Child Safeguarding Practice Review

Neglect

Contents

Introduction

1. The Shropshire Safeguarding Community Partnership (SSCP/the Partnership) agreed to undertake a local Child Safeguarding Practice Review (CSPR) to consider the safeguarding of children where there are concerns about neglect. To identify systemic learning and recurring practice issues, three different families that had been notified to the Partnership and were the subject of Rapid Review meetings were considered[1].
2. The learning from the consideration of agency involvement with the children and their parents is in the following areas:
   - The need to seek, share, know and consider a parent's history and vulnerabilities, and understand the impact this will have on their children
   - Children who are electively home educated or have poor school attendance
   - Supporting parents to meaningfully engage with services to benefit their child
   - Responding to information shared anonymously, or by family or friends
   - The need for contingency planning and multi-agency involvement when a plan ends
   - The vulnerability of children who move area
   - The coexistence of neglect with other forms of abuse
   - Poverty awareness

The Process

[1] In one of the families there were also significant concerns about sexual harm and abuse and a separate CSPR has been completed which focuses on this and has been published on the SSCP website.

3. Two independent lead reviewers[2] were commissioned to work with a panel of managers and safeguarding leads from Shropshire to undertake the review. Together they identified the learning, and agreed the recommendations included in this report.

4. There was some delay in the decision to undertake this CSPR due to each separate case not individually meeting the criteria for a review. However, it was acknowledged that three separate Rapid Reviews about neglect may indicate a systemic issue that required consideration.

5. The three Rapid Review processes that preceded this CSPR included the submission of detailed agency chronologies and reflection about the initial learning. These and further information shared at the Rapid Review meetings was the starting point for the CSPR. Each agency involved was also asked to provide further reflection on their agency involvement and to consider whether any single agency recommendations were required before the completion of the review. An action plan is progressing.

6. Three separate face-to-face multi-agency meetings were held with Shropshire professionals who had been involved - one for each of the families. The meetings included discussions about this involvement and about the wider systems in which the professionals work. Those unable to attend were spoken to by the lead reviewers in separate smaller meetings.

7. Two of the mothers (from Family 1 and Family 3) and one of the children (from Family 1) met with a lead reviewer and a representative of the SSCP in June 2025, and their views are included below. It was hoped that the parents in Family 2 will also agree to contribute to the review, so that learning can be identified from their perspective. They have not engaged, however.

The children

Family 1
A large family that moved to Shropshire from another area some distance away in 2019. All the children were of school age at the time. They had been on child in need plans when they relocated but had previously been on child protection plans due to neglect and sexual abuse in the family environment. In 2023 the police reported serious concerns about the state of the home, following their attendance due to allegations of sexual abuse made by two of the older children in the family. At the time the youngest children were being electively home educated, and the older children were NEET[3]. Subsequent assessments have identified neglect, emotional, physical and sexual harm. The children lived with their mother and stepfather.
Family 2
A large family known to Early Help practitioners due to concerns about the children often being unkempt, hungry, with recurrent headlice and frequently unwell. There was poor engagement with health services and issues with school/nursery attendance. In May 2024 one of the children, who was nearly three years old, had a large, infected burn on her foot and no medical attention had been

[2] Nicki Pettitt is an independent safeguarding consultant and an experienced lead reviewer. Hannah Bates is a social work manager and safeguarding consultant. They are both entirely independent of the SSCP.
[3] Not in education, employment or training

sought. The police visited the home and found poor home conditions and limited food. The children lived with both parents, although their father did not officially live there.
Family 3
Two children living with their mother. Several anonymous allegations were made about neglect and emotional abuse, particularly of the older school-aged child. They were being electively home educated when police were called saying the child had been left home alone. When seen he had many injuries (bruises, cuts, large scratches, bite marks and abrasions) over his body. Both children presented as dirty, and the home smelled strongly of cannabis. The assessment that followed determined that the children had experienced neglect. The identity of the children's father/s is not known.

8. The CSPR considered each family separately, but this report summarises the main learning found across them.

9. As there was significant learning from considering the sexual abuse in Family 1, a separate report has been written. Published on the SSCP website on 17/04/2026, it is called *Child Safeguarding Practice Review, Family 1, Child Sexual Abuse and Neglect*. This report will focus on the learning specific to neglect but also acknowledges that neglect and child sexual abuse often co-exist.

Learning

Learning area: The need to seek, share, know and consider a parent's vulnerabilities and the impact this may have on their children

10. When a parent has significant vulnerabilities of their own, including childhood abuse, the professionals working with them or their children must be aware of the parent's experience as a child and how this may impact on them as an adult and a parent. Research indicates a higher risk of neglect and abuse in families where parents have been victims of childhood abuse themselves, and where mental health problems, domestic violence and/or substance misuse are an issue. Knowing the parent's history is also crucial to ensure that appropriate support is provided, that engagement is meaningful, and that any risks are identified and acknowledged in any plans. In each of the families there were gaps in knowledge about the parent's, including about their childhood experiences. The review has found, partly from speaking to the parent's directly and partly from available agency records, that most of the parent's had their own trauma in childhood and as younger adults, and that this has impacted on them as parents.

11. The mother in Family 1 experienced domestic abuse throughout her childhood and in her own relationships, and she was the victim of sexual abuse in her home from the age of five years. She told the review that while she was close to her mother and has struggled emotionally since she died, she had not been 'a protective mum'. She described herself as suffering from complex PTSD. It is known that her partner, who has recently been convicted of child sexual abuse, also experienced physical abuse and violence when a child.

12. Very little was known about the childhoods of the parents in Family 2, however there was knowledge about Mother struggling with the recent death of her own mother at the time of the concerns. Historic records available to the review state that the father in Family 2 was diagnosed with emotionally unstable personality disorder[4] in 2006, but there is no evidence this was known to any of the professionals working with the family in Shropshire until after the incident leading to inclusion in this review.

13. The mother in Family 3 was known to have been adopted as a young child. She told the review that her adoptive mother was an alcoholic, and that her adoption had effectively broken down, resulting in her coming into care at age 13. Being removed from birth parents and then an adoption breakdown can have a profound impact on a child that can continue into adulthood. She said she had been in a domestically abusive relationship where she had been physically assaulted as a young adult. The mother told the review that no professional had explored her history or her own experience of being parented. She acknowledged that she had her own mental health issues and had regularly used cannabis, and that she was in a new relationship that was domestically abusive. Both the mother and her partner claimed the other was the perpetrator of abuse. As part of the review, agencies were asked to check their records and knowable information about Mother 3's past mental health and alcohol misuse were evident. It is essential that those working with a family where there have been these types of concerns recognise the likelihood they will be repeated or reemerge and are therefore likely to have an impact on the children.

Learning area: how services support parents to meaningfully engage with them to benefit their child.

14. In all the families considered there were examples of offered assessments or support being refused or avoided by the parents. This tended to be accepted by professionals, without the impact on the children always being considered. Professionals need to be child-focused, even when parents choose not to engage with services, and ask whether this may contribute to any safeguarding concerns. Due to the need for consent for most services to be involved, professionals told the review that they must accept a parent's lack of engagement. This can then normalise the avoidance of services.

15. It was concerns about the home environment in December 2022, along with the avoidance of health professionals, that led to a referral to COMPASS[5] from the health visitor about the children in Family 2. The school of the older children was contacted, and they shared their longer-term concerns about low school attendance, the children often being unkempt and grubby, and the eldest child (then aged 8) having five incidents of bruising to face and arms thought to be from lack of supervision. The school had not made a referral to COMPASS, believing that the threshold for a social work assessment would not be met. It is their view that poor school attendance and 'educational neglect' is often not recognised by CSC as a safeguarding issue. However, CSC told the review that they wish they received referrals about any neglect concerns sooner. A whole family assessment was completed, and a family support

[4] EUPD can include extreme mood swings, difficulty managing intense emotions, difficulties forming and maintaining stable relationships, and impulsivity.

[5] COMPASS is the front door for children's social care for receiving new enquiries regarding concerns for the welfare or protection of children and young people in Shropshire. COMPASS promotes the offer of Early Help to children and families in the first instance, where it's safe to do so.

worker was involved who undertook a graded care profile 2[6] with the family. They acknowledged that this was not very thorough as they were 'rarely let into the home'. The GCP2 tool is felt to be helpful, and in this case it was used directly with the mother to scale concerns to explain what the neglect concerns were. There are reported issues with the electronic tool for the GCP2 that staff find frustrating, however. The family support worker tried to understand why neglect featured for the children, and recognised that a family bereavement, the cost of heating, and some poor conditions in the home (e.g. mould) contributed to the family's challenges.

16. Despite the lack of engagement with family support, Targeted Early Help (TEH) was recommended. Improvements were noted in the home and with school attendance over the months that followed, and there appeared to be improved engagement. Those involved at the time told the review that they can now see that while it often appeared as if there was engagement with the plans for the children, Mother would in fact regularly ring and cancel appointments and would often have excuses not to be at home or to attend appointments or meetings. What can now be seen as a lack of meaningful engagement was not adequately identified, questioned or understood then.

17. It is also noted that the focus of professionals was on the mother and not the children's father, who was usually present but was not engaged with directly. The school told the review that they had never seen the father, and the health visitor for the younger children only saw him once, on a video call. Although most agencies were told he didn't live with the children, the midwives for the last child had him recorded as resident. TEH told the review that they did not consider where he lived, focusing their work mostly on the mother. Another learning point recognised during the review is that there is still a need to improve recording of contacts with families across agencies to ensure that those present are always listed with full names and relationship to the child, including details of the involvement of father/non birthing parent.

18. TEH closed their involvement with Family 2 partly due to some improvements, and because the mother said she no longer required or wished to receive support. Around six months later two separate anonymous COMPASS referrals were made. (More below) TEH contacted the mother, but she declined support. Following this, a discussion was held with the Public Health Nurse regarding the timing of the next Health Visitor home visit with a view to the issues raised in the anonymous call being considered by them. The Health Visitor attempted five home visits over the following six months but had no success in seeing the family. She told the review that she was not aware of the anonymous referrals so did not share her lack of contact with her safeguarding leads or with any other agency. Having considered the concerns that persisted about the children over time, there was an earlier need to consider their lived experience through a lens of probable neglect. There must be a focus on the impact on a child of them missing immunisations, speech & language and audiology appointments, and their poor school attendance and punctuality.

19. There is a risk, when working with a family where the parents have significant vulnerabilities of their own, to lose focus on the child. The relationships that are developed with parents can lead to a

[6] The GCP2 is a practical tool developed by the NSPCC and in Shropshire it is the agreed partnership tool used to support practitioners measure the quality of care a child receives and is used where *neglect* is suspected/ known.

professional reluctance to challenge parents, or to reflect deeply on a child's experience. This is particularly a risk when the parent is engaged, plausible, likeable and appears to gain personally from professional interventions. In the case of Family 1 there was a need to ensure that the focus remained on the children despite the needs of their mother, and her reassurance that she was behaving in their best interests. When working with someone you like and have significant empathy for, the 'halo effect' can occur. This is where practitioners are more likely to judge a person as trustworthy, even where insufficient information is available to inform the basis of this assessment. When practitioners perceive parents as open and engaging, they tend to feel reassured. Risks can be overlooked or minimised when there is parental cooperation, and parental deception may be missed or parenting capacity overestimated.[7] In the case of Family 3, those involved at the time can recognise that they were reassured by the mother being articulate and educated and reflected that the system can struggle with families who are middle class. Although the midwives involved at the time of the younger child in Family 3's birth made a referral to COMPASS due to concerns about the home conditions, the older child being present and not in school, and their concerns about the way the mother spoke to the older sibling, which was good practice. They also shared their concerns with the health visitor, although a copy of the actual referral was not shared. No action was taken.

20. Front line staff from partner agencies also stated that a difficulty for them is that families who have a history of poor engagement do not tend to accept Early Help input, and do not tend to maintain any changes made during a short period of Early Help support. This appears to have been the case in the families considered by the review. In the case of Family 2, the school said that any engagement and slight improvements in respect of the home conditions or parenting led to the case being 'quick to close'. There is also a wider issue that can have an impact, which is how children step up from Early Help if there are concerns, as didn't always happen here. This appears to be linked to changes in managers and lack of consistent permanent staff at the time which created a system pressure.

21. The term 'disguised compliance' is not always helpful, as it implies deliberate avoidance, which may not be the whole picture. There is a need to consider how meaningful a parent's actual engagement is, the impact of any avoidance or missed appointments, and what may be getting in the way when there is evidence of poor engagement. From the point of view of the family, they may also feel that there is little point in engaging with services when their issues are dismissed or where support is inconsistent or ineffective. The child spoken to by the review said that they felt let down by many professionals over the years, and that there was little attempt from most to build a relationship with him, or to understand his needs. Their mother said that offers of support were not always delivered, for example respite care and more support in school. Information received from the previous Local Authority where the family had lived shows a pattern of the children regularly not being bought to health and mental health appointments.

22. The mother in Family 3 spoke about how hard it was to engage with professionals when much of the contact at the time was virtual and not face to face. She felt that she would have engaged with support

[7] https://cspm.csyw.qld.gov.au/getattachment/dd453153-6025-4cb3-a2d5-e8af32c4df8d/PG-Bias-in-child-protection-decision-making.pdf

if those involved understood the issues she faced, including understanding of her being in a controlling relationship and how this might hinder her accepting support. Mother 3 also shared her reflections on receiving telephone calls 'out of the blue' from COMPASS (or indeed any other agency). She described how hard it can be to listen and hear what is said and to make an informed decision about giving consent to an assessment, particularly when you have mental health issues or are in an abusive relationship, also adding that a neurodivergent person may struggle with phone contact. As this is common practice, it is worth considering, in the age of increasing numbers of nuisance calls or scams, whether this is an appropriate way to engage a parent or consider the risk to a child.

23. When expecting a new baby in 2022, the mother in Family 2 booked late for her pregnancy at 20 weeks gestation. Learning has been identified by maternity services about the need to make a referral to the maternity safeguarding team and undertake a home visit when an expectant mother books late. Home visits were undertaken after the birth of the baby, and there were no concerns. However, professional worries about the older children appeared to escalate following the birth of the baby, with the GP, hospital, health visitor, school and nursery sharing or noting concerns about lack of attendance. This is a common pattern in families where neglect is an issue. The demand of a new baby can cause an escalation in neglect of the older children as priorities compete. It is important that those working with the older children recognise this and monitor their care and engagement with services following a new sibling arriving.

24. In July 2023 Peart published a helpful article[8] of 'bite sized tips' to help professionals to explore and understand how and why a parent may not be engaging with professionals in the best interests of their children. It includes the following which needed to be considered by those working with the families considered in this review: Evidence of inconsistent progress across different areas (as was the case with families 1 and 2). Over-eagerness to please or to avoid confrontation, often to avoid difficult conversations, as was the case in all the families at certain times. Reliance on short fixes, as was the case in families 1 and 3 when the parents changed the children's schools or opted for EHE rather than addressing the root of the problem, alongside evidence in all the families of a reluctance to engage long-term and make sustained changes.

Learning area: The need to robustly consider information shared anonymously or by family / friends.

25. A CSPR completed previously in Shropshire (family G) recommended that assurance is sought that concerns and referrals are not dealt with based on a hierarchy of referrer and that when, for example, neighbours and workers who may be perceived to have less status than others make referrals, that these are treated with an equal weight of importance to other referrals. This is relevant as referrals to COMPASS from family members or anonymous sources were shared in respect of both Family 2 and Family 3, and they were not given a robust response. Reviews nationally, and the independent inquiry into child sexual abuse[9], have found that professionals tend to give less credence to information shared anonymously or by a family member or friend who wishes to remain anonymous. The national CSPR

[8] https://www.mysocialworknews.com/article/how-to-spot-disguised-compliance-the-top-5-giveaways
[9] https://www.iicsa.org.uk/

into the 2020 deaths of Arthur Labinjo-Hughes and Star Hobson found that concerns shared by family members were repeatedly ignored or dismissed. That review stressed the need to listen closely to relatives who have concerns and to recognise that they have a credible insight into a child's lived experience. They can provide the 'child's voice', particularly when that child is rarely seen by professionals, as was the case here.

26. The review was told that there is a concern in Shropshire about seeking or sharing information when a referral has been made by an anonymous source. COMPASS, for example, do not talk to health professionals about children in these situations. This is in part due to not having consent, due to an anxiety about how plausible an anonymous referral may be, and concern about how those being spoken to will respond. The review was told that GPs, for example, are unlikely to share information without explicit consent or as part of a child protection investigation (S47).

27. Concerns were shared about Family 2 with the First Point of Contact[10] by a close family friend in 2023. The information was plausible and required serious consideration as a safeguarding issue. There had been concerns about the children before, that had similarities with what was shared, and that identified ongoing risk of neglect. They included poor home conditions, lack of food and heating, scabies and other recurring illnesses. Not all the previous concerns had been shared with CSC, so without checks with schools particularly, the information shared by the friend was not triangulated. As the terminology used by the friend was a 'need for support', it was determined that an Early Help response was required rather than being shared with COMPASS. Shortly after, a referral was received from a member of a Facebook group sharing that Mother was regularly posting asking for money to feed her children. This was also passed to Early Help. As no consent was received for an Early Help response, no further action was taken.

28. There were several contacts with CSC from neighbours who wished to remain anonymous (this is not unusual) about Family 3, starting in 2021. The first shared information about Mother being heard to mock and shout at her child. Mother was contacted and denied any negative language towards the children, and no further action was taken. A further contact was made later in 2021 stating that Mother was verbally abusive to the older child and gave further examples of the unpleasant things she allegedly called the child, sharing that the child was often upset. The school were contacted to make them aware, and a request was made for them to monitor and report any concerns. In December of 2021 a neighbour reported to CSC that the child had been left home alone and that they had gone to the neighbour's house. He was returned home and concerns about the home conditions were shared. At the time the child was being home educated. Mother was contacted and agreed to agency checks. These included the education access team and the health visitor for the younger sibling, who had completed a home visit and reported to CSC that she had no concerns. CSC took no further action.

29. In 2022 a neighbour called CSC to raise further concerns about shouting and emotional abuse of the older child in Family 3, allegedly the younger child was being encouraged to join in the taunts by their mother. The outcome was that it did not meet the threshold for further action. In 2023 another police

[10] Members of the public can contact the first point of contact to discuss the issues and if there are safeguarding concerns or a need for family support it progressed to either COMPASS (CSC) or EHAS for a response.

force shared information that a member of the public had witnessed a physical assault by the mother on the older child in a public place. West Mercia Police were contacted with the family details which were established from the car registration details. Officers attended the home and spoke to the child, who denied he had been assaulted, and the officers had no other concerns, noting that the children looked clean and well and that the home had plenty of food and toys. They did not contact EDT to see if a joint visit was possible, and neither West Mercia police nor the other Local Authority informed Shropshire CSC of the incident. West Mercia Police deemed, at the time, that it did not meet the threshold for information sharing. The review has found that both incidents needed a social work response to the safeguarding concerns shared by those making the referrals. During the review West Mercia police reconsidered the incident and acknowledge that it should have been referred to CSC.

30. There is a need to ensure that any decision making about the need for a social work assessment (or indeed as part of an assessment) includes direct contact with the person who made the referral, if this is possible, as it was certainly in the case of Family 2 and potentially for Family 3. This ensures that information either not shared or not recorded at the first point of contact is available to those speaking to the family and/or deciding on the next steps. The neighbour, friend or family member may be intimidated or feel guilty about raising concerns, and it can require an understanding and sensitive approach and conversation for them to share the entirety of their concerns. They will also be more likely to take responsibility to report any further incidents in the future if they feel listened to, which could be important in helping safeguard the child/ren.

Learning area: Children who do not consistently attend school or are electively home educated (EHE)

31. It is widely recognised, and has been a finding of many CSPRs, that children who are not seen regularly at school can be more vulnerable than their peers, as can children who move schools regularly an have periods not in school. The number of children where school attendance is an issue have increased since the Covid 19 pandemic, and the number of children being EHE has also grown. Nearly a seventh of primary school children and a quarter of state secondary pupils are persistently absent, or missing at least one day every two weeks, according to official figures.[11] UK wide persistent absences in all state secondary schools have risen from 13% in 2018-19 to 24% in 2022-23. In Shropshire the number of children registered as EHE was 149 in 2019, rising to 531 by August 2023 – a more than three-fold increase. These numbers have stretched services and led to increased concerns about children who were otherwise known to be vulnerable, as was the case for those considered in this review.

32. When children are not seen regularly by professionals, for whatever reason, this can lead to abuse or neglect not been identified. Children then do not have the opportunity to share their unhappiness, either directly or by their behaviour. This was an issue for most of the children considered by this review. All the children in Family 1 had periods of poor school attendance and the younger siblings were later EHE, the children in Family 2 had poor school and nursery attendance, and the older child in Family 3 was EHE for a time. While many families home school their children successfully, there is

[11] Ofsted

a need for professionals to be curious about children who are not in school, particularly when there has been an history of neglect or avoidance of professional scrutiny.

33. This is a complex area with few easy answers. In England, local authorities have limited powers to monitor the quality of home education or the safety of the children being EHE. There is no duty on parents to register their children with the Local Authority, and professionals have no automatic right to see the child without the permission of the parent. This means that either intentionally or unintentionally, parents can exploit the system. EHE can mean that children are invisible to services and that plans to support or safeguard them may be more difficult to implement.

34. The children considered here had the involvement of education professionals in the Local Authority, including the Education Welfare Service (EWS) and the EHE service. The older child in Family 3 had attendance issues at school dating back to 2018, and an Education Welfare Officer (EWO) was involved and had sent warning letters for nonattendance and lateness. The child had also attended four different primary schools and had several periods of being EHE. In March 2022 the EWS shared information with CSC that the child had been removed from school and home educated five times, and there had been sporadic engagement with the EWO. Later that year the child was back in school, but their attendance was just over 60%, declining in 2023 to between 51 and 57%. When the EWS contacted the mother, she informed the school that she was going to educate him at home, and processes were put in place for this, including a visit from the EHE service in September. The child was seen, and no concerns were noted during this visit. It is not the role of the EHE service to challenge the choices made by the family to remove a child from school, although there was evidence that the decision may have been made to avoid scrutiny of the child's poor attendance.

35. In May 2024 the national CSPR panel published a briefing titled Safeguarding Children in Elective Home Education. It includes the themes that had emerged from the Panel's analysis of rapid reviews and LCSPRs completed between October 2021 and November 2023, and recommendations to improve practice with these children who may be specifically vulnerable. Including the need to ensure that 'children's voices, needs and perspectives have been considered in the decision by the parent/carer to home educate them' and that children's vulnerabilities and safeguarding needs are understood at the point of being removed from school rolls, including if there have been concerns about not being brought to health appointments.' There is also a need to question and understand exactly why a child is being EHE, and how the parent will ensure their educational needs will be met this way.

36. In summary, home education can mask harm and can lead to a child being isolated and invisible to services. The right of parents to have autonomy over their child's education, while needing to be respected, also needs to be challenged when there have been concerns in the past that might indicate child neglect, including the child's educational needs not being met. This was required for the relevant children considered in this review, as it is now known that they did not receive any real or meaningful education while at home. The review was told that there have been recent improvements in practice in the EHE team, with a focus on seeing the home and the plan for education through the eyes of the child, and increased use of Early Help meetings with those where there are concerns.

37. Professionals identified concerns about digital neglect in Family 2. This is where children are given excessive (and unmonitored) screen time, and where parents are on screens and not paying attention to the children. It was known that the children's fathers use of video games interfered with his sleep and interactions with his family. Digital neglect can have serious consequences for children, including on their academic performance, their ability to build healthy relationships with others, and the risk of them encountering on-line dangers. There were also concerns about the children in Family 1 and Family 2 playing video games in lieu of other educational input.

38. Children who have a history of abuse or neglect are also more vulnerable to contextual abuse when they are not in school. There has been a focus on the links between children excluded from school and exploitation. The school attended by one of the younger children in Family 1 was aware of both the child's vulnerability due to his history. They telephoned the schools in the previous area to seek information on the children. The school also worked hard to keep him in school and to support him when some of his concerning behaviours may have led to exclusion. They were aware that the older children in the family who had been permanently excluded from school had ongoing very poor outcomes as young adults. The school's commitment to the child was and remains important in safeguarding and supporting him. They have recognised that he required an assessment for neurodiversity and arranged this. The child was spoken to by the lead reviewer with a teacher at their school and their positive relationship was very clear.

39. There is a lot of work being undertaken in Shropshire to make the response to children who are EHE more robust, including a clear focus on those where there are safeguarding needs, and improved engagement with a child's GP. There has also been an improved focus on educational neglect, and a conference is being held in the autumn of 2025. There is a clear policy with a section on safeguarding. [12] So, no new recommendations are being made here.

    Learning area: the need to recognise the significant impact on children of chronic neglect, with the need for multi-agency information to be considered, and contingency planning when CSC close their involvement and concerns reemerge or persist.

40. During the review, there was a view shared by schools and health professionals that MARFs including indicators of neglect, such as poor school and health attendance rarely meet the threshold for a social work assessment, or a strategy meeting. Likewise, there is reportedly an issue with the courts recognising long term neglect as meeting the threshold for care orders which was not relevant to this case but provides a wider context of not recognising the harm that results from chronic and long-term neglect. CSPRs undertaken nationally have reflected on this issue, stating that neglect tends to become visible over time, rather than a one-off abusive incident such as a non-accidental injury or allegation of sexual abuse, there is a tendency to delay interventions. There is also a tendency to underestimate the impact of neglect, particularly emotional neglect, with the damage to the child not always being adequately assessed and understood. Some of the damage is likely to be longer term with poor outcomes in areas such as education and mental health.

[12] https://next.shropshire.gov.uk/media/0pvbmqny/shropshire-council-elective-home-education-policy-12052025.pdf

41. Those involved with the families considered here recognised that had they formalised joint working with other professionals earlier, and put the information held across agencies together and within the knowable historic context, there would have been a more robust agreement that long-term and ongoing neglect was a feature. They could also see the benefit of completing and sharing neglect tools. Poor school attendance, seen alongside children not being bought for immunisations or health appointments, and regular cancellations of visit by early help workers and health visitors, begins to build a picture of neglect that is more concerning and impactful on the child. Those involved can see the benefit of working with other agencies to compile joint chronologies of concerns and using these alongside MARFs, with a clear statement where neglect is identified and named. The same solution can be used when there are concerns about the response of another agency to safeguarding concerns about a child, and the benefit of working with other professionals involved to challenge decision making and discussing whether a child is in the right place in the system. Those working with Family 1 recognised during the review that they did not always share the known family history or other agency information when completing MARFs but can now see the benefit of doing so and intend to do this in future. A recommendation has been made to encourage more meaningful referrals in cases of neglect.

42. The review considered the need to improve the use of strategy meetings when neglect concerns are identified, to ensure that partner agency information is formally shared and all relevant agencies are fully involved in decision making. This includes the need for Early Help to be invited and to attend when a family known to them is the subject of a strategy meeting, which is not currently common practice. Each child should be specifically considered in a family where neglect concerns are identified, and a strategy meeting is held. Each child will have diverse and different needs. Medical assessments should always be considered in S47 investigations into neglect concerns. In the case of Family 1 there were no strategy meetings held despite significant concerns about the sexualised behaviour of one of the children, indicators he was being scapegoated and neglected, and chronic concerns about school attendance and the lack of food in the home.

43. When a child is closed to CSC without a robust assessment that includes understanding why neglect has featured and why changes in the past have not been maintained, this must be challenged by partner agencies. As, without this, there is likely to be a further decline in the living conditions and parenting received by the children and repeat referrals. The review was told that there has been a lot of focus recently on the need to consider the 'why' when working with families where neglect features, and recognition that this was not the case when the bulk of the work was being undertaken with the families considered here. There is also an increasing understanding of the need to consider the cumulative impact on the children of care that has not been good enough over time which needs to be embedded and seen across all children and families and all agencies. There are still times when there is a focus on a particular concern and solving it practically, such as working with Family 2 to get the heating on, rather than taking a step back and recognising it as an indicator of child neglect.

44. The review was told that decisions to close or step down a case are usually made by CSC, when such decisions should include the views of all the professionals involved with the child and the family,

particularly those who will continue working with them at the end of any assessment or plan. There is also a need for an agreed and transparent contingency plan when a child is closed to CSC or TEH.

Learning area: recognition of the additional vulnerability of children that move area

45. Reviews show that children who move often face extra challenges in education and in getting support for special needs. There also tends to be gaps in the information held and known about them. While a move may be presented by parent's as wishing for a fresh start, or because they are escaping an abusive partner or family member, the move can also mean that the family are able to avoid consistent and knowledgeable professional oversight. All of this was relevant for the children in Family 1. There was a need to consider the move as an additional vulnerability when considering their needs on their arrival in Shropshire in 2019.

46. The parallel CSPR that considers the sexual abuse of the children in Family 1 also considers the fact that the children had moved from another area where there had been significant agency involvement, including child protection plans for the children due to neglect and sexual abuse in the family environment. This includes the potential learning for agencies in the previous area, where the potential indicators of on-going sexual abuse in the family home were not robustly identified or addressed. This was partly why, when the family arrived in Shropshire, the concerns about and risk of sexual abuse were seen as historic rather than potentially current, and the focus of the work being the prevention of neglect. The additional needs of the children were acknowledged, so the child in need plans continued, with a new social work assessment being completed in Shropshire.

47. A move will inevitably lead to changes in the professionals involved with the children and can disrupt trusted or accepted relationships, as well as losing much of the softer information help in agencies that is not necessarily written down. One of the children told the review that they had a social worker in the old area who was good, as they would spend time with him and listen to what he had to say. They said that this was not something that happened after the move, until the more recent change of worker at the time that the child came into care. It has been acknowledged by CSC that there was a lack of consistent allocation, and issues in the social work team at the time with poor management oversight, which was exacerbated by the children only being on child in need plans for a relatively short period of time. At the time Child in Need meetings were only expected to be held every 8 weeks, so there was little opportunity for all of those involved with the children in the family to meet up during the duration of the plan.

48. There were some delays in receiving information from the previous area, the need to chase documents, and some gaps in what was shared that continue to be absent at the time of the review. (Information from the previous Local Authority for this review was received just before completion.) Partner agencies should follow a range of tasks to safeguard children who move between areas, especially when there are existing concerns. They include following the expected protocols for transfer of records, timely and robust multi-agency information sharing, and the particular oversight of the children who are most vulnerable, including those on a child in need plan and previously on a child protection plan, as was the case with Family 1.

Learning area – neglect co-existing with domestic abuse and/or sexual abuse

49. Domestic abuse featured in at least two of the families. The impact on children of domestic abuse is well known to professionals in Shropshire. The additional impact when it co-exists with neglect is also recognised. In Family 1 the children had experienced violence between their parents prior to the move to Shropshire. Mother told the review that her recent partner, who is now serving a custodial sentence, was controlling of her and physically abusive to the children, and that she can now see that the children were fearful of him. Domestic abuse also featured in Family 3. Both the mother and her most recent partner have made allegations of violence from the other, and the police were involved on occasions from 2023 due to this. Firstly, when the partner made allegations against Mother, and then when she made counter allegations. Information was shared with CSC, and no action was taken, however a referral was made to West Mercia Women's Aid for the mother as a victim but not in respect of the male partner, or in respect of Mother as a potential perpetrator.

50. There are known difficulties for services in respect of recognising domestic abuse where the allegations are made by a man with an alleged female perpetrator, or where there appears to be mutual or bi-directional violence or abuse. It can happen that within a family there is not just one victim and one perpetrator. Professionals need to recognise that domestic abuse is not always this straightforward and that a deeper understanding of relationship dynamics is required. In this case there was little done to understand the complexity of the adult relationships and the impact on the children. Professionals also need to keep an open mind as to whether the primary victim may be male.

51. The children in Family 1 were either directly sexually abused or aware of the sexual abuse of a sibling. A parallel CSPR has been completed that focuses on this. However, it is important to repeat here that children who are neglected are more vulnerable to sexual abuse and to be exploited by perpetrators, and that professionals must always have an open mind to this co-existence. This is particularly the case when sexually abuse has occurred in the family in the past, including of the parents in their own childhood.

Learning area: the need for poverty aware practice.

52. There is an increasing awareness of the need for poverty aware practice. The Joseph Rowntree Foundation's 2025 UK Poverty Report states that around three in ten children in the UK is living in poverty. It is important to recognise the impact on children of family poverty and poor housing conditions, that also allows the presence of neglect to be established when required. This is complex as the two issues can overlap, and cost of living increases can create pressure and impact on a parent's mental health. Professionals in communities with high levels of poverty need support in this area, as they must challenge themselves and others about thresholds for neglect and the need for holistic assessments alongside the provision of practical support.

53. There is a risk, when poverty exists, that parents may be seen as neglectful when they are struggling to meet their children's needs due to a lack of resources. There is also a risk that neglect is missed when poverty is an issue. Agencies must also robustly consider if their essential support is masking child neglect and providing 'scaffolding' to children where neglect is present. Those involved with

Family 2 particularly found this challenging, with the provision of support via targeted family support and early help that did not robustly name and identify neglect, and that made little difference to the children's lived experience.

54. It is expected that the national CPR on neglect[13] that is due to be published early in 2026 will be considering this issue, and the neglect subgroup of The Partnership will be considering in detail the learning from that review on publication, so no further recommendation is made at this time.

Reflection on previous reviews where neglect was present.

55. A Serious Case Review (SCR)[14] was completed in Shropshire in May 2021 'The G Children' where neglect featured. The review found learning very similar to what was found when considering practice and systems in respect of the three families considered here. This included the need for improvements across the system in consistently responding to the recognition of abuse, maltreatment & neglect in the household, the quality & effectiveness of assessment, planning and interventions, making opportunities to hear and understand the daily lived experiences of the children in the household, and the quality and effectiveness of multi-agency working. There was also learning that concluded that there was a 'hierarchy' of referrer, with referrals made by neighbours and workers who may be perceived to have less status, not being given the weight required.

56. Recommendations were made in the G family SCR that focused on identifying neglect and linking the databases for Early Help and Children's Social Care, and the need for Children's Social Care to access information held by the Early Help service to inform assessments and decision making. Also recognised was the need to improve responses to concerns when parental consent is not given, improving the response to information shared by family and friends, improved understanding about when a formal pre-birth assessments is required, and the need for the Partnership to consider the best mechanism and criteria for escalating concerns where parents that overtly, or covertly, fail to engage, disengage or demonstrate inconsistent engagement with professionals. Recommendations were made that are being actioned, and while most will not be repeated here, this review is requesting that assurance is sought about the need for early help records to be considered in social work assessments.

57. Recommendations have also been made in the parallel CSPR published in April 2026, which focuses on the sexual abuse in Family 1. They are in respect of recognising the additional vulnerability of children who have moved. Then consideration of the report 'understanding and responding to sibling sexual harm and abuse' by Dr Elly Hanson and the need to make a plan for improved practice, including the need for a strategy meeting to be held when a child is showing concerning sexualised behaviour.

Conclusion and recommendations

[14] Started prior to changes to statutory guidance.

58. This consideration of the practice with the children and their parents, and some of the wider challenges in Shropshire (and nationally) has highlighted that professionals need; ongoing support to identify neglect, particularly emotional neglect; increased curiosity about the significance of predisposing vulnerabilities, parental history and capacity, situational factors, and how they cumulate; and how to make referrals that are effective in summarising concerns over time which focus on the impact on the child and reflect on difficulties in meaningfully engaging the parents. However, this review has found that there is also good practice locally, with a good understanding of the impact of neglect over time and its coexistence with other forms of abuse.

59. Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans.

60. It is expected that the learning from this review, including the single agency learning, will disseminated in a timely way across the multi-agency safeguarding partnership, and that the single agency actions have been completed and embedded. Having considered the learning included in this report, the following recommendations are made with the aim of ensuring that the required improvement actions are achieved:

Recommendation 1

The Partnership to request that a task and finish group is established to complete a piece of work across agencies about how to improve COMPASS referrals, by the inclusion of multi-agency information and concerns, over time, that focus on the impact on the children.

Recommendation 2

Alongside recommendation 1, the Partnership to consider how they can improve the response, across agencies, to concerning information shared by members of the public.

Recommendation 3

The Partnership to consider how to ensure improved contingency and 'exit' planning, with clear instructions about what should happen when a child closes to TEH or CSC[15], so that the family and agencies with continued involvement with a child are clear about expectations.

Recommendation 4

The Partnership to request assurance that any social work assessment now includes robust consideration of the information held in Early Help records.

[15] Any process that is devised should be flexible for use by professionals when a single agency piece of work is concluding.