Local Child Safeguarding Practice Review

"George"

October 2022

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1.Introduction and background to the review

1.1 Introduction:

Wigan Safeguarding Children Partnership notified the National Child Safeguarding Practice Review Panel of a serious safeguarding incident relating to George, a white British 23-month-old boy in March 2022.

A Rapid Review was undertaken and on 28th April 2022 Wigan Safeguarding Children Partnership tripartite leadership proposed to the National Child Safeguarding Practice Review Panel that a Local Child Safeguarding Practice Review should be commissioned. This was agreed by the National Panel and the review commenced in June 2022.

1.2 Background:

In March 2022, George was living with his mother (known as MG for the purpose of this report) as his sole carer. He had commenced nursery 1st Feb 2022 three days per week but was absent from 2nd March to 24th March as MG reported she had lost her employment and was unable to pay for his place.

On 24th March 2022 George was brought to nursery by his mother. Very shortly after his arrival several bruises and abrasions to his face were noticed by staff looking after him, and on further observation they noted more than 20 different injuries. As part of the immediate police and social care involvement that day a Child Protection medical was undertaken, and scans determined that in addition to the visible injuries George had a significant subcutaneous swelling on his head. MG was arrested on suspicion of assault, and at the time of this review the criminal investigation is ongoing. Upon his discharge from hospital George was placed with a foster carer on an Interim Care Order and proceedings in the Family Court are continuing. George has thankfully made a full physical recovery from the injuries; however, it is early to evaluate the emotional harm caused by the physical abuse and neglect he experienced up to March 2022. People who know George have noted that he displays behaviour that carers find challenging and continues to present as being withdrawn.

George, prior to March 2022 is described by professionals who knew him directly as being a toddler who was withdrawn, shy, sad, expressionless, struggling with language, didn't really know how to play with toys, was under stimulated and wanted to avoid being touched. Since he has been removed from his mothers care he is described as doing well, 'a very different child', smiley, happy and is becoming confident around adults, appropriately tactile with adults, and having a good bond with his father and grandfather.

2 The Review Process and Methodology

The process of gathering facts and chronology of what happened in George's case provided a framework of narrative from which a systemic learning approach[1] could be developed. The review has therefore focussed far more on identifying root cause and understanding the organisational and practice context to contributory factors. The review comes from the premise that all organisations and practitioners involved commit on every level to safeguard children like George, and that where that has not been achieved then we should look for a systemic understanding wherever possible.

The review undertakes to:

a) Provide analysis where practice or guidance exceeded expectation, and to identify opportunities to further promote this good practice.
b) Analyse, without hindsight bias, any areas of concern with full recognition of the complex and difficult circumstances in which professionals working to safeguard children operate.
c) Facilitate reflective dialogue with professionals involved in the case on a multi-agency footing to exchange views and understand context of the lived experience of working with George and his family.
d) Provide and consider organisational information and apply analysis of the provision of services to George and his mother.
e) Consider George's lived experienced centrally to all analysis and recommendations.
f) Gather an understanding what was known by which agencies, at which times over the case and sufficiency of responses.
g) Consider the interface in this case between services in the Children's and Adult's sectors. This is a Local Child Safeguarding Practice Review and therefore focuses on George first and foremost, however it was evident from Rapid Review stage that there is valuable learning to be taken forward regarding how services who have known MG over her life supported her across transition to adulthood.

The Reviewer had access to all information submitted to agencies from the Rapid Review and a range of Children's Social Care information additionally requested covering February and March 2022. In addition, the review draws on 2 panel meetings and a practitioner event which took place 30th September with most agencies represented. The reviewer has also considered previous Local Child Safeguarding Practice Reviews undertaken in Wigan and their action plans in ensuring minimal replication of recommendations, and relevant learning from National Child Safeguarding Practice Review Panel reports.

The report format includes:

- A brief report outlining MG's history with focus on learning rather than narrative.
- Learning points are identified as such as they appear in context through the analysis. If they require changes to practice, policy or procedure, or by individual or collective agencies this is captured in a 'Learning points' Section in the report.
- Recommendations for Wigan Safeguarding Children Partnership to consider in response to the overarching analysis of George's case.

[1] Tools including Double-Q, Behaviour Over Time (BOT) and Causal Loop were used by the Reviewer.

3.Time period considered in the review:

The Local Child Safeguarding Practice Review covers the period from MG's pregnancy with George (summer 2019 onward) to 25.3.22. Agencies were invited to give more detailed chronologies from 1.3.22 – 24.3.22 after it was identified in the Rapid Review that there was significant agency involvement in the final three weeks leading to George's injuries being noticed.

After the Key Lines of Enquiry were developed further information regarding MG's history with Children's Social Care and housing were requested and helpfully received as her transition across children's to adults' services emerged as an important systemic theme.

4 Parallel Processes:

There are Care proceedings which at the time of writing in October 2022 remain ongoing and it is thought likely that the Court will order a Fact-Finding Hearing[2] to be undertaken.

Criminal investigations in relation to George's injuries also continue at the time of writing. The Reviewer has been in regular contact with the Detective managing the case and undertook a joint visit to MG in July 2022 as part of the review process to gather her views.

5 Local Child Safeguarding Practice Reviewer and Panel:

This review was commissioned internally within Wigan Safeguarding Children Partnership and the author is Rick Bolton, Social Worker, Business Manager for the Partnership. A Panel consisting of the Safeguarding Leads from across all agencies involved with George and his mother was informed to support this process to agree the methodology and outcomes. Attempts were made to contact George's father during the review process, unsuccessfully.

6 Initial Key Lines of enquiry:

The following KLOE's emerged from the Rapid Review Process. Each was further developed in the Local Child Safeguarding Practice Review.

1. Practice, delays in decision making, and oversight in the Child First Partnership Hub
2. Consideration of George's mother's needs, vulnerability, transition.
3. Consideration of George's lived experience and identification of sources of risk.
4. Noncompliance by NWAS with Bruising in Non-Mobile children protocol.
5. Good / exceptional practice by George's nursery.

7 Child's voice and experience:

As will be outlined further in the review, George's experiences are not consistently recorded in documents and case records across the partner agencies. However,

[2] Practice direction 12J Family Proceedings Rules 2010.

though secondary, it was helpful to discuss George's lived experience with his mother, the professionals who knew him before and after the index incident of 24th March and his current social worker.

8 Key focus: MG's background, pregnancy and George's birth:

8.1 George is MG's only child and was born in May 2020 when she had recently turned 20 years of age; the relevance of her age will become clear over the following sections of the review.

8.2 For a considerable period of the pregnancy George's father was thought to be a male who his mother had briefly been in a relationship with who is considerably older than her and who has an extensive, entrenched criminal history. Towards the end of the pregnancy MG told some professionals who were working with her, though not all, that George's father may be another male (known as FG in this report) who she knew from her previous supported accommodation, and this has subsequently been confirmed through paternity testing in the current care proceedings.

8.3 MG has a history with Children's Social Care and other professional agencies going back to 2003. Her father has never had a role in her life. She told the Reviewer that her childhood was 'just neglect all the time' because of her mother's drinking and wider substance misuse; her mental health and being in domestically abusive relationships, and she described that she had 'always' had to look after her younger siblings. Due to educational neglect, poor home conditions and lack of appropriate boundaries being put in place by MG's mother, MG was subject of a Child Protection Plan for 3 years from 2014 to 2017. During this time, she spent time residing with her mother's ex-partner along with her next-youngest sibling, whilst her two younger siblings remained with her mother. MG told the Reviewer that she felt responsible for them because what was happening to them was what had happened to her, and nobody was stopping it. As far as she was concerned, she was being seen as something of a positive factor in supporting her siblings and she recounted to the Reviewer that she was told this on several occasions by the Social Workers involved.

8.4 However, in 2018 MG's two younger siblings were removed from their mother's care and placed in foster care due to the enduring and at times acute neglect. MG told the reviewer that people had been fine with her taking care of her siblings until that point and she didn't really see that anything was any worse (for her siblings) at that point than it had been for years, and that she had been taking care of them.

8.5 After this unsettled period, MG moved into semi-independence with supported accommodation combined with on-site training. Her progress there from 2017-2019 was exceptional; rarely do young people in that setting sustain a tenancy that well and engage so constructively with the provision on offer. When MG became pregnant with George, she had to leave that provision, something she understood fully, and she stated to the Reviewer that she was ready to leave and live independently – she refused the option offered to her of a mother and Baby Unit. She moved into her own flat a couple of months before she gave birth to George, shortly before the first National Lockdown of the Covid-19 pandemic.

8.6 Discussions in the Panels and Practitioner event identified that previously in Wigan a Family Nurse Partnership[3] model existed but this ceased to be commissioned in late 2019 shortly before MG's pregnancy with George. FNP would have been a wholly appropriate offer for MG. Based on her evident ability to engage and work with supportive professionals in supported accommodation it was felt by practitioners that she would have engaged Family Nurse Partnership Programme support were it available.

8.7 In 2021, MG was referred by her GP after several visits, for an assessment in relation to her learning needs and possible assessment for autism. Latterly, in late 2021 – early 2022 this assessment was completed, and MG received a diagnosis of autism. MG explained to the Reviewer that this reduced her anxiety as she had always considered that there was "something different about her" and that this helped her to make sense of it. MG was not supported to attend school by her mother, and resultantly any appreciation of whether her behaviour suggested she may benefit from an autism assessment was essentially lost.

8.8 The brief background to MG above, is relevant to the systemic understanding of what her needs were going into her pregnancy with George. MG is a young woman who has a significant history of trauma across a range of domains. She experienced sustained neglect and exposure to risky and toxic adult behaviours throughout her childhood and adolescence. Through her teenage years she experienced adversity in terms of living arrangements, separations from her siblings, educational disengagement (prior to her move into supported accommodation) and poor mental health.

8.9 MG felt that she was ready to live independently and care for George. Sadly, commencing in early July 2020 and repeated several times over following weeks, MG reported to health professionals that she felt that she was not bonding with George.

8.10 Concerns continued over July and August 2020. This included information received about MG leaving George in the care of others, MG permitting unsupervised contact with FG who was, at that stage (to some agencies) the putative father, and around whom there were on-file, concerns about him presenting a risk of domestic abuse.

8.11 There is evidence of good practice by George's Health Visitor referring the case to Children's Social Care for further assessment in July 2020 due to these concerns and additional ones around MG allowing her younger sibling to move into her flat and his associates being there. There was timely response from Children's Social Care and a Strategy meeting on 20.8.20 resulted in a period from Sept 2020 to April 2021 of George being a Child in Need (CIN).

8.12 The CIN plan ensured a coordinated approach to supporting George and his mother which was responsive to new risks; for example, in November 2020 a Strategy meeting was convened in relation to the drug use of MG's siblings and links to offending, and this led to a S47 investigation with the outcome of this being to continue the CIN plan.

8.13 MG was offered and engaged to some extent services in relation to both her mental health and her bonding including a specialist attachment and bonding service. The engagement was however inconsistent across services and at times the chronology

[3] A programme for first time mothers under the age of 20. Offering intensive and structured home visiting, delivered by specially trained Family Nurses, from early pregnancy until the child is two.

shows failed appointments, last minute cancellations and what practitioners in reflection have considered may have been avoidant behaviours.

8.14 The CIN process through winter 2020 into Spring 2021 provided a framework of monitoring and protection around George. Such was the presentation of MG's needs; all agencies were looking to respond to her needs so that consequentially she would be in the best place to able to meet George's needs.

8.15 In taking George off the CIN plan in April 2021, it is apparent that the professionals involved were heavily influenced by three factors; self-reporting by MG (certainly around her Mental Health); the desistance of further contacts or referrals to services over early 2021; and that FG had been assessed by this stage as not presenting a risk. The decision to end the CIN was unanimous but shows collective over-optimism; there had not been a sustained period of positive changes – different to a sustained period of lack of crisis – and there was an ongoing pattern of help seeking behaviour from MG that was perhaps interpreted as positive resilience but on reflection practitioners involved accepted could have been evidence that she was finding it difficult to cope. When primary care (GP and NHS111) information was received for this review, MG had more than 40 GP contacts over the preceding 2 years prior to March 2022 many of which, when reviewed by panel members, related to self-limiting childhood ailments in George; a reframing of this behaviour by professionals involved may have led to a more accurate understanding of her capacity to cope.

8.16 After closure of the CIN in April 2021, in May 2021 a referral came into Children's Social Care again. On this occasion this related to MG allowing her older sister to move in with her, who had had her own children removed from her care. The second, in July 2021 is a detailed account from an anonymous neighbour regarding neglect of George referring to him being left in the care of a 15-year-old whilst MG went to work, being made to eat 'adult food' and watered-down milk, and that the house was filthy with George crawling around in rubbish. The outcome of this was a check between Children's Social Care and the Health Visitor and, due to annual leave being planned, a visit 3 weeks later was planned.

8.17 Both incidents were deemed not to meet the threshold for Strategy discussion and on both occasions, MG declined offer of support at an s17 Children Act level. This rationale for this decision is not detailed; George was only recently removed from CIN and the level of concerns that had initially raised him onto that in Summer 2020 were now being repeated in 2021. There are no records to suggest that George's lived experience was guiding responses at that time.

8.18 From reviewing the records across the partnership agencies there is only slight mention in the health records of MG going into the diagnostic pathway for autism and eventually being diagnosed. Greater sharing of this would have better informed intervention approaches, as mothers with autism face additional challenges with communication and may require tailored approaches[4].

8.19 Notably, this is the first anonymous contact with services outlining concern about George, a pattern that continued.

[4] Pohl, A.L., Crockford, S.K., Blakemore, M. *et al.* A comparative study of autistic and non-autistic women's experience of motherhood. *Molecular Autism* **11**, 3 (2020). https://doi.org/10.1186/s13229-019-0304-2

9 Concerns in January and February 2022

9.1 MG had two adolescents frequently staying at her flat; one of whom is Looked After and was repeatedly reported missing. On 9th,16th, 21st of February this young person was located by Greater Manchester Police in MG's property and returned home yet MG, culminating with a Recovery Order being made on 2nd March. MG was clearly aware that she should not harbour these young people but continued to do so. The Greater Manchester Police attendances at the property are recorded but there is no reference to the presence of George or checks on his wellbeing in these logs; it may be that he was present, and his wellbeing assured but it is not recorded.

9.2 On the 21st of February, the Health Visitor also attended the property, and there is good practice evidence of her challenging MG about the state of the property, liaising with Children's Social Care about the adolescents present and assuring George's wellbeing.

10 Key focus: 8th March 2022

10.1 This day gives a lens on the systemic issues in this review. Over the course of the day, there were visits to George's home by the Health Visitor, two social workers, and Police officers however none were operating with an awareness of the any of the other's interactions with MG and George that day. The common theme of 'silo working' where agency records are not shared, and professionals are working in isolation is rarely focussed on a 12-hour period and it is unhelpful to consider learning from this case as wholly aligned with where it is seen in other reviews.

What occurred on 8th March was real time complexity of information sharing across agencies, and not easily ameliorated. It has been challenging even at the stage of Local Child Safeguarding Practice Review to fully sequence these events as some agencies automatically time / date entries on case records (e.g., Greater Manchester Police) whereas in others it is solely reliant on practitioners to enter a specific time for that day and some records appear as '00:00, 08.03.22'.

08/03/2022 (1st)	**H.V Record** Home visit by Health Visitor. Improvement in home conditions noted. George was observed throwing and spitting food on the floor. The HV discussed motivation to make improvements to the home and the risks of George being exposed to numerous visitors, which can contribute to instability within the home. MG noted she was unable to continue taking George to nursery as she had outstanding nursery fees that she could not pay as she was no longer in employment. Early help and Startwell was offered but declined. Maternal mood is self-reported as low.
08/03/2022 (2nd)	**Greater Manchester Police records** 14-year-old female detailed above following being reported MFH was located at the address of MG and removed to her own

	carers. 14-year-old male also present.
08/03/2022 (3rd)	**Children's Social Care record** - Unannounced home visit completed. George not present, he was in the care of CMG. Concerns raised about 2 young people who had been reported missing from home and had been found in the property. The Police were present and removed the missing teen from the property. The home was observed to be clean and appropriate for George with clean bedding and toys observed.
08/03/2022 (4th)	**Children's Social Care record** unannounced home visit completed by the social worker for the older teen found at the address, however she had already been removed from the address by the police by this time. The SW made detailed record of being approached by youths outside MG's address asking her if she was here to buy cannabis off MG etc and a strong smell of cannabis. There is no record of George in this visit.
08/03/2022 (5th)	**Children's Social Care record "**Telephone call from CMG to out of hours to advise she was worried about MG's mental health as she had returned home and told her she will throw George on the train tracks. CMG reported that MG is not allowing her to take George to a place of safety. CMG was advised to contact the police for support with this."
08/03/2022 (6th)	**Children's Social Care record** out of hours telephone call from CMG who reported she was going to pick George up.
08/03/2022 Also, that day	**Greater Manchester Police Record** Report received by Greater Manchester Police that MG on several occasions has been verbally abusive and threatening in public that day towards a previous friend with whom she had fallen out.

10.2 The Health visitor and nursery nurse attending in the morning of the 8th observed George; the record captures his experience and voice, and the challenge and advice back to MG about the instability caused to George by there being a range of visitors to the property, and how this may affect his sleep and wellbeing.

10.3 Later, that day around 5pm Greater Manchester Police, pursuant to the pattern established over February of a young person who was MFH being at MG's property, attended and removed the young person. There is no record of George in this log.

10.4 George's Social Worker attended around the time the older child was removed from the property and was told by MG that George was with another of her family

members (CMG in this report). There are positive recordings about the home at that point.

10.5 Slightly later that early evening, the Social Worker of the child who had been removed from the property by the police attended but was unaware of the police, other social worker or Health visitor contacts that day.

10.6 On the 8th of March 4 different professionals / agencies attended MG's property, each not knowing of the others attendance. This is a point for agencies consideration; MG was being told by some professionals not to have so many visitors coming in an out of her property because of the effects on George, though made 4 uncoordinated attendances to her flat that day. The Local Child Safeguarding Practice Review Panel and practitioners considered that as an individual with autism, MG may have found this messaging confusing and conflicting.

10.7 Even later, CMG contacted the out of hours service with concern about George. There is an important issue to describe here relating to earlier learning in the Rapid Review and panel meetings: from the chronology Children's Social Care provided to the review (above) it reads that CMG had contacted Children's Social Care Out of Hours team with concerns for George's safety as "MG has told her she was going to throw him (George) on the train tracks". The record reads that she had been advised to instead contact the police and call back to the Out of Hours team with how it went. That would have been an inherently risky response in such circumstances and a significant practice concern. However, when the Reviewer interviewed the practitioner, she explained that her recording was poor and outlined that situation in better detail; CMG had contacted the Out of Hours Team saying that she was on her way to pick George up because she was concerned about threats that MG had made about George. She was calling for advice of what she should do should MG not agree to let him go with her and the practitioner advised her to call the police if that was the case when she got there. This places a different context on the interaction. The only consideration to the safety of this advice is that George's welfare could have been assured by asking Greater Manchester Police to undertake an immediate welfare check.

10.8 There is a lack of integration of real time records across single agency (Children's Social Care) or multi agency (Children's Social Care, Greater Manchester Police, NHS) systems and this is insoluble through the scope of this review. It is important to note it though, as it is an aspect outside of practitioners control, which has a significant effect on the ability to observe and respond to situations based on real-time information. The panel and practitioners noted some possible improvements that could be made relating to use of 'flags' on records and significant event recording. The reality is that practitioners across agencies do not have time to review all existing history in relation to a case when they are unfamiliar with for example a practitioner in out of hours services. A detailed chronology with key risks identified assists this.

10.9 Additionally, in the lead up to 8th March there was considerable amounts of information available, that would have linked up the concerns around the teenagers who were missing from home and located repeatedly at MG's property, MG herself and George. These opportunities were not actualised until after the 8th of March and this emphasises the necessity of mapping around young people who go missing from home, the adults with whom they associate but also the safeguarding considerations for any other children that they may encounter.

10.10 Finally, the 8th of March shows again the repeating pattern of people outside of George's household raising concerns about his safety and wellbeing again; in this case CMG. When extended family or neighbour concerns had been raised over the course of George's life the response, or lack of, is not considered to be due to decisions being made about the motivation or maliciousness of the report. Practitioners described in the review process that there was always a feeling that the interventions already in place were able to respond to the new information coming in and keep George safe.

10.11 It is not possible to infer that decision making in relation to these anonymous contacts was manifestly unsafe - some did not indicate acute and immediate risk - but the rationale for decision making is not well recorded on some occasions.

11. Period 9-24 March 2022

11.1 George was not in nursery at this time, and it is notable that the only consistent adult care he had been experiencing, albeit briefly, for 3 days per week was removed.

11.2 On the 9th of March George's social worker made an announced visit early in the morning; George was noted to be very sleepy and hard to rouse. Being minded of the concerns around cannabis use in the household from the day this may have raised more concern, and this was certainly compounded by a call from another family member on the 14th of March that they were concerned, having looked after George for a day, that he had slept almost continuously for 24 hours and that several members of the family had concerns that he had been drugged. There was management oversight of the case on the 14th, but no timescales indicated for when George should be seen.

11.3 On the 15th of March George was taken to the GP by MG in relation to behavioural problems and referred to a community paediatrician and was seen by his Health Visitor on the 16th of March. In these visits concerns were raised about George having pulled at his hair and having areas of bald patches and having problems eating. This was determined in further examination to be a form of alopecia often linked to stress.

12: Incident on 24 March 2022

On the morning that George returned to nursery for the first time in over 2 weeks the staff at the nursery showed a good level of curiosity about his wellbeing and MG relayed the information about his hair loss. Soon after being dropped off, staff noted that George had other facial injuries and bruises that prompted further examination and led to the noting of over 20 injuries. He was also noticeably 'clingy' and unsettled.

13. Findings:

The findings encapsulate all the Key Lines of Enquiry (KLOE's) and learning extracted via the review process, document review, panel meetings and practitioner learning event.

13.1 KLOE 1: Regarding delay in the Child First Partnership Hub highlighted in the Rapid Review was explained during the Local Child Safeguarding Practice Review as being due to a weekend when screening of referrals / contacts does not take place in the manner it does Monday to Friday. There may be a consideration for Wigan Safeguarding Children Partnership to improve this to make it a 7-day process, but this would be a strategic response and the impact of this delay in this review is not so great as to lead to it becoming a Recommendation. Capacity, system demand and covid pandemic impact all interacted negatively in George's case. George was born within a few weeks of the first national lockdown of the Covid-19 pandemic. Services abjectly, and in some cases permanently changed the way that they operated in the space of a matter of weeks. On a very practical level, for MG as a young mother with undiagnosed (at that stage) autism, and who had moved from a highly supportive semi-supported accommodation with routine to living alone the changes to the working relationships on top of practical arrangements would have been especially difficult to cope with. For services, demand even pre-pandemic was at a stage of risking safe delivery[5] but after an initial reduction in demand this demand on safeguarding partners services increased towards the middle of the pandemic period with schools reopening etc[6]. Practitioners involved in the review from health and social care spoke of caseloads that were in March 2022 and continue to be far more than optimal levels and their belief that this impacts safe decision making from the perspective of not having time to review and reflect on information from across a range of agencies to inform better decision making.

13.2 KLOE 2: Regarding MG's experiences, understanding of her needs and transition. Services to MG over her adolescence and transition to adulthood offered her practical stability (e.g., supported accommodation), but without an overarching Transitional Safeguarding strategy; a context that is not unique to Wigan[7]. As MG left supported accommodation to give birth to George aged 19 a process that pulled together professionals that knew her over the previous 2 years and a pooling of her history would have better informed the next steps for her and the unborn George. Practitioners in the review considered that services needed to be better 'trauma informed' – an inexact phrase to describe a whole culture of working, but this need can be exemplified by adult services practitioners having no idea about some of the most salient parts of her background and the abuse / neglect she had experienced.

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[5] https://www communitycare.co.uk/2020/04/03/social-work-caseloads-70-percent-childrens-practitioners-struggle-survey-shows/

[6] Baginsky, M., Manthrope, J. (2021) The impact of COVID-19 on Children's Social Care in England. Science Direct Available at: The impact of COVID-19 on ChildrenÃƒÂ¢Ã‚Â€Ã‚Â™s Social Care in England | Elsevier Enhanced Reader

[7] Cocker, Christine, Cooper, Adi and Holmes, Dez (2022) Transitional safeguarding: transforming how adolescents and young adults are safeguarded. British Journal of Social Work, Vol.52, Iss.3

Working with MG with an active knowledge of her background would have contextualised some of her behaviour and choices, particularly in understanding her attachments and rejections of services, her help seeking behaviour and early attachment difficulties with George. It may have also offered useful insight on why throughout the period of living in her own flat she sought unhealthy relationships with younger teens and how best to work with those issues at a level deeper than advising her against doing it – essentially getting practitioners to be able to understand 'why' MG behaved like she did rather than just 'what' was happening. A significant underlying, unexplored to some extent, factor was what is now known to be MG's autism; early diagnosis would have allowed practitioners to consider alternative and perhaps more effective ways of working. There is a balance to be struck in all this with MG's self-determinism and choices as she hit 18 years of age but with a young person with her history approaching parenthood in late teens a consolidated strategic and operational transition approach would assist. On a more practical level specific to this case, MG has never presented as being reluctant to talk about her past. The Care Act 2014 places a duty on local authorities to conduct transition assessments for children, children's carers and young carers where there is a likely need for care and support after the child in question turns 18 and a transition assessment would be of 'significant benefit'[8].

13.3 KLOE 3 George's lived experience; his voice is not consistently captured due to lack of collaboration between agencies in key periods of his life. Some records offer high quality observations of George and his interactions with his mother, however what is not clear is how this formed part of the decision making. To evidence this point; George was variously described by practitioners who knew him in late 2021 – early 2022 as withdrawn, shy, expressionless, avoidant of being touched etc. This was at the same times as there were concerns across other records about home conditions and various people residing there, concerns from extended family about him being drugged and him being left in the care of teenage acquaintances of MG, and latterly of him pulling his own hair out. The recordings are broadly agency exclusive and not shared in real time, so the usefulness of noting his experiences and what George was telling us through his behaviour was lost.

13.4 KLOE 4 regarding NWAS not following the Bruising in Non-mobile infants Protocol on an occasion they attended George's house was, candidly, one that NWAS had put forward at Rapid Review stage. NWAS had attended the home in Feb 2021 on an occasion where MG said that George had fallen off the bed. This was investigated robustly by NWAS and there is a context that there were no apparent bruises or external injuries seen on George by the crew, he seemed soothed by that stage, and that MG was happy to assume responsibility for his care should his condition change. NWAS have reiterated practice guidance across their workforce to undertake referrals and addressed it with the crew involved. As such the response is commensurate and there is no benefit from a recommendation in this respect.

13.5 KLOE 5: Exceptional practice by George's nursery: The practice of the nursery on the morning of the 24th of March was an example of excellent practice. The curiosity of staff greeting George that morning after a period of absence led to them

[8] Care Act (2014) Available at:Care Act 2014 (legislation.gov.uk)

having appropriate concern about the injuries / abrasions on his face and undertaking the full examination of his body very shortly after he arrived. The nursery was asked by Greater Manchester Police to take photographs of the injuries and to send them via email. The manager had the awareness of Safeguarding Policy to challenge this request initially and point out how it went against their guidance. It was acknowledged by GMP that requesting these images had been custom and practice, however it was recognised that this policy wasn't appropriate given safeguarding processes. Therefore, there has been a change of policy within GMP, which has been cascaded to all Wigan staff and disseminated through WCSP. Throughout the initial response, George was supported by staff who knew him and could comfort him whilst management proceeded to action the concern.

The Reviewer and Local Authority Early Years Safeguarding Lead visited the nursery as part of the review process to get a better understanding of the systemic reasons for this good practice. It is a nursery which is part of a private regional group, and they have a requirement for all staff in their settings to be Level 2 Safeguarding trained; considerably above the expectations laid out in national guidance. The staff could also describe how a 'safeguarding first' culture is fostered through it being in every level of performance monitoring and staff briefings, and how a comprehensive debrief had been undertaken at the time and subsequently with staff involved with George. In this review it was apparent that there is a clear thread of safeguarding being important through practice, guidance, monitoring, leadership and senior leadership systems.

Other findings outside of the KLOE's

13.6 **Missed appointments, late cancellations and rearranged appointments were not consistently responded to**. The National Child Safeguarding Practice Review Panel's 2020 Annual Report outlines the importance of following up on 'missed appointments, blocking of communications, and cancelled visits', which are typical signs of parental avoidance (CSPRP, 2021c). Skills in critical thinking and analysis alongside managerial oversight may promote early identification of such patterns and encourage deeper exploration providing the opportunity for practitioners to work differently. Also impacting on this is the lack of considering MG's known Learning Difficulty and her, at that stage undiagnosed but impactive autism which would have offered some context to her behaviour.

13.7 **There is evidence of professional over-optimism in the case** regarding MG's capacity and likelihood to change. The decision to end CIN in April 2021, whilst agreed by all agencies, was not made with full reflection and consideration of information available and the learning pointed to in the findings of KLOE 2 above. The possibility of MG returning to the unsafe practice of allowing friends and risky adults to stay at the property was predictable based on recent behaviour where MG had not recognised the impact on George or in fact herself from a criminality perspective, further, the push and pull factors that lead to MG behaving that way do not appear to have been understood or influential in the decision to end the CIN intervention. Practitioners appear to have been heavily influenced by self-report from MG, and her assurances that she would continue to engage but this was not backed by consideration of her capability to do this.

13.8 MG experiences of losses of her relationship with her siblings linked with her identity as a young carer was not understood. MG was known to be a young carer by services working with her and her siblings; this was not a sudden change for her – she told the Reviewer that taking care of them and assuming responsibility for practical and emotional support for her siblings in the absence of appropriate care given by her own mother was a developmental part of her identity. In the Local Authority taking appropriate steps to protect her siblings in 2018 and place them in Care, there was no evident consideration to how this may affect MG's self-identity or support put in place – MG thinks that this would have helped her understand[9].

13.9 There are ongoing challenges in achieving the same level of intervention that the Family Nurse Partnership (FNP) scheme offered until slightly before MG's pregnancy with George. The FNP model was developed with the support of young women like MG in mind and had considerable success in Wigan, however the commission was discontinued in late 2019. The capacity of 0-19s services offer an equivalent level of intervention, with the benefits it brings of consistent intensive contact with midwifery and health visiting and the coordination of other agencies into the plan, is not currently in place. A review of the 0-19 offer is underway at the time of writing this Local Child Safeguarding Practice Review, and the reviewer encourages the use of MG / George's experience in that review process.

13.10 Missed opportunities to share information across partners. In many LCSPRs there is evidence of information not being exchanged efficiently within a closed system such a CP, CIN, or Early Help Processes so it is not helpful to just log information sharing as a problem in this case. There are set-piece methods of coming together to share information; in George's case most recently, this was via CIN reviews but these at best are monthly. The amount of change, the differing factors and multiple contacts between George and professionals meant that period information sharing at set points e.g., CIN reviews would not capture them. For example, the frequency of notable contacts in the first 2 weeks of March 2022 across agencies was difficult to unpick in chronologies for this review, let alone for practitioners potentially working with George and his mother over the course of a single day like the 8th of March. This requires investigation of whether there are opportunities in the increasingly agile digital world to share data between practitioners involved in a case across agencies in real-time. Whilst this might not be possible, the Reviewer thinks it is important to note the disabling rather than enabling effect that lack of shared systems causes and that this is soluble for practitioners.

13.11 Unseen men and unexplored individuals. There is evidence in the case of services responding appropriately in calling a Strategy Meeting when there was a suggestion putatively that George's father was a known, entrenched and dangerous offender who had been recently released from a long custodial sentence. By the time he was to be assessed, he had been recalled to prison, so this became a low risk. Subsequently, when MG disclosed that another male may be the father, there was a similar response. There is accepted learning in the case about a lack of follow through when MG was advised to get a Domestic Violence Disclosure in relation to the (now confirmed) father ; Greater Manchester Police failed to action this request. It is conceivable that this perhaps led to MG thinking that the lack of response was a positive sign, however in the broader sense the risk itself was worked with by all

[9] Helena D. Rose & Keren Cohen (2010) The experiences of young carers: a meta-synthesis of qualitative findings, Journal of Youth Studies, 13:4, 473-487, DOI: 10.1080/13676261003801739

agencies. Overall, the risks that both the putative father and George's father may present were recognised and George's wellbeing was well protected. What was less understood and considered contemporaneously was the nature of the relationships MG had with them considering what was known about her vulnerabilities and what this might have told services about her needs. MG is increasingly vulnerable to abusive partners due to her own experiences of abuse and neglect[10], and this risk continues into her adulthood. There were other individuals known to be frequenting MG's property, for example the two adolescents who were repeatedly missing from home, and other acquaintances ; there is insufficient evidence of enquiry about these individuals by agencies who had contact with MG and who had on occasion met them. There is ongoing work in Wigan Safeguarding Children Partnership to address variable practice around professionals exhibiting appropriate child-centred curiosity, and this case provides further examples of the need for this improvement.

13.12 Demand on services and the workforce: Practitioners and managers involved in this review cited their frustrations at the lack of time, caused by service demand, impacting on whether the requisite previous history of an individual / family can be consistently considered in decision making. Caseloads across the partnership were described as far higher now than they were pre-pandemic.

14 Conclusions and Summary:

14.1 The cause of the injuries to George that prompted this review cannot be commented on. However, in the first 23 months of his life George was neglected; omissions in his care, being left with children who were unable to competently care for him, material neglect in poor home conditions, and exposure to drugs and anti-social behaviour in the household from his mother's associates. The reasons underpinning his mother's inability of lack of motivation to provide quality parenting were insufficiently considered.

14.2 Collectively, the CIN approach over 2020-21 provided a framework for the observation of George and collaborative working across agencies ; at times this was effective but even without hindsight bias it can be said that the decision to end the CIN was based on false positives (i.e. relatively unchallenged self-reporting by MG of positive change and a period of no professional concerns for George – an issue which is only as patent as being measured against previous concerns and there is a lack of, for example, Graded Care Profiling). The onset of behaviours in summer 2021 that had previously caused concern, such as having teens staying in the flat when they were MFH, coupled with MG refusing to work with services being offered on a voluntary basis, should have at least caused multi-disciplinary consideration of escalation.

14.3 George's case offers Wigan Safeguarding Children Partnership an opportunity to understand how the effect of trans-generational abuse and neglect can manifest in parenting behaviours, and how the lack of understanding the childhood trauma can undermine attempts made by agencies to promote good parenting practice.

[10] Ravinder Barn, Nadia Mantovani, Young Mothers and the Care System: Contextualizing Risk and Vulnerability, *The British Journal of Social Work*, Volume 37, Issue 2, February 2007, Pages 225–243, https://doi.org/10.1093/bjsw/bcl002

15 Recommendations for Wigan Safeguarding Children Partnership to consider and action:

15.1 There are findings in the review which are repetitious of findings in other Wigan Safeguarding Children Partnership Local Child Safeguarding Practice Review's that the Reviewer has considered, so if their occurrence in George's case acts to reinforce those themes and workplans. These action plans can be revisited to ensure that they respond to the context of them in George's case.

These include:

- Critical thinking, professional curiosity and undue optimism – a recurrent theme.
- Consideration of threshold application at point of closure of cases (in this case the CIN closure).
- Ensuring the child's voice and lived experience is central to the case and is leading the decision making of professionals.
- Unseen men (however specific focus needs to be developed on the effect of these men in relationships with vulnerable women / those with experience of abuse).
- Development of practice approaches and practitioner skills that show an awareness and responsive empathy in the work and planning for individuals who have experienced trauma.
- Variable practice quality in the written plans and targets in cases at all levels of intervention.

15.2 However, the following recommendations are made with specific reference to George's case:

1. Wigan Safeguarding Children Partnership should ensure that the learning from this review is shared across practitioners in all agencies. This should, wherever possible, be in multi-agency groups so that group reflection is encouraged, and it provides an opportunity for practitioners to gain greater understanding of the roles of each other's agencies in cases like this.

2. Wigan Safeguarding Children Partnership and Wigan Safeguarding Adult Partnership should both receive this review and consider the sufficiency of current transitional planning, whether this is aligned with the expectations of the Care Act 2014 and whether the correct trigger points are in place to start the planning based on George's case. Achieving this would mean that better, earlier, informed planning would be in place for adolescents known to services to have multiple areas of vulnerability as they transition into receiving an adult service offer.

3. The partnership should consider directing a review of the data infrastructure cross-agency to identify whether improvements can be made within the current systems. The review identified opportunities for automatic chronological entry to be implemented, discussions around easier flagging of key incidents arose in multi-agency practitioner discussions, and considerations of whether better recording

practices can be achieved. These issues need further exploration. A positive outcome for this would be the ability for practitioners so see real-time updates across agencies outside of set review timings and without the necessity to rely on either email or phone updates.

4. Wigan Safeguarding Children Partnership should review and consider the sufficiency of intensive support to young mothers in the 0-19 pathway, and in partnership with WSAB consider review how the partnerships supporting young women like MG who may go on to have another child/children. Health and Local Authority partners in the review may wish to cite and use this case in the ongoing local dialogue around how the local area reaches the expectation in the Health and Care Act 2022 of creating commissioning models that do not compete across the child to adult transition[11].

16 Next steps – Progress Report and learning

16.1 Steps have been taken across the partnership to make progress against the learning and recommendations set out in this case. Learning products have been produced and disseminated virtually and face to face across the partnership.

16.2 A number of agencies have progressed learning and provided assurances from rapid review stage, inclusive of single agency learning identified and responded to by NWAS relating to the injuries in non-mobile infants protocol.

16.3 GMP have implemented several systemic and process changes around responses to Domestic Abuse and the consistent application of Clare's Law.

16.4 WWL Safeguarding team, have also introduced a number of systemic and process changes alongside reviewed training materials and increased training opportunities for the workforce. These changes relate to pre-birth assessments, responses to domestic abuse, trauma informed practice, professional curiosity & having difficult conversations. Further work is being undertaken to improve practices to capture the daily lived experience of the child.

16.5 All partner agencies have expressed their recognition of the work required to embed the learning highlighted in this report and are in the developmental stages of workstreams to reflect this. Due to the pace at which this case has reached completion, partners feel that they would benefit from more time to produce robust evidence that progress and learning is embedded. Partners are committed to the WSCP business unit quality assurance process for the completion of action plans and will provide further updates and evidence via that process.

[11] Get in on the Act, Health and Care Act 2022, LGA Get in on the Act: Health and Care Act 2022 | Local Government Association

Appendix A

Panel Members:

Job Title	Agency
Business Manager	Wigan Safeguarding Children Partnership
Specialist Nurse for Safeguarding Children	Wrightington Wigan and Leigh NHS Foundation Trust
Targeted Commissioned team manager	Homes, Wigan Council
Deputy Designated Nurse, Children in Care	GM Integrated Care Partnership
Named Nurse for Safeguarding	Wrightington Wigan and Leigh NHS Foundation Trust
Interim Designated Nurse	GM Integrated Care Partnership
Service Lead for Children's Safeguarding	Wigan Council
Senior Lettings Officer	Allocations, Wigan Council
Safeguarding Practitioner	North West Ambulance Service
Safeguarding Leads, Children and Families	Greater Manchester Mental Health NHS Foundation Trust
Operations Manger across Wigan & Leigh	We Are With You (Substance Misuse Service)
Safeguarding Lead for GM	North West Ambulance Service
Detective Constable	Greater Manchester Police Case Review Unit

Agencies represented at Practitioner Learning Event:

Job Title	Agency
Safeguarding Specialist Nurse - Children	Wrightington Wigan and Leigh NHS Foundation Trust
Team Manager	Building Attachment and Bonds Service
Health Visitor	Wrightington Wigan and Leigh NHS Foundation Trust
Operations Manager	Semi Supported housing provider
Nursery Manager	Private Nursery Group
Senior Manager	Private Nursery Group
Social Worker	Wigan Local Authority Children's Social Care
Team Manager	Wigan Local Authority Children's Social Care
Service Manager	Wigan Local Authority Children's Social Care
Safeguarding Lead for GM	North West Ambulance Service

Appendix B : Abbreviations:

Abbreviation	Full Terminology
CIN	Child in Need
CMG	Family member of George's mother
FG	George's Father
FNP	Family Nurse Partnership
GMP	Greater Manchester Police
GP	General Practitioner
HV	Health Visitor
KLOE	Key Line of Enquiry
MFH	Missing from home
MG	George's mother
NWAS	Northwest Ambulance Service
SW	Social Worker