteria for autism spectrum concern based on DSM5 because he had significant deficits in social communication, significant sensory needs as well as need for routine and some overflow motor behaviours. The likelihood of Bella also having autism spectrum concerns was discussed. The hospital paediatrician wrote to HV1 and suggested that it would be important to encourage the parents to link with a parent support group and the national autistic society. There is no evidence that this was ever discussed.

4.37 There are many risk factors for developing autism, some genetic and others environmental, including psychosocial deprivation in infancy, which is defined as a lack of caregiver stimulation and attachment. It is impossible to know what part early neglect and psychosocial deprivation play in either the development of autism or the exacerbation of what was genetically determined. What is clear is that children who are on the autistic spectrum require good quality parenting and appropriate, caring and stimulating environments to fulfil their potential. Their parents need appropriate help and support to meet the needs of their children.

4.38 It has not been established whether Bella is on the autistic spectrum, but her emotional development, social communication and ability to connect with adults has vastly improved since being placed in foster care. The same progress has been seen with Ben.

4.39 Over the period of this review there is considerable evidence that Bella and Ben's global developmental delay was seen as a manifestation of an underlying organic disorder; for Ben that was ASC and for Bella the likelihood that she would develop ASC. This was despite HV1 noting in 2018 that a lack of stimulation was the likely cause, which she did not share with any other professional and although a TAC plan was developed, the lack of a copy of this document means it is unclear what was on offer for either the children, mother or father. A year later SALT1 formed the same conclusion about the likely impact of a lack of stimulation by mother, which was impacting on both children's development. She shared her worries with HV1 who SALT1 believed had put a plan in place; despite having never seen the plan or attended any meetings where it was discussed. HV1 told mother that Bella's developmental delay was understandable because of her brother's diagnosis of ASC; a focus on the disability rather that enabling and supporting mother to provide an effective parenting response and to address what mother now describes as feelings of inadequacy and depression. Mother said within the review process, that she did not know how to respond to Ben's needs and a pattern developed of Ben not sleeping, of Ben's behaviour not being managed by mother (because she did not know how) and this lack of containment impacting on Bella.

4.40 The paediatric neonatal team and pre-school were not told about the concerns about a lack of stimulation for the children and mother reporting that she was not coping at home. They were not worried about mother's interaction with the children, and there is nothing to suggest there was any indication of poor attachment when seen in these settings away from home. What was clear was that the children struggled to communicate and was sometimes distressed in paediatric health appointments; this was attributed to their global developmental delay. The developmental delay as something that needed to be addressed through structured support and specialist services, most of which were not provided as onward referrals were not accepted. There is no evidence that anyone considered how mother was coping with two young children and the enhanced parenting required for children with disabilities.

4.41 Mother talked to professionals about Ben's poor sleep, his lack of communication and both children's poor eating patterns including eating off the floor and not being potty trained. There was overall professional sympathy for mother and what she had to cope with as a single parent. HV1 told HV2 at handover that "*mother was doing well in difficult circumstances".* This assumption that mother was coping did not take account of the evidence and there was no consideration of whether mother needed more advice to parent children with a diagnosis of ASC and more support for herself as a young, single parent. There is no evidence that she was asked about what help she needed. Professionals did not consider Bella and Ben's developmental delay and poor developmental progress in the context of their individual needs, the circumstances in which they lived and the neglectful parenting they received.

What is the practice issue?

4.42 There is significant evidence that disabled children are around three times more likely to be subject to neglect[xix], this neglect is much less likely to be identified and they are not always offered appropriate assessment or services[xx]. There are many reasons for this, including society's attitudes to disability, the lack of training and perceived limited experience of many professionals of working with disabled children, understanding the complex link between disability and child neglect alongside professional sympathy for parents. Some of these factors seem to have been at play in the professional response to Bella and Ben. Mother said she was not managing to address the children's needs and was not coping. This request for help was not responded to. There was a lack of recognition that parenting children with an ASC diagnosis requires good parenting quality skills and well supported parents. Without this, a pattern can emerge whereby parents do not develop skills to support their children's development, their behaviour and sleeping patterns are not managed well, and parents can then be caught in a cycle of feeling both that they are failing, and their children are unmanageable. This can lead to a sense of hopelessness and helplessness, exacerbating feelings of failure and undermining warm, caring and attachment making parental/child relationships.

4.43 The unaddressed neglect of disabled and neuro-diverse children is a significant issue, which will impact on them fulfilling their potential. Professionals need to recognise the tendency to see a lack of progress and impaired development as caused inevitably by the disability, and think about the role that the parenting they receive and the environment they live in. This did not happen for Ben and Bella.

Lessons Learned 4: Are professionals locally equipped to respond effectively to the chronic signs of neglect and confidently take action?

4.44 The first lesson learned focusses on the identification of the early signs of neglect. This one focusses on the professional response to chronic concerns about neglect. It is effective practice that in November 2021 the pre-school for Bella and Ben's school acted on concerns and made appropriate referrals. This led to an immediate strategy discussion and child protection enquiries being initiated. A child protection medical was sought but declined. The reason given was that there was a possible arm fracture that was several days old. It was then agreed that Bella would be taken urgently to see the GP because the surgery had previously been monitoring her weight. The decision to not have a specialist child protection medical was incorrect. There were unknown concerns about a possible untreated injury and weight loss. This has been addressed through the Swindon Health Attendance at Strategy Discussion Protocol and child protection medical pathway.

4.45 A social worker was allocated and undertook a home visit the day after the strategy discussion. She found the home to be in a poor state of repair and unhygienic. Mother said that she had not taken Bella for medical attention when she thought she had a fractured arm. Mother also reported that she had given Ben a larger dose of medication than was prescribed to get him to sleep. The write up of this visit in the child's electronic file/Sec 47 assessment does not provide a clear picture of the state of the house at this time or how the children looked and seemed.

4.46 A GP's appointment was made for the next day. The social worker made it clear that this appointment was in the context of a child protection enquiry but did not attend to provide more information about the context. This left mother to self-report what the issues were. Fortunately, the GP immediately recognised that Bella was undernourished, looked uncared for and unwell.

4.47 Mother was asked to take Bella to hospital where there were also immediate concerns. This led to a further visit to the home by the out of hour's social work team. They found the home to be in a toxic state, with faeces across the floor and curtains. There was very little food in the house, and the small amount available was mouldy. Ben looked unwell and uncared for. Mother seemed oblivious to the concerns or the state of the children's wellbeing. Appropriate action was taken for both children to come into care.

4.48 It has not been possible to speak to the social worker from Swindon who carried out the first home visit and to understand why the chronic nature of the neglect the children were subject to was not recognised and responded to with immediate safeguarding action. However, there have been previous reviews locally and nationally where the immediate response to concerns about chronic neglect has been to focus on the physical circumstances alone, and a belief that this can easily be fixed by asking parents to clean up the house.

What is the practice issue?

4.49 Neglect is a complex issue, which requires a robust response. The physical circumstances in which children live are important, but they are only one manifestation of neglect. Professionals assessing in these situations need to consider using a structured tool such as the Graded Care Profile 2 or the neglect screening tool and to take a holistic approach including asking six questions[xxi]:

1. **How persistent is the neglect of these children and how effective have been efforts to create change?** For Ben and Bella, the neglect had been persistent since birth, though clearly not recognised, and so the cumulative aspects would have been hard to establish. There had been few efforts to create change, but where services had been provided to the children, there had been little change.

2. **What type of neglect have the children been subject to?**

    a. Physical

    b. Emotional

    c. Educational/stimulation

    d. Medical

    e. Supervisory

    There were concerns across all these dimensions for Bella and Ben, but the absence of a robust early assessment of neglect had not linked these together to form a picture of global neglect. The focus here was on the physical circumstances, and not what life was like for Bella and Ben, and how the physical circumstances interacted negatively with their health needs, emotional needs, and need for stimulation.

3. **What is the impact of the concerns about neglect on the child and what do we need to see change for them?** There was considerable evidence available at this time about the impact of neglect on Bella who presented as looking malnourished, uncared for and with a possible injury that was untreated. When Ben was seen, the same was true for his immediate appearance. Further exploration would have provided information about their global developmental delay; they were behind in all areas.

4. **What is likely cause of the neglect and what needs to be done to address it?** This question was never asked. Establishing causal factors for neglect is critical to create change. If professionals do not know what is causing the neglect, they cannot do anything about it. There were some clues here. Mother’s low mood, a query about not complying with professional advice and her feelings that the children were too difficult to look after. This indicated possible poor attachment and likely depression for mother.

5. **Is the neglect of children deliberate (an act of commission) or unintentional, but nonetheless harmful (an act of omission)?** This is an important question that always needs to be asked. The lack of early identification, analysis and response a meant this was hard to establish. The only evidence available was that mother had deliberately misled professionals about seeking medical attention for Bella and taking her regularly to see the GP regarding her weight. This suggests that she recognised the importance of these actions but had not done them. It is important to see this in the context of the mother seeking help and support and not receiving it. She recognised that she needed help and was not meeting the children’s needs. This was just not responded to.

6. **What other forms of harm has the neglect enabled?** Neglect can leave children vulnerable to sexual abuse, sexual and criminal exploitation, physical and emotional abuse. There was no evidence that this was an immediate issue for Bella or Ben, though the lack of medical attention for Bella could have been analysed as leaving her subject to pain.

4.50 Bella and Ben were recognised as having been significantly neglected by most professionals in November 2021 and action to safeguard them was taken. What has emerged is the variability in understanding chronic neglect and what an assessment/child protection enquiry needs to focus on.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Bella and Ben’s circumstances are a reminder of the need to equip all professionals, not just social workers, with the knowledge, skills and frameworks to identify and respond to the neglect of children, particularly disabled children, from early signs to chronic pervasiveness neglect and to consider how best to support parents and enable change, which boosts parental confidence and efficacy and improves children’s developmental trajectories.

RECOMMENDATIONS

1. Wiltshire Safeguarding Vulnerable People Partnership and Swindon Safeguarding Partnership to ask partner agencies how they are assuring themselves that the workforce is enabled to recognise, name and respond appropriately to the early signs of children being neglected by their parents/caregivers and to consider when this neglect has become chronic in nature. This to include a focus on:
    - Child centred practice
    - Effective plans and interventions to support parents and enable them to develop effective and appropriate parenting responses.
    - Good quality record keeping
    - The use of chronologies
    - Focussed early help assessment processes and the neglect screening tool/ Graded Care Profile2
    - The use of plans and reviewing mechanisms
    - Information sharing and the lead professional role
    - Ensuring a robust response to the neglect of disabled and neurodiverse children
    - Working to identify chronic neglect.

2. There needs to be some clarity sought about the connections between early support plans (Wiltshire) and the Early Help Assessments and plan (Swindon) and My Support Plans. What are the expectations, should they merge, how can information from one be shared with the other so that a holistic picture of children’s needs emerges.

3. Wiltshire Safeguarding Vulnerable People Partnership and Swindon Safeguarding Partnership should develop brief guidance and a pathway for addressing faltering growth in children. This can be used to raise awareness amongst professionals.

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