Warwickshire Safeguarding

Child Safeguarding Practice Review
GRACE

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1 Introduction

1.1 The Warwickshire Safeguarding Partnership agreed to undertake a Local Child Safeguarding Practice Review (CSPR) to consider the professional involvement with a thirteen-year-old child to be known as Grace and her family[1]. Grace took a significant and intentional overdose in January 2021[2], followed by another apparent attempt around four months later. The partnership recognised the potential that lessons could be learned about the way that agencies work together to safeguard older children who have experienced neglect and emotional abuse and who attempt to harm themselves.

1.2 Learning has been identified in this review regarding:

- Considering a child's behaviour as a reflection of their historic and current lived experience
- The need to speak to the child, consider their history and think beyond pregnancy prevention when prescribing contraception to children
- Understanding the cumulative impact of neglect and emotional harm on children
- When one child in a family is the focus of professional engagement, consideration of the impact on the other children is required, including a view to prevention
- Seeking and recording consent for sharing adult health information as part of a child in need plan
- The need to involve both parents in assessments, support and plans for children
- The impact of COVID-19 on services and on children and families

2 Process

2.1 An independent lead reviewer was commissioned[3] to work alongside a panel of local professionals which met on a regular basis to undertake the review. Each agency that worked with Grace and her family were asked to provide chronologies including analysis and identification of single agency learning by all involved partner agencies with both children considered. Despite the impact of COVID 19, professionals involved at the time were meaningfully involved in discussions about the case and were consulted about practice more generally.

2.2 The lead reviewer intended to speak to family members to provide information on this review and to identify any additional learning from their perspective. Father met with us in April 2022. Despite numerous attempts, neither Grace nor her mother have responded. There will be a further attempt to share the learning with Grace at the time of publication.

[1] The family are white British and no specific learning regarding the professional response to their culture was identified.
[2] Around the same time, several other local children made serious attempts on their lives. Initially there was concern among partner agencies that the cases may be linked. This was not the case for Child M.
[3] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of Serious Case Reviews and LCSPRs and is entirely independent of the WSP

2.3 This report has been written with the intention that it will be published and only contains the case information that is required to identify the learning.

3 Case Information

3.1 Grace was living with her mother, her mother's female partner and the youngest two of her siblings in overcrowded accommodation at the time of her first overdose. Her father lived with another family at the time but there was ongoing contact, and periods when Grace had lived with him.

3.2 The children in the family had been open to Children's Services at various points during their childhoods, including three periods on a child protection plan due to their parent's substance and alcohol misuse and neglect of the children. They had spent a significant amount of time being cared for by other family members, including one on a special guardianship order. Another older child was in the care of the local authority. Grace had lived with both her paternal grandmother and her father for extensive periods when she was of primary school age.

3.3 Grace was described as a sensitive and timid child who worries about her parents and sometimes struggles to attend school due to her anxiety. The death of her grandmother in 2019, who previously cared for her, was said to have had a significant impact on her. Despite her ongoing mental health difficulties, she aspires to go to college and has maintained friendships with several other young people. She is currently living with a family member, is the subject of a child protection plan and the review was told that meetings are being held under the Public Law Outline that are considering Grace and the two other youngest siblings.

4 Learning and analysis

4.1 The review has identified learning gained from the information shared during the Rapid Review, from the agency chronologies, during the consultations with professionals involved at the time, and when speaking to the family. The learning points identified are highlighted below, followed by the explanatory analysis.

Learning point 1: In order to understand what a child might be communicating by their behaviour, professionals need to build a relationship with a child and seek to understand the child's current and past lived experience.

4.2 Grace's life had been difficult for much of her previous childhood. She has largely lived with adults who had significant vulnerabilities of their own in a neglectful and risky home environment. Grace also experienced disruption due to several moves between family members. Her mother is known to have substance and alcohol misuse issues, domestic abuse in her current and past relationships and her mental health has been a concern for much of her adult life. Around the time that Grace returned to her care the mother was seeking mental health support due to anxiety, depression, self-harm and traits of an obsessive-compulsive disorder. The children's father is also known to have misused alcohol and substances, and his relationship with his most recent partner was thought to be abusive and emotionally harmful to the children living with them. The lived experience of Grace and her siblings needs to be understood in the context of what they have witnessed over time and the impact of their primary role models on their emotional development.

4.3 The first report of concerns about Grace's mental health and wellbeing was in August 2020 when the CAMHS crisis team were involved after Grace was said to be struggling with anxiety. The GP had then seen Grace in December 2020. She reported anxiety and was signposted to a counselling service, which was not pursued. It is likely to be significant that this was just a few weeks after her mother had taken an overdose, but the GP who saw her was not aware of this. This event likely had an impact on all the children. It is not known what led up to mother's attempt on her life, but it is known that the younger children, including Grace, were living with her at the time. The school were aware of this and they did checks with the MASH to see if the children were open to CSC at the time and have since reflected that they could have made a referral when it was confirmed that the case was closed at the time. Research shows that the children of adults with mental health issues are at increased risk of having mental health issues themselves, both in

childhood and as adults. It is also known that people bereaved by the sudden death of a friend or family member are more likely to attempt suicide if the deceased died by suicide than if they died by natural causes[4]. In the case of Grace there appears to be a degree of learned behaviour, difficulty in managing feelings, and a parent who does not have the space and ability to provide the necessary consistent emotional support to a mentally vulnerable child. It appears that those working with the children were not aware of the mother's overdose until much later.

4.4 When a child is cared for by parents or parental figures with their own significant issues and vulnerabilities, this has an impact on the practical and emotional care of that child. In this case the adults are known to have or to have had difficulties with their mental health, alcohol and substance misuse and domestic abuse. Historic records show that the children's early years included neglect. This involved lack of supervision, limited food, inappropriate care arrangements, poor routines and boundaries, missed medical appointments for the children, deficient home conditions, inconsistent school attendance and lack of stimulation. This was known to be largely due to their mother's poor mental health and parental substance misuse, which resulted in a struggle to recognise and meet the children's needs.

4.5 Those who were working with Grace and her siblings from 2020 had some understanding that neglect had been an issue when the children had previously lived with their mother but told the review that the extent or longevity of the issues were not fully appreciated. There is a good understanding of the impact of neglect of this type on young children, but less so of the impact of neglect over time or the serious impact of ongoing and long-term emotional neglect on an older child. The NSPCC and Core-Info published a review in 2014 called Neglect or Emotional Abuse in Teenagers Aged 13-18. It states that 'neglect and emotional abuse are often not recognised in teenagers or may not be taken seriously by professionals' and that 'there is a lack of research which identifies the feelings, or experiences of this population. Many of the behaviours exhibited by emotionally abused or neglected teenagers may be interpreted by others as a lifestyle choice or 'acting out' when they may in fact be an indicator of neglect or emotional abuse'. For Grace, there were indicators at the time being considered by this review that her behaviours were a reaction to long term abuse and neglect and inconsistent and vulnerable relationships with her care givers. The initial focus was on the recent issues in her life that may have led to the overdose, as more information was shared about the family history and the parent's own issues, the more insight there was into the root causes of her issues.

Learning point 2: Professionals need to ensure that they consider the cumulative impact of neglect and emotional harm on children who are struggling with their own mental health when assessing and deciding on the need for support or a plan. A chronology with multi-agency information that considers the child's life experience is essential.

4.6 It has long been understood that there is a correlation between emotional abuse and neglect and self-harming, including overdoses.[5] This is largely due to the impact of emotional neglect on the ability to cope with negative emotions, along with a long-term tendency towards depression and anxiety. In the case of Grace, concerns about her emotional wellbeing were first shared with professionals in August 2020, five months before her serious overdose. The ambulance service was called by Grace's mother due to her having a severe headache and what appeared to be a physical reaction to the grief she was feeling about her grandmother's death. The CAMHS crisis team undertook an assessment over the next few days. Grace reported that she had no plans to harm herself although she admitted that she had thought about overdosing at times. CAMHS input concluded with signposting for bereavement support, advice on safe storage of medication (in her mother's house but not her father's), completion of Dimensions (an online tool which enables the client and professionals to explore what level of concerns there are in several aspects of the

[4] British Medical Journal 2016. Pitman et al University College London

[5] Lang CM, Sharma-Patel K. The relation between childhood maltreatment and self-injury: a review of the literature on conceptualization and intervention. Trauma Violence Abuse. 2011;12(1):23–37.

client's life) and a referral to the neurodevelopment team for an autistic spectrum disorder (ASD) assessment. Among other things, Grace had told CAMHS that she sometimes heard voices. This was thought to be linked to her likely ASD rather than a mental health problem. An assessment for ASD had not been completed and the family were told there was likely to be a long wait. This is case is not unusual in this regard, as there are extensive waiting times for ASD assessments locally, regionally, and nationally. There were no checks made with other agencies to see if there had been any history of abuse or neglect, as this is not part of the assessment at this level of CAMHS intervention (low risk). However, the review was told that the CAMHS crisis team are currently piloting having a social worker in the team who can access CSC records to assist assessments. In this case that would have led to an improved understanding of Grace's history and the complexity of her issues at this early stage.

4.7 Grace had lived with neglect and emotional harm for much of her childhood. Practice in neglect cases, which is led by the procedures and policies used, can focus on individual episodes or issues of concern, with a failure to step back and look at patterns of parenting and the impact on children of care that dips just above and then below 'good enough' on a regular basis. The cumulative nature of neglect needs to be understood and always considered when working with children who have been affected by neglect. When working with a family where the care of the children is occasionally on the right side of 'good enough' this can lead to a view that the impact on the children will not be as serious as sustained neglect. However, each incident or episode of concern needs to be examined with an understanding of what the child has experienced before to assess whether a multitude of factors, when considered together, constitutes significant cumulative harm[6]. The national Safeguarding Practice Review Panel's annual report published in May 2021[7] states that 'the recognition of cumulative[8] neglect and its impact continue to be a key challenge for practitioners' nationally.' In the case of Grace and their siblings, their life experience, the care they have received for much of their childhood and the emotional impact of the lack of stability from several moves between carers is likely to have had a significant impact on them and will have contributed to Grace's issues.

4.8 Professionals often report that it is difficult to provide an effective service to vulnerable adolescents who display a range of complex behaviours, which can then lead to reactive rather than planned responses and a focus on the child's behaviour rather than understanding the causes of the behaviours. In this case physical and emotional neglect throughout her life was a likely cause of the difficulties facing Grace. It is always a risk, when working with cases that involve the neglect of teenagers, that incidents and distractions may led to crisis management practice, largely due to concerns about the immediate risk to a child because of their poor mental health or risky behaviours. In the case of Grace, her overdoses and voiced wish to die made the professionals involved concentrate on the incident being a response to what was happening at the time and the need to keep her safe in the short to medium term. Grace was assessed by the CAMHS crisis team who reported their view that she had acted on impulse due to a family death and the breakup with her boyfriend. They did not feel that she needed long term support for any mental health needs and noted that she was on the waiting list for a neurology assessment. CAMHS did believe that she would require a therapeutic intervention however, rather than the medication that was repeatedly requested by both Grace and her mother. At this stage they were not aware of her mother's history of mental health issues or the significant case history.

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

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984767/The_Child_Safeguarding_Annual_Report_2020.pdf

[8] The terms 'cumulative risk' and 'cumulative harm' were first identified by Bromfield and Higgins in Australia in 2005. They defined cumulative harm as 'the effects of patterns of circumstances and events in a child's life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.'

4.9 Without understanding the cause of a child's behaviour, the focus of intervention can be on the need for the child's behaviour to change without adequate consideration of factors within the family that may contribute to what is going on. There was a likelihood therefore that the explanation for Grace's overdose (struggling to cope with the death of her grandmother and boyfriend issues) would be accepted without an adequate understanding of the long-term neglect and the on-going risk to Grace of emotional harm where she was living. This acceptance also contributed to the decision to work with the family under a child in need plan in the months following the serious overdose in January 2021. This continued despite emerging concerns, such as her mother discharging her from hospital against advice before a further mental health assessment had been completed, the lack of attendance for blood tests following this discharge, concerns about mother's mental health and drinking/substance misuse, domestic abuse incidents at home, and a further small overdose when Grace was visiting her father's home. What was missing at this time was the consideration of Grace's behaviour through the lens of her history and experiences. It is acknowledged however that if a family states that they are willing to work with professionals, this usually leads to support being provided under a child in need plan rather than a child protection plan. The review was told that a TIRs project[9] is being developed across Coventry and Warwickshire and it has been agreed that this review will be shared with those developing the Project to ensure that the learning is considered.

4.10 The decision to hold an Initial Child Protection Conference (ICPC) in September 2021 was made after an incident where Grace was taken to A&E due to being very distressed and requiring a CAMHS assessment, followed by Grace's mother's statement that she no longer wished to cooperate with a child in need plan and one of the siblings stating she had been physically assaulted by her mother. Mother's GP also shared that the mother had reported to them that she had recently tried to cut her wrists. The fact that many of the current concerns were like those that had been seen throughout the children's childhood was stated alongside the current concerns, so the threshold for a Child Protection Plan was met and that the case was considered at a legal planning meeting. There was a three-month delay in holding a PLO/meeting before action with the family. At the time of this review being completed (January 2022) the case remains in pre-proceedings.

4.11 There were various indicators that Grace's needs were not being met at home in the months that followed her overdose, and that her mental health was being impacted on by this and her history of emotional abuse and neglect. For example, in May 2020, her mother told CAMHS that Grace did not wish to attend an appointment that had been offered due to concerns about Grace's on-going low mood and suicidal thoughts. When spoken to on the phone, Grace stated she did in fact wish to attend, and it was suspected that her mother and her partner had been drinking heavily the night before and that this was why her mother was unable to take Grace to the appointment. This information was shared with the social worker who was completing a child and family assessment at the time. The mother's response to this concern was anger, denial and a stated refusal for Grace to see the CAMHS worker again. School attendance was also an issue at the time. The three children living with their mother had attendance ranging from 44 – 75% with very little communication from their parents with the school. Poor school attendance is an indicator of child neglect and is known to have a long-term impact on a child's wellbeing and more general outcomes. It is important that schools communicate this to children and their parents, and consider what multi-agency support is required in these cases, escalating their concerns with a safeguarding referral if required.

4.12 Father stated during the review that he was rarely told about parent's evenings or contacted by the school about any issues, including when there were concerns about attendance or behaviour. There is also no evidence that he was contacted to gain his support and consent for the CAMHS

[9] The TIRS project is the Trauma Informed Recovery Support (TIRS) Framework within health for working with children like Grace, that considers ACEs and the impact of trauma on a child's wellbeing and mental health.

work. He told the review that he would have wanted to be involved if it was possible. Grace received a lot of support in school, and her poor attendance increased concerns. It was decided following an assessment that a child in need plan was suitable, which had a focus on whether Grace would be able to access medication and attempt another overdose. There was no escalation that any agency did not agree with this as a response, and no challenge about the need to assess whether neglect was a feature for Grace and her siblings.

4.12 Several professionals were aware that Grace was sexually active. During her hospital stay following her first overdose in January 2021 a CSE questionnaire was completed with 13-year-old Grace by hospital staff, and it emerged that she had a boyfriend in the year above and was sexually active. The police and CSC visited Grace in hospital, but this matter was not discussed with her, as the focus of the visit was that several local children had made suicide attempts in 24 hours and they were investigating any connection. (There was none.) No criminal investigation was 'raised' at the time by the police. On reflection the police told the review that the children were both under 16, there was nothing to suggest it was not consensual, and that 'there is no appetite to criminalise children'. There does not appear to have been any consideration of a specific strategy meeting to consider if there were child protection implications from Grace's sexual activity, as the focus was on her mental health and the focus of the strategy meeting where this was discussed was Grace's suicide attempt.

4.13 Shortly after a move to a social work team that undertakes longer term work with families in June 2021, there was a concern that 13-year-old Grace may be pregnant followed by a further domestic abuse incident in the family home. A plan for Mother and her partner to live separately while work was undertaken was implemented under the child in need plan, however the partner soon returned as her support was required. It is interesting to reflect on whether the gender of the partner had an impact on the acceptance of this.

4.14 In respect of the pregnancy, a social worker spoke with the child and her mother, and both denied she was pregnant or had a termination, and they would not provide the identity of the boy she had sex with. The police were contacted, and it was agreed that it was an appropriate response for the child's social worker to pursue this issue. At the time there does not appear to have been any expectation that the police were updated, but recent changes to working practice mean that it is expected that an update on any enquires and plan made in respect of the child is shared with the police and recorded by them.

4.15 During a strategy meeting in September 2021 it was shared by the MASH health representative that the family GP was aware that Grace was sexually active and that they had prescribed the oral contraceptive pill at her mother's request some months before, and that this happened without the GP seeing the child and accepting her mother's statement that she was in a 'serious relationship' with a boy of a similar age. There does not appear to have been consideration of whether the Gillick competence or Fraser guidelines[10] were met for Grace, as it was her mother who was requesting the medication. The age of the boyfriend was also not recorded. While parental consent was not an issue, sexual abuse or exploitation was a possibility. The explanation that Grace was in a relationship and had a 'long-term boyfriend' at age 13 was accepted by the GP however, along with her mother's agreement to buy a blood pressure machine to monitor her while on the contraceptive pill. The GP would have had information available that there was a concern that Grace may have an ASD and that she had been on a child protection plan, and this does not appear to have been considered. Learning has been identified for the GP service regarding the need to arrange a face-to-face appointment which included a discussion alone with the child when prescribing contraceptives to a child under 16, and that records should include an explanation that safeguarding concerns have been considered. As stated in paragraph 4.12 above, the police

[10] https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines#heading-top

opened an investigation following Grace's statement during the completion of a CSE form in hospital, but as the family did not share the identity of the boy, no further action was taken.

4.16 Following consultation between the social worker and the CAMHS worker and the well attended strategy meeting in September 2021, there was more of an understanding of the wider context of Grace's lived experience and mental health issues, which was reflected in the appropriate decision to hold a child protection conference in respect of Grace and her child siblings. The report from a contact with her by CAMHS at this time stated 'the impression was that Grace was a young girl displaying difficulties regulating her emotions, with poor impulse control resulting in her being reactive to her current complex social circumstances'. It was also noted that Grace had a history of trauma and attachment issues.

Learning point 3: When there are a number of children in the family, with one or some of the children showing the most obviously concerning behaviours, consideration on the impact of this on the other children, as well as their future response to what they experience at home more generally, should always be assessed. This includes seeking and considering information on the adults in the home.

4.17 There is no doubt that during the months being considered by this review, the focus of professionals was on Grace. However, there were two other children in the family, one older and one younger. They were likely to have had similar life experiences, including long term emotional abuse and neglect. It is known that children will respond in different ways to their experiences, with some appearing more resilient than others. One of the children was at primary school during this time and there were few if any concerns about her. Capacity is an issue for all services, and there are limitations to what can be achieved for the whole family when the focus must be on one child due to the level of concern and risk for them. When considering the younger child, the review concluded that she is likely to require focused early intervention and support, and this has been discussed with CSC and her school. For much of the time that support was being provided to Grace, her younger sibling was effectively 'invisible'. Despite being invited to the strategy meeting held prior to the ICPC held on the three children, the youngest child's school did not attend. There is limited evidence of involvement in the core group, perhaps because the focus remained on Grace and the need for the school to prioritise time spent in meetings during COVID-19.

4.18 Understanding the parent's history and on-going vulnerabilities also need to be part of the work being undertaken. There are issues of consent that need to be considered however. The MASH for example, will undertake full multi-agency checks if the referral is thought to be a child protection matter, but checks on the adults are limited otherwise. Seeking health information on parents, including regarding their mental health, tends to only be completed when there is a S47 investigation being undertaken, as it requires consent and health partners are clear that this needs to be in writing from the adult. There needs to be more consideration to seeking and gaining consent even if an assessment is not thought to reach the criteria for a S47 investigation, as this case shows that having information on the parents, for example the mother's recent overdose, is essential to understand the impact on the child. the review has also identified that the mother's GP was prescribing several medications to her which may have had an impact on her parenting, including high doses of anti-psychotic drugs that were thought to potentially be a risk to the mother's health but without evidence of consideration of the impact on her as a parent. The review considered the many difficulties for professionals such a health visitors, early help workers and social workers in both seeking the required consent and ensuring there is a record of this being given in a way that is acceptable to adult health services, however notes that for a child who is the subject of a child in need plan, as Grace was, the multi-agency team around the child should and could ensure that this consent is provided and utilised. This requires further exploration by the partnership, in order to enable the information being available to safeguard children.

4.19 There was single agency learning identified during the review about the need to ensure that agencies working with just one family member think family. For example, Strengthening Families

noted that there could have been consideration of adding Grace and her younger sibling to the CIN plan that they had in place during 2019 regarding the older sibling. The Front Door identified that strategy meetings should consider all children who visit the household. In 2020 a meeting had been held about the children residing at Grace's father's home but didn't consider Grace and her siblings although they often stayed at the house.

4.20 As well as the need to consider the parent's history and other children in the family when there is a serious issue with one of the children, there also needs to be consideration to other households where the child spends time. In this case there was a lot of contact between Grace and her father. CAMHS identified good learning about this, stating, 'when parents are separated but the child spends time with both parents, however infrequent, efforts should be made to ensure the estranged parent knows how to keep the child safe such as locking medication safely away.'

Learning point 4: The COVID-19 pandemic has had an impact on families and on the ability of professionals to respond to children and families requiring support.

4.21 There is no doubt to any professional working during the COVID-19 pandemic that there has been an impact both on families and on the professional response to any issues that are on-going or emerging. A briefing paper was published by the national Child Safeguarding Practice Review panel in 2021 regarding the serious safeguarding incidents reported to them during the initial COVID-19 outbreak (March – September 2020). Their analysis shows that COVID-19 exacerbated risk due to an increase in family stressors (including an increase in domestic abuse and mental health concerns alongside less wider family support), children not being seen as regularly, school closures, and the requirement for ensuring safe professional practice.

4.22 In Warwickshire, as is probably the case nationally, schools have been missing meetings regarding children due to very real capacity issues due to COVID. This was ongoing at the time of the review due to the Omicron variant is leading to teachers catching COVID for a second or third time. The review was told that there is 'absolutely no slack in the system'. GPs in Warwickshire were only providing virtual appointments at the time, which was the case when the contraceptive pill was prescribed to Grace.

4.23 For the newly formed CAMHS crisis team, there was an impact due to increased demand and a change in how they had to work with families as their office was closed. They tried to communicate on the telephone with both CSC and the school following the initial overdose and when Grace was again referred to them, to no avail. The review has found that there were capacity issues at the time, in part due to the response to COVID-19, but also systemic issues with telephone calls not being returned, the lack of use of other forms of communication such as emails and limited formal escalation of the issue to managers who could assist. This meant that many weeks passed with CAMHS working with Grace in isolation without key information that was available to the school and CSC being shared.

4.24 It is recognised that the most vulnerable families were impacted more from the restrictions and rules during the first national lockdown. With schools closed and limitations to how often people could leave their homes, Grace's family had to manage in seriously overcrowded housing, exacerbated by their mental health vulnerabilities, difficult adult relationships and history of substance misuse. The impact of the COVID-19 restrictions on five people living in a small one-bedroom flat at this time cannot be overestimated. By the time that Grace was exhibiting concerning behaviour, the pandemic had entered another peak and there was a second national lockdown. It is not known if this contributed to her despair. According to statistics from the DforE (Department for Education) nationally there was a 25% increase in children being assessed as having a mental health need during the year to April 2021. They also note that this may not reflect the whole picture due to a 31% decline in referrals from school because of periods of restricted attendance.

4.25 In Grace's case the school found it hard to encourage the children to attend school, as it was not compulsory for much of the time in question. The school reflected that Grace had become used to being at home with her mother and struggled to later leave her again when school commenced. With hindsight, it appears that Grace was worried about mother's enduring mental health problem and substance misuse. While Grace was not seen as young carer at the time, there were several indicators that she was anxious about her mother when she was not at home and her wish to provide emotional support. Those initially assessing Grace's mental health following her overdose were not aware of her caring role, as her mother did not share information about her own mental health and other stresses except the bereavements in the family.

4.26 COVID-19 also appears to have delayed provision of larger housing for the family. Grace's mother informed housing that her daughters had returned to her care and that she was severely overcrowded in December 2019 and was placed into a priority band in March 2020. The family were re-housed at the end of March 2021, a year after the COVID-19 outbreak started in the UK. During the initial months of the pandemic, house moves were strongly advised against in government guidance, which had an impact on the housing providers. This created delay across the system. In this case housing arrears that required a Discretionary Housing Payment (DHP) application also played a part, along with Grace's mother refusing an earlier offer of a property as she knew and had a dispute with one of the neighbours.

4.27 As well as an impact on the mental health of both parents and children, COVID-19 appears to have led to increased domestic abuse in households, including Grace's, with concerns about domestic abuse in both her mother and father's respective relationships. The NSPCC recently released findings following analysis of data from the Office for National Statistics which show there was an 8% increase in child protection referrals because of incidents of domestic abuse over the same period. In child M's experience there appears to be a link between her mother's mental health, substance and alcohol misuse by her mother and her mother's partner and the couple volatile relationship, with all of which were largely invisible to a number of professionals until September 2021. The police shared information about occasional disputes between Grace's mother and her father's partner, both face to face and on social media. There were also reports of disputes with neighbours. Such matters added to the difficult lived experience of Grace and her siblings at the time.

4.28 Working with harder to engage parents was exacerbated during the COVID-19 pandemic, as families could more easily avoid professionals and use their fears about COVID as a reason to miss appointments and keep their children home from school. There was evidence that Grace's mother did not always prioritise her children and that she could avoid professional scrutiny when required. She also told the GP in May 2021 that CAMHS had advised she contact the GP for a prescription of anti-depressants. The GP checked with CAMHS, which was good practice, and was told it was not likely that this advice would have been given. The GP also advised that that the family had reported that Grace had recently taken an overdose of 8 paracetamol and had not wished to heed his advice to go to A&E as she 'appeared well'. (This is thought to be the incident that occurred at her father's home, although that was reportedly Ibuprofen, not paracetamol.)

5 Conclusions and recommendations

5.1 The review has identified learning for individual agencies and for how agencies work together when considering the case of Grace. It has also seen evidence of good practice and committed professionals who worked hard to try and help Grace.

5.2 Extensive helpful single agency learning was identified during the review. For example, the Independent Reviewing Service who is responsible for the chairing of child protection conferences identified that their process for escalating concerns about delayed responses or outcomes requires work and a clear monitoring procedure to follow up any concerns that are escalated. They have made a recommendation to ensure the required improvements.

5.3 The single agency chronologies completed by the agencies involved in the review include a number of recommendations to address the need for improvement action, including single agency SMART action plans which will be monitored by the Safeguarding Partnership.

5.4 Having considered the learning that has not been addressed in the single agency actions, the following additional recommendations are made to ensure improvements.

Recommendation 1:

The Partnership to consider how they can be assured that the Coventry and Warwickshire Partnership NHS Trust are addressing waiting times for ASD assessments. The Partnership should also ask the National CSPR panel to liaise with the DforE and DoH regarding delays in ASD assessment and the concerning impact on vulnerable children

Recommendation 2:

All relevant partner agencies to be asked to provide evidence regarding how they are ensuring that:

The siblings of children with complex issues receive an assessment and early help/preventative support

That assessments and plans give due consideration to all the children who spend time in a family home

Recommendation 3:

The Partnership to seek assurance from the Integrated Care Board that GPs are briefed and trained to think beyond pregnancy prevention including considering the risk of abuse when prescribing contraception to children

Recommendation 4:

The Partnership must specifically consider the cumulative impact of neglect and emotional harm on older children when reviewing and launching their revised neglect strategy, using this case as an example. The action plan should include an impact audit

Recommendation 5:

The Partnership to undertake a piece of work which includes:

Asking agencies to review the current systems and practice regarding seeking consent for information sharing, including about parental health

Considering what further support is required to ensure that information is appropriately sought, provided, considered, and recorded