RBSCP
ROCHDALE BOROUGH
SAFEGUARDING CHILDREN PARTNERSHIP

Local Child Safeguarding Practice Review Report

Child K1

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CONFIDENTIAL (OFFICIAL) – RESTRICTED – NOT TO BE SHARED

Contents

1. Introduction

1.1. This report covers the findings of a Local Safeguarding Practice Review relating to a child to be referred to as Child K1.

1.2 In February 2025, Child K1 was transported to Hospital 1 with hypothermia, hypoglycaemia, malnutrition and severe dehydration. Child K1 was noted to be incredibly emaciated. Child K1 was 19-months-old and weighed 4.4kg; the average weight for an infant of Child K1's age would be approximately 11kg.

1.3 Child K1 was found to have paper thin skin and there was generalised severe muscle wastage. There was no fatty tissue noted on Child K1's body. There was wasting to the buttocks and pressure sores extending along the spine down to the sacrum and across the bony prominences of the sacrum and hip bones on the lower back (posterior superior iliac spines). There was excoriated skin breakdown across the entirety of the nappy area/ genitals and evidence of severe clinical dehydration, renal failure, and malnutrition on serial blood tests.

1.4 Child K1 was at risk of re-feeding syndrome, which has its own serious complications and can pose treatment management challenges. It was determined that Child K1's nutrition rehabilitation would take a significant length of time and there would be a need for intense monitoring.

1.5 Child K1's presentation of hypothermia, hypoglycaemia, severe malnutrition, dehydration along with renal failure, evidenced by severe abnormality of blood salts, could have led to death if it had not been identified and emergency treatment initiated.

2. The purpose

2.1. The purpose and underpinning principles for undertaking safeguarding reviews of children's cases are set out in Working Together 2023[1]. The Children and Social Work Act 2017 gives responsibility for how a system learns lessons from serious child safeguarding incidents to the Safeguarding Partners (Integrated Care Board, Police, and Rochdale Children's Social Care.

3. The process

3.1. The circumstances of this case were discussed by the Rapid Review panel in March 2025. All agencies agreed that the criteria for a Local Child Safeguarding Practice Review were met as neglect was suspected in this case. This decision was endorsed by the National Child Safeguarding Practice Review Panel.

3.2. The rapid review process highlighted the potential for identifying improvements in

- the processes for recording, making decisions and assessing possible high risk referrals into the Rochdale EHASH
- multi-agency sharing of information with regard to safeguarding and promoting the welfare of the children and families

3.3. This particular review will use the child's case to review the following Key Lines of Enquiry:

- Explore whether the voice of K1/K1's lived experience was considered, and understood by professionals and how it influenced practice.

[1] "Working Together to Safeguard Children 2023." HM Government.

- Explore whether relevant policies and procedures were being followed? If not, what were the barriers to this?
- Consider what actions were taken to understand the impact of mother's childhood trauma, her mental health & possible SEND in the context of her parenting capacity.
- Explore whether agencies were professionally curious in respect of family dynamics and previous family contact in the context of maternal grandmothers caring responsibility.
- Were there any barriers for agencies to effectively engage mum & maternal grandmother as a care giver? And if so, were concerns elevated appropriately?
- Explore the effectiveness of assessment and forums in managing risk and assessing, recognising and responding to neglect.
- Consider whether escalation policies and supervision were used appropriately and whether there is evidence of effective managerial oversight.
- Is there evidence that practitioners were 'Thinking Family'? What was known regarding K1's wider family?

3.4. In June 2025 a lead reviewer[2] was commissioned to work alongside local professionals to undertake the review.

3.5. Agencies were requested to complete Learning Summary Proformas of their involvement with Child K1 and the family during the review period, from 1st June 2022 until the date of the critical incident in February 2025.

3.6. A multi-agency review panel[3] met in August 2025 to consider the Learning Summary reports.

3.7. The practitioners event took place in September 2025 with representative from all the involved agencies except.

3.8. The reviewer produced a draft report in October 2025 which was reviewed by the panel and amended in line with the panels comments.

3.9. The report was presented to the partnership in April 2026.

3.10. Family members were approached and invited to contribute to the review. The reviewer is grateful to one of Child K1's relatives for contributing to the review. Child K1's mother indicated a willingness to contribute but ultimately did not engage. This is recognised as a limitation to the review.

4. Summary of learning themes

4.1. The following are the main learning themes:

- The need for increased professional curiosity to establish the lived experience of the child
- The need to seek supervision when the actions or inactions by parents and carers are preventing or making it difficult for practitioners to practice in line with policy

[2] Nicki Walker-Hall has a background in health working predominantly with children. Nicki has an MA in Child Welfare and Protection and an MSc in Forensic Psychology. Nicki is an experienced reviewer of both child and adult safeguarding reviews. Nicki is entirely independent of the BSCP.

[3] The panel consisted of representatives from all the key agencies

- Greater emphasis needs to be placed on retrieving historical information, including information from education services, at the start of a services involvement
- The importance of managerial oversight in guiding frontline social workers and ensuring action on plans have been completed prior to case closure
- The importance of sharing all relevant information at strategy meetings and maintaining focus on the concerns that led to the meeting being held
- The need to establish the root cause of faltering growth identified in children

5. Child K1's story

5.1. Prior to the period under review it was noted in the parental records that mother had been referred into the Sunrise team in 2021 for a child sexual exploitation risk assessment following a sexual assault that had happened during a missing from home episode. There was an ongoing police investigation in relation to this disclosure and the CSE risk assessment was completed to explore how mother could be supported to increase her safety. The records outline that mother had moved to the area in 2016. Records indicated that domestic abuse was a feature in mothers' childhood and that made maternal grandmother vulnerable.

5.2. Mother registered her pregnancy in December 2022. A dating scan in January 2023 indicated she was 16 weeks pregnant, this would be classed as a late booking. Due to mothers age at the time (17) she was supported by the Rochdale, Oldham, Midwifery enhanced service (ROMES) team, a service for under 19's. Mother acted appropriately during the pregnancy reporting concerns and being available for appointments with the midwifery service. In April 2023, a referral was made by the Midwifery service to the local Health Visiting Service for mother and Child K1. There was no indication mother had been known to children's social care in the referral. Within the referral it was noted that mother had a diagnosis of Dyslexia. Mother was offered an antenatal contact with the Health Visitor which resulted in a no access visit. Mother did not attend on two occasions for a blood test to test for gestational diabetes.

5.3. In May 2023 mother requested a transfer of her care to an alternate Trust, no reason was given. Mother was advised how to do this. Mother duly transferred her anti-natal care late in her gestation to another local provider (hospital 2).

5.4. In June 2023, Child K1 was born at 40-weeks gestation weighing 3420g. It was reported that whilst on the post-natal ward mother became anxious and teary stating she could not handle the baby. Mother was supported by maternal grandmother and maternal aunt. Whilst on the ward there was an argument overheard by the midwife between mother and her partner which resulted in him being warned that he would be asked to leave if it was to continue. This information was not shared with the postnatal midwife on discharge.

5.5. A maternity information referral form was sent to the Health Visiting service. The referral outlined that mother was 17 years old and was under the enhanced community antenatal service as she was identified as vulnerable. Mother reported she was suffering from anxiety and had never been medicated but this was due to be investigated by the GP.

5.6. The father of Child K1 was reported to be living in Wales and mother was not currently in a relationship with him. Mother reported she had a new partner. It was

reported her new partner was happy with her pregnancy and supported her. The new partner was aware that he was not the biological father of the Child K1. Mother was living with maternal grandmother who was reported to be supportive in labour. Mother also had a sister who it was felt was supportive.

5.7. In July 2023, the new birth visit was completed by the Health Visitor. Mother was still living with maternal grandmother. No smoking/drugs or alcohol use was reported. The records advised that Child K1 was not in contact with the father and he would not be registered on the birth certificate. No safeguarding concerns were outlined at this stage. Mother reported she had anxiety, she had never taken any medication for this or had any therapy. Mother advised this mostly affected her around crowded and busy places. Mother advised feeling well at the time; she denied any social care history however the records show intervention from the sunrise team (exploitation).

5.8. Child K1 was not brought for the 6-8 week check with Health Visitors. Another appointment was arranged with mother via telephone, it was reported that mother sounded 'flat' on the phone. Child K1 was brought to clinic by maternal grandmother and no concerns were identified with growth or development. Maternal grandmother reported no concerns for mother's mental health however mother was not spoken to address any potential worsening mental health. There is no evidence Child K1 was seen by the GP for an 8 week check.

5.9. In October 2023 Child K1 was not brought to baby clinic. The Health Visitor called mother and maternal grandmother reported Child K1 had an ear infection and was reported to have been seen by the GP. Grandmother reported mother was ok and no concerns regarding her parenting. The Health Visitor rang a month later to speak to mother and was unable to make contact. Child K1 had been seen by the GP but there is no record of an ear infection. Child K1 was noted to be developing and growing within expected centiles with a weight of 6.53 kg (75th centile).

5.10. There were four occasions that Child K1 was taken to Hospital 2 with concerns around health which were appropriate presentations. Once was due to oral thrush, one due to nappy rash and the final two due to feeding concerns. On three of these occasions, Child K1 was presented by maternal grandmother. On the other occasion, mother was supported by maternal auntie.

5.11. In April 2024, Child K1 presented to Hospital 2. Maternal grandmother was concerned about Child K1 due to refusing feeds overnight and reduced interaction. At this contact, a family member raised concerns with the hospital that Child K1 was being neglected by mother but didn't want maternal grandmother or mother to know that she was "checking up on them" as they would be upset. The family member advised that mother was asleep on the sofa this afternoon whilst Child K1 was left unattended upstairs crying. A social care referral was made by Hospital 2. Child K1 was discharged home to continue encouraging fluids and re attend for repeat blood tests. Child K1's weight in March 2024 was 8.4kg and 35 days later it was 7.25kg; this information was shared with the Health Visitor Team and a text message was sent to mother to arrange follow up.

5.12. Two days later Child K1 was brought to Hospital 2 by maternal grandmother as planned for repeat blood tests due to her urea being high. It was agreed that Child K1 would need to have repeated blood tests due to triglycerides and cholesterol being high.

5.13. Following the referral in April 2024, EHASH reported to the Health Visiting team that mother had agreed to accept some support and would like to engage with groups and seek support around getting into training or work. The family were closed to children social care before lateral checks had been completed.
5.14. The Health Visitor conducted a home visit. Maternal grandmother was reported to be providing 'a lot of care'. Mother was in bed on arrival but came down and interacted with Child K1. Child K1's weight was reported as 7.8kg which was a slight increase. Mother reported anxiety attending groups.
5.15. A second referral was received anonymously soon after and it was reported that no action was taken by Children's Social Care as mother had consented to work with the family hub. It was later established that the family worker was unable to contact the family but that someone from the health Visiting service was due to see Child K1 that day. Child K1 was seen in clinic by the nursery nurse within the health visiting service with mother and maternal grandmother. Some unusual movements were noted, positively her weight had increased. Maternal grandmother noted that they had received a letter from Hospital 2 advising that there no concerns with health and development regarding Child K1 but maternal grandmother wanted the unusual movements followed up.
5.16. The health visitor identified that Child K'1 had some delayed gross motor skills and consent was sought to make a physio referral. It was reported that mother had no concerns with her own mental health. It was noted that maternal grandmother had attended the outpatient appointment at Hospital 2 with Child K1; mother was not present.
5.17. The Early Years worker made multiple attempts to contact the family over a 5-week period but was unsuccessful, closing the case having had no direct contact.
5.18. Child K1 was seen by a physiotherapist in September 2024, who confirmed a delay in development. Activities and the findings were emailed to maternal grandmother and a follow up was arranged. Child K1 was subsequently seen by the Health Visiting service and identified as not meeting age-appropriate developmental milestones. It was noted that the Child K1's basic needs were being met, Child K1 was dressed appropriately for within the home and appeared to be clean. No significant health or safeguarding concerns were identified at the visit.
5.19. Child K1 was not brought to a subsequent physiotherapy appointment and there was no response to the letters sent out: as a result, Child K1 was discharged. The Health Visitors reviewed the records at this point and identified no further Health Visitor intervention required.
5.20. Mid-December 2024, a further anonymous referral was made to EHASH. The referrer identified the following concerns: Child K1's hair was matted, Child K1 had a bottom sore, was leaking wax from ears, had thick cradle cap, dirty fingernails, was underweight and Child K1's clothes were dirty. This information was shared with the Health Visiting team. The Health Visiting team shared further information with the EHASH regarding Child K1's missed appointments. The Health Visiting team noted that Child K1 did not have an allocated social worker and that the last time Child K1 was seen was at an allocated appointment at the community hub in September 2024.
5.21. Children's Social Care completed a home visit on the same day as the referral, Child K1 was seen with mother and maternal grandmother. There were concerns regarding Child K1 being under weight, her nappy rash and long dirty nails. Mother was

reported to be upset by the referral and was seen to engage with Child K1 and show affection. Mother did not consent to Social Care involvement so it was agreed that the Social Worker would contact her the day after for further discussion. When this occurred, mother continued to withhold consent.

5.22. Between the 7th and 21st January 2025, numerous calls were made to mother to gain her consent and engage her in a Child and Family Assessment but these were unsuccessful. At this point, a strategy meeting was convened due to the non-engagement from the family; the Team Manager felt it would be unsafe to close the case without holding a meeting. At the strategy meeting it was a unanimous decision that threshold had not been met to progress to section 47. The case was closed with no further action. Child K1 had not been seen since mid-December 2024. It was decided that the Health Visitor should follow up the missed health appointments.

5.23. It was noted that Probation had shared information prior to the strategy meeting regarding mother' ex-partner who was due to be released from prison this was cause for concern.

5.24. Nineteen days after the strategy meeting Child K1 was admitted to hospital in a critical condition.

6. The Learning

6.1 Detailed and case specific analysis is outlined below in relation to the key lines of enquiry.

Explore whether the voice of Child K1/K1's lived experience was considered, and understood by professionals and how it influenced practice.

6.2 There is evidence that whenever practitioners had contact with Child K1 they made observations of the interactions between Child K1 and both mother and maternal grandmother and that nothing within those interactions caused any concern. Practitioners noted positive attachments and Child K1 looking to both mother and maternal grandmother for reassurance and emotional warmth. Whilst this is positive, there were many occasions when appointments were missed, mother did not accompany Child K1 to appointments, practitioners had no access visits or mother was in bed on home visits. This reduced the amount of opportunities for practitioners to observe the mother child relationship.

6.3 Practitioners were not sufficiently curious in regard to the family history meaning practitioners were unaware of maternal grandmothers' incarceration for drug related offences when mother was young, mother's resultant 18-month period in the care of a family member, or a previous assessment around mothers' vulnerability to child sexual exploitation. Whilst this assessment deemed mother a low risk to exploitation it was agreed that following this incident, mother would need support.

6.4 There were further opportunities to consider Child K1's lived experience by exploring further some of mothers' relationships with males when they visited mother following Child K1's birth. An incident on the post-natal ward where an argument was overheard by the midwife between mother and her partner, sufficient that he was warned he would be asked to leave if it was to continue, was not shared with the Community Midwives or the Health Visiting service. The recordings of the social care workers who visited the family home, do not reflect any discussion or consideration of Child K1's lived experience. Whilst further visits to undertake an assessment were planned by

Social Workers, because they were unsuccessful in gaining entry Child K1's lived experience was not explored further. Following a strategy meeting and the decision section 47 enquiries were not required, the child and family assessment was halted and the case closed so no further attempts were made to visit Child K1. An NSPCC briefing[4] found that professionals faced various barriers to gaining an understanding of the child's life and developing a stable relationship with them. In some cases, professionals didn't take adequate action to overcome or challenge those barriers effectively.

6.5 It is now clear that maternal grandmother was doing much of Child K1's care and when she left the family home for a period in January/February 2025, mother did not adopt a caring role. Practitioners did not explore what a day in the life of Child K1 entailed therefore, it can be concluded Child K1's lived experience did not influence practice.

Learning point: Practitioners need to be more curious to establish the lived experience of the child, by exploring who is providing care for a child and whether there are indicators suggestive of neglect that warrant further exploration with partner agencies.

Explore whether relevant policies, procedures and were being followed? If not, what were the barriers to this?

6.6 Rochdale Safeguarding Partnership policies and procedures are designed to provide detailed, consistent, and agreed upon guidelines for agencies to cooperate and safeguard the welfare of children and young people across Rochdale. They provide a framework to aid and support practitioners in their day to day practice.

6.7 During the antenatal period all midwifery policies and procedures were followed. Following a hospital admission for acute diarrhoea and the identification of a significant drop in Child K1's weight, the Faltering Weight policy based on NICE guidelines[5] was not followed. Weight loss following diarrhoea and/or vomiting is expected, however Child K1's weight had dropped nearly two percentiles which should have acted as a red flag to practitioners. Weight loss due to an acute episode of illness usually reverts to pre illness level within days but Child K1's did not. Child K1 did gain weight but, having had a birth weight that sat between the 50th and 75th percentile which initially followed the same trajectory, it was, by Child K1's 9-12 month review, sitting on the 25th centile. Whilst this does not equate to a drop of two centiles which is considered statistically significant, it was borderline with no plan to repeat the weight.

6.8 Agencies had clear guidelines/policies in regards to engagement, there is evidence that these were not always followed. Child K1's mother was known by services to be young, isolated and had self-reported that she was suffering from anxiety. These factors should have prompted a proactive and persistent approach to engaging her, and vicariously Child K1, in services. Whilst missed immunisations and secondary care

[4] Voice of the child: learning from case reviews Summary of key issues and learning for improved practice around the voice of the child May 2024

[5] Faltering growth: recognition and management of faltering growth in children NICE guideline Reference number: NG75 Published: 27 September 2017

appointments were followed up by the GP practice and secondary care, this was not always in a timely manner. It has been noted that the 'was not brought' policy in place does not give specific guidance on managing child appointments.

6.9 The Social Care policy on visiting frequency for Children in Need (CIN) was followed, however discretion is needed as there are times when more frequent visits are required to support timely and complete assessments; delays in completing the assessment hindered timely decision making.

6.10 The policy around timeliness of strategy meetings was not followed. There was a four-week delay further delayed by five days due to Police availability. Based on the presenting evidence – non-engagement, lack of access to Child K1, avoidance by both mother and maternal grandmother, and missed health appointments, the decision to hold a strategy meeting should have been made sooner.

Learning point: There was inconsistent use of policies and procedures to support practitioners practice. When actions or inactions by parents and carers are preventing or making it difficult for practitioners to practice in line with policy, this needs to be identified and further considered with partner agencies and within supervision.

Consider what actions were taken to understand the impact of mother's childhood trauma, her mental health & possible SEND[6] in the context of her parenting capacity.

6.11 Whilst records held within health visiting indicated that maternal grandmother had been in an abusive relationship between2006 and 2008, and potentially beyond, there is no evidence that this was explored with mother or maternal grandmother so the impact is unknown.

6.12 The Police also had recording of these domestic abuse incidents and evidence that they shared this information with partner agencies at the time.

6.13 In 2021 mother was a victim of sexual abuse and concerns were raised in respect of potential sexual exploitation. Whilst this information was known to children's social care and the police this information was not held in the records of any of the health services currently involved.

6.14 Mother indicated she was suffering from anxiety which impacted on her attending crowded or busy places, there was no formal assessment of her mental health until Child K1's 9-12 month review, and although mother reported she was going to see the GP with regards to this, there was no follow up to establish if this was true or to ascertain the outcome. It is not clear whether this self-reported anxiety was being considered in relation to post-natal depression or as a response to adverse childhood experiences and trauma.

6.15 Mother reported a diagnosis of dyslexia which was not known to some services. The health visiting service were aware of this but there is no evidence this was discussed in terms of its impact on mother. Some services recorded mother had moderate learning difficulties but it is not clear if this had been assessed or if it is correct. Services were unaware that mother had school refused during her teenage years and missed much of her education.

6.16 Children's Social Care completed an introductory visit where mother's childhood trauma, mental health and potential learning needs were not explored; this was reported, at the practitioner's event, to not be unusual on an initial visit. Lateral

[6] SEND - special educational needs and disability

checks with partner agencies who had prior involvement with mother were not completed; these would have better informed the social worker in relation to mothers' history. Subsequent lack of engagement of mother, despite numerous attempts, meant there was a lack of opportunity to gain a deeper understanding of mothers' history, experiences and parenting capacity.

6.17 Mother joined the GP practice during her pregnancy with Child K1, the records that were sent from the previous GP had no coding to flag that there had been any issues in relation to childhood trauma, mental health or SEND. The GP practice would therefore have needed to read all historical letters and attendances to ascertain this information. Secondary care records show no information with regards to childhood trauma, mental health or SEND.

6.18 Whilst mother was still a child during her pregnancy she was no longer attending school. If she had been this would have automatically provided an opportunity for relevant historical information to have been shared across the partnership.

6.19 The lack of an enhanced health visiting service to carry on the work of the ROMES services and offer an enhanced service specifically designed to work with young and vulnerable mothers, reduced the potential for school nursing information to be sought.

Learning point: Historical information is being lost as children transition into adulthood and/or move across geographical areas and services. Greater emphasis needs to be placed on retrieving historical information at the start of a services involvement.

Explore whether agencies were professionally curious in respect of family dynamics, previous family contact in the context of maternal grandmothers caring responsibility.

6.20 The community midwives', when completing their referral to the health visiting service did make mention of the living arrangements and the health visiting service did complete a genogram and note that maternal grandmother was "doing a lot of the cares" however, wider curiosity in respect of family dynamics, history or maternal grandmothers caring abilities/responsibilities were not explored by any service. An assumption seems to have been made that maternal grandmother was supportive based on self-report and her either accompanying mother or bringing Child K1 to appointments.

6.21 Information held on Police systems regarding maternal grandmother being charged with drugs offences, and subsequent incarceration, was not known to other agencies and was not shared during the strategy meeting held in 2025. This information would have alerted those professionals involved to an interruption in the maternal grandmother/mother relationship and provided further information regarding additional adverse childhood experiences and trauma to consider during contacts and assessments.

6.22 Whilst mother returned to maternal grandmother's care on her release from prison, her sister chose to remain in the care of the family member citing unhappiness with maternal grandmother's care giving.

6.23 The reviewer learned from a family member that there was an unusual dynamic between mother and maternal grandmother, with a somewhat unhealthy co-dependency. Mother was reported to be feisty and had caused damage to property

and bruising to maternal grandmother historically. Maternal grandmother appeared afraid of mother at times and was reluctant to confront mother when she felt mother was not caring for Child K1 adequately. A longstanding issue was that maternal grandmother would make excuses for mother's behaviours. The family member was clear that as well as keeping her distance from practitioners', mother was also keeping her distance from family members.

Learning point: Practitioners were not sufficiently curious to establish who was part of the family network and who was providing Child K1's care. Exploring this further could have alerted professionals to the extent mother was abdicating responsibility for Child K1's care, and led to additional conversations as to whether maternal grandmother was either suitable, willing or capable of delivering those cares. Contact with wider family members could have provided additional information that would have assisted practitioners.

Were there any barriers for agencies to effectively engage mum & maternal grandmother as a care giver? And if so, were concerns elevated appropriately?

6.24 There was limited exploration to understand why mother did not engage with services. Mother had identified that as part of her anxiety she struggled in crowded and busy places. Whilst the ROMES service took account of this and offered all visits at home, post the birth of Child K1 a number of the appointments for Child K1 were in busy centres or A&E departments which may have affected mothers' ability to present Child K1. There is no evidence that this factor influenced the way services managed contacts.

6.25 Practitioner's at the practitioners' event identified that not all midwifery services had access to BadgerNet so some midwifery information was held electronically and some in paper records, reducing practitioner's ability to gain a full picture of the services involvement and any safeguarding concerns.

6.26 The health visiting service identified that they would usually have offered another antenatal appointment following their initial no access visit but due to extreme staffing issues, as a result of high levels of sickness and vacancies within the team, this was not possible.

6.27 Practitioners were often unclear whom they were speaking to when using the contact number given, as it appeared that mother and maternal grandmother were sharing a mobile telephone and neither was truthful about whom practitioners were speaking to. In discussion with the family member the reviewer learned that both mother and maternal grandmother had mobile telephones but actively chose not to provide this information.

6.28 Mother did clearly express a fear of Child K1 being removed from her care, however where this fear originated was not fully explored.

6.29 Mothers reported moderate learning need was not explored sufficiently to understand what impact this was having on mother or on her ability to parent Child K1.

6.30 When maternal grandmother reported she was doing a lot of the cares it was within the first 8 weeks post Child K1's birth by caesarean section and would not have appeared unreasonable as mother was recovering from surgery. Maternal grandmother subsequently reported that mother was adapting well which served to reassure practitioners.

6.31 Maternal grandmother was not always open and honest with practitioners which caused some confusion and lack of clarity for practitioners.

6.32 No practitioners felt the issues identified were of sufficient concern that they needed to elevate these within their organisations.

Learning point: Local midwifery IT systems are not accessible to health visitors. As a result, it is essential that practitioners share information with regards to any barriers to engaging families such as anxiety or learning difficulties in writing. Practitioners need to establish whom they are speaking to. If families are being avoidant this should be seen in the context of safeguarding.

Explore the effectiveness of assessment and forums in managing risk and assessing, recognising and responding to neglect.

6.33 When services were unsuccessful in engaging mother this limited the opportunities to assess and ultimately manage the risks. The health visiting service had limited contact with mother carrying out their assessment with maternal grandmother. This reduced the health visiting services ability to identify if mother was meeting Child K1's needs and whether she required additional support.

6.34 There was an opportunity to gain a greater understanding of the family following referral's to children's social care. The first referral was quickly closed and although the second referral lead to limited children social care involvement, a subsequent strategy meeting to explore the neglect concerns identified within the referral, became secondary to concerns regarding an incarcerated male, recorded as Child K1's father, who was due for release.

6.35 Research[7] based on learning from previous case reviews is clear that neglect is a cumulative process, not an isolated incident, so it's important that professionals build up a picture of a family's situation over time. An opportunity to explore this on a multi-agency basis presented at the strategy meeting. However, information that should have supported a view that Child K1 was being neglected was not presented in a way that made those present realise the threshold for section 47 with progression to Initial Child Protection Conference had been reached.

6.36 The issues raised by the family member in relation to nappy rash, ear wax and cradle cap had yet to be fully explored as the Social Worker had only been able to gain access on one occasion. The Social Worker's findings suggestive of neglect e.g. Child K1 being dressed in unclean clothes, the kitchen being messy, the living room being cluttered, a urine smell throughout the house but more distinctive in Child K1's bedroom, a TV in Child K1's room said to help Child K1 fall asleep, were not presented as evidence suggestive of neglect. No one from the Health Visiting service was present to share information regarding missed appointments, and growth and developmental delay concerns, thus the accumulative evidence of neglect was missed.

6.37 If a full chronology had been collated it would have demonstrated 24 missed health appointments, unexplained faltering growth, concerns regarding development, and avoidance of practitioners.

6.38 The meeting did not fully consider:

[7] NSPCC – Neglect: Learning from Case Reviews 2022 https://learning.nspcc.org.uk/media/1345/learning-from-case-reviews-neglect.pdf

- gaps and difficulties in information gathering from mother and maternal grandmother,
- information from health services remaining outstanding,
- non-engagement and avoidant behaviours,
- the role of maternal grandmother,
- historical information,
- mother's history and learning difficulties

6.39 Practitioners appear to have been distracted by information regarding the alleged father of Child K1's criminality. The fact that he had no contact with Child K1 influenced the decision not to proceed into child protection.

6.40 There is acknowledgement that the family were not engaging but the rationale for closure centres on the fact that there was no contact between Child K1 and alleged father and that Child K1 appeared healthy and happy with no concerns regarding Child K1's interactions with mother. Practitioners at the practitioner's event informed the reviewer that at the home visit there was no evidence to support the concerns expressed in the referral. No further contact was made with the referrer to seek any additional information when the family were not engaging.

6.41 Following the decision that the threshold for section 47 enquiries had not been met, mother did not consent to child in need (CIN). As a result, no multi-agency meetings were held and a formal child and family assessment was cancelled before completion thus preventing an opportunity to build on the limited information gained during the initial social worker visit. Follow-up visits from the health visiting services were not arranged until the following month.

Learning point: Making a decision not to proceed to section 47 enquiries based on partial information proved problematic. Those attending the strategy meeting did not have complete information in relation to signs of neglect. Those present needed to consider whether they had sufficient information to be able to make a decision. They had an option to gather further information and complete the child and family assessment to better inform their decision making. The strategy meeting could then have been reconvened.

Consider whether step up and supervision policies were used appropriately and whether there is evidence of effective managerial oversight.

6.42 The only service to identify this case as requiring management oversight or supervision was children's social care. At the practitioner's event services continued to struggle to see that this case met the criteria for supervision or for stepping up, thus it is likely that a similar case would not evoke use of the associated policies.

6.43 On allocation of the case to a social worker there was a clear management decision detailing what actions needed to be completed. Mothers' resistance to CSC involvement prevented the social worker from completing a number of the actions. If further contact had been made with the referrer the social worker would have been made aware that mother was using the same avoidant behaviours with family members. Whilst initial supervision took place there needed to be more robust follow-up and accountability with consideration of a strategy meeting at this point. Following the social workers initial visit mother avoided telephone contact on eight occasions

and there were eight attempts to see the family within the home. Despite the lack of contact, it was four weeks prior to a decision being made to hold a strategy meeting; there was an additional delay of five days before the meeting taking place due to police availability. These delays meant that when the strategy meeting took place it was over a month since Child K1 had been seen and at this stage the child and family assessment should have been complete.

6.44 The strategy meeting did not fully consider mother's non-engagement which meant that the concerns hadn't been fully explored with mother, the assessment hadn't been completed, significant health information was outstanding and unclear, the role of maternal grandmother was not clear and mother's history and potential learning needs had not been explored. As a result, it is difficult to evidence the rationale for the decision that the case did not meet the criteria for Section 47 enquiries. Undertaking such enquiries would have provided clarity on missed health appointments, potential reasons for Child K1's weight loss, an opportunity to see Child K1 again and a general health check completed and an opportunity to better understand the roles of mother and maternal grandmother in caring for Child K1 and whether mother had any learning needs likely to impair her parenting.

6.45 The decision that there was no requirement to undertake section 47 enquiries appears to have informed the decision not to proceed with the child and family assessment and there was no further assessment of mother's non-engagement. As a result, Child K1 was not seen by a social worker again. This decision was not explored further through managerial oversight.

6.46 When section 47 did not proceed, no update or minutes were provided to the non-attending services prior to Child K1's attendance at hospital in a state of collapse, thus reducing their ability to challenge or escalate concerns.

Learning point: This case demonstrates the importance of robust challenge within supervision and managerial oversight to identify cases with outstanding actions, and in guiding frontline social workers and ensuring action on plans have been completed prior to case closure.

Is there evidence that practitioners were 'Thinking Family'? What was known regarding K1's wider family?

6.47 Rochdale have adopted a 'Think Family'[8] approach where the involvement of parents (together or apart), carers and children (unless this poses a risk) is a priority. The approach suggests 'support should be based on timely, high quality assessment and intervention delivered through a clear plan of work which is regularly reviewed'. Unfortunately, and with the benefit of hindsight, it appears opportunities to undertake assessments, and deliver interventions were either prevented or not taken forward. The lack of a holistic assessment to understand the family and establish the role each person took in relation to Child K1 is key.

6.48 Whilst midwifery and the health visiting service did complete genograms limited information was obtained. A number of males are referred to by their first name only with no dates of birth given which would make it difficult to assess their suitability to be around Child K1. There was limited background information obtained around

[8] The Think Family initiative was formally introduced by the Department for Children, Schools and Families (DCSF) in 2008

maternal grandmother and Child K1's maternal aunt. There is no evidence that genograms led to further exploration of the family dynamics or were reviewed or updated at subsequent contacts.

6.49 Concerns regarding 'hidden fathers' are often highlighted and research[9] has identified a number of reasons for this including:

- The dynamics of practitioners' relationships with the men in children's lives affected the level of help they received.
- Professionals avoided asking mothers about the men in a child's life due to worries that the questions were invasive. This led to professionals not being aware of an adult male's presence in a home and the true amount of time that he was spending with a child.
- When practitioners met new men in a child's life, there was a lack of curiosity about the role they were playing and the level of influence they were having on the family.
- Some male caregivers or male partners deliberately avoided in-person meetings with professionals due to the feeling that they would be not listened to or seen as 'difficult', while in other cases the men avoided contact because they were suspicious of services.
- If a man in the household of a child was threatening or intimidating, then professionals did not feel comfortable or safe engaging with them, impacting their decision making and management of cases.

However, in this case we also have a partially 'hidden mother.' This was not identified and considered by practitioners. The needed to enhance professional curiosity is clear.

6.50 There needed to be greater recognition of the wider family and their concerns. Although they were not living within the household they were trying to protect Child K1 but were not included in wider family network contacts. Although they sometimes provided information anonymously, a think family approach might have included them in mapping and given a stronger reflection of inside information that professionals were not able to see or access.

6.51 In July 2025 3 x Bee Brilliant, Think Safeguarding Professional Curiosity Learning events have been delivered across Manchester University NHS Foundation Trust where professional curiosity, think family and safeguarding response to the 'hidden male' have been explored.

6.52 As a result of avoidance tactics, contacts between practitioners and mother and maternal grandmother became somewhat superficial, reducing practitioner's abilities to delve further into the functioning of the household or the cause of Child K1' weight loss, slow growth or developmental concerns. Contacts centred on addressing the 'here and now' rather than establishing the bigger picture and identifying the accumulative concerns.

Learning point: This case highlights the importance of thinking family. Family members, and particularly those who have raised concerns, are better placed than practitioners to see children. When practitioners are experiencing difficulties in accessing children family members are well placed to provide information on whether

[9] NSPCC Unseen men: Learning from Case Reviews 2022. https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/unseen-men

they have been able to access the child recently and whether their concerns had diminished or escalated.

7. Good Practice

- Involvement of the ROMES team ensured mother received and enhanced package of support during her pregnancy and in the immediate post-natal period
- Completion and sharing of the Maternity Information Sharing Referral
- There was a proactive outreach to both mother and maternal grandmother by the GP in relation to non-attendance and wider discussion at a multi-disciplinary team meeting
- Evidence of the health visiting team following up on letters and sending text reminders for appointments
- Good communication between services in relation to non-attendance

8. Learning points

8.1 The partnership need to take action to address all the learning points collated below:

Learning point 1: Practitioners need to be more curious to establish the lived experience of the child, by exploring who is providing care for a child and whether there are indicators suggestive of neglect that warrant further exploration with partner agencies.
Learning point 2: There was inconsistent use of policies and procedures to support practitioners practice. When actions or inactions by parents and carers are preventing or making it difficult for practitioners to practice in line with policy, this needs to be identified and further considered with partner agencies and within supervision.
Learning point 3: Historical information is being lost as children transition into adulthood and/or move across geographical areas and services. Greater emphasis needs to be placed on retrieving historical information at the start of a services involvement.
Learning point 4: Practitioners were not sufficiently curious to establish who was part of the family network and who was providing Child K1's care. Exploring this further could have alerted professionals to the extent mother was abdicating responsibility for Child K1's care, and led to additional conversations as to whether maternal grandmother was either suitable, willing or capable of delivering those cares. Contact with wider family members could have provided additional information that would have assisted practitioners.
Learning point 5: Local midwifery IT systems are not accessible to health visitors. As a result, it is essential that practitioners share information with regards to any barriers to engaging families such as anxiety or learning difficulties in writing. Practitioners need to establish whom they are speaking to. If families are being avoidant this should be seen in the context of safeguarding.
Learning point 6: Making a decision not to proceed to section 47 enquiries based on partial information proved problematic. Those attending the strategy meeting did not have complete information in relation to signs of neglect. Those present needed to consider whether they had sufficient information to be able to make a decision. They had an option to gather further information and complete the child and family

assessment to better inform their decision making. The strategy meeting could then have been reconvened.

Learning point 7: This case demonstrates the importance of robust challenge within supervision and managerial oversight to identify cases with outstanding actions, and in guiding frontline social workers and ensuring action on plans have been completed prior to case closure.

Learning point 8: This case highlights the importance of thinking family. Family members, and particularly those who have raised concerns, are better placed than practitioners to see children. When practitioners are experiencing difficulties in accessing children family members are well placed to provide information on whether they have been able to access the child recently and whether their concerns had diminished or escalated.