Executive Summary of Joint Family Reviews (LSCPR and SAR)

Family A and Family B

Shropshire Safeguarding Community Partnership

Reviewers Clare Hyde and Mark Griffin

Contents

Introduction

1. This executive summary is based upon two Family Reviews, commissioned by the Shropshire Safeguarding Community Partnership (SSCP). The reviews examined the experiences of two families who will be known as Family A and Family B. Both reviews were prompted by tragic deaths of the mothers, Jessica (Family A) and Michelle (Family B), under complex circumstances.
2. The reviews aimed to focus on the lived experiences of family members, the effectiveness of multi-agency involvement, and the systemic issues in safeguarding practices. The review spans multiple years and identifies areas for improvement in how agencies engage with and support families facing complex challenges.

Methodology

3. The circumstances in both families fell within the criteria for a Safeguarding Adult Review[1] and a Child Safeguarding Practice Review[2]. The SSCP felt it was important that joint family reviews should be undertaken to enable the children's lived experiences to inform the way agencies support families in Shropshire. This approach was agreed by the Adult's and Children's Statutory Case Review Groups. Rapid Reviews took place in both cases to enable immediate learning.
4. Reports were submitted as part of the Rapid Review process, chronologies and Individual Management Reviews (IMR). Follow-up discussions and communication with agencies.
5. Panel meetings took place between October 2023 and December 2024, but there was no practitioner or learning event.
6. There were significant delays in progressing the Family B review because of the timeliness and quality of information provided by certain agencies and on Panel feedback on draft versions. The reviewers' analysis has been constrained by a lack of factual details, and for some instances, it has been necessary to hypothesise.
7. The Lead Reviewer met with professionals from Harry's school and Children Social Care (CSC) to discuss the case and learning.
8. The lead reviewers Clare Hyde and Mark Griffin are independent of any service or agency in Shropshire.

Understanding the family's experiences

9. All of those taking part in this Joint Review have been keen to ensure that the voices of all the family members were at the heart of the reflection and learning that has taken place.
10. Both families were invited to participate in the reviews. Several attempts were made to contact Jessica's children, Lucy and Olivia, Jessica's sister and father from Family A and Michelle's daughter, Emily from Family B to advise them that a review was taking place and to invite them to contribute in a way that was comfortable and meaningful for them. Unfortunately, no response was received from Family A and Emily was unable to participate in the process. It was not therefore possible to seek their views or to learn more about their experiences.
11. The Lead Reviewer met with James, the father of Harry and Emily, who contributed to the review and also provided information regarding Michelle, Harry and Emily.

[1] https://www.legislation.gov.uk/ukpga/2014/23/section/44

[2] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

12. Harry has limited communication and cognitive development, and it was felt that it was in his best interests that his experience should be captured through his father, school and CSC.

Agency Participation in the Joint Review

13. The following agencies participated in all aspects of this Joint Review:
    a. West Mercia Police
    b. West Midlands Ambulance Service
    c. Children's Social Care
    d. Adult Social Care
    e. Sixth Form College
    f. Early Help Services
    g. School
    h. GP Surgery
    i. Midlands Partnership Foundation Trust
    j. Shropshire Community NHS Health Trust
    k. Shrewsbury & Telford Hospitals Trust
    l. Shropshire Fire & Rescue Service
    m. Robert Jones & Agnes Hunt Orthopaedic Hospital
    n. Action for Children

14. These reviews acknowledge the significant effort and commitment made by all agencies in providing their reports and chronologies; the resource implications of reviews can be significant and the hard work in providing a chronology or report is not under-estimated.

Terms of Reference for the Review

15. Terms of Reference were agreed by the Review Panel, Both reviews were structured under the main headings.

- The lived experience of the family.
- Assessment and consideration of Michelle's/Jessica's parenting capacity and the impact of health conditions.
- Single and multi-agency assessments and working
- Missed opportunities.
- The impact of the Covid-19 pandemic.

16. The review period for Family A was January 2018 to 15th December 2022 and for Family B the period from January 2017 to 10th May 2023. Any relevant background information prior to this time period was also included in the review as considered necessary.

Summary of the cases

Family A

17. Jessica (aged 37 at death) experienced difficult childhood experiences and her first child, Lucy, was born at age 18 and second child, Olivia, at 23. They lived together and her daughters assumed caregiving responsibilities due to Jessica's declining health.
18. Jessica suffered from significant physical health issues with severe psoriatic arthritis, obesity, and depression. Jessica's deteriorating health and self-neglect significantly impacted her

parenting capacity and the home environment. She withdrew from external support systems and faced social isolation. Jessica experienced severe obesity.

19. Jessica did not ask for help and avoided contact with health professionals, school staff and with her father and sister. No one had been inside the home (other than for housing repairs and checks) for a significant period before her death.
20. The daughters experienced significant emotional stress and educational challenges due to their caregiving roles. Olivia was 9 years old, and Lucy was 14 years old at the start of the review period in 2018.
21. The home environment was found to be of concern, with neglect of basic hygiene and safety.
22. As far as agencies are aware neither Jessica nor Lucy had any contact with Lucy's father during the time scale of this review.
23. Olivia had regular contact with her father, who raised concerns to her school that Jessica was not leaving the house or allowing anyone in and felt this was due to her embarrassment about her size.

Family B

24. Michelle (aged 51 at death) was the primary caregiver for her two children, Emily and Harry. Both Michelle and Harry had complex health needs. Michelle had several health concerns including a heart condition and severe anaemia. Michelle experienced severe obesity.
25. Olivia was 12 years old, and Harry was 5 years old at the start of the review period in 2017.
26. Michelle had a another child and experienced significant traumatic events before the review period.
27. Michelle asked for help from agencies and explained that she was struggling to cope because of her disabilities and ill health. Michelle displayed resilience in some areas but struggled with self-care and maintaining a safe home environment for her children. She used some avoidance strategies to prevent professionals from accessing the family home
28. Harry has Down Syndrome and was on a Child in Need plan from 2017-2023 (the length of the review period). Although Harry is mainly non-speaking, he is not non-verbal, he can say some words and can make sounds/noises.
29. Harry was not taken to several health appointments, and his personal hygiene was not always satisfactory.
30. Emily suffered from psychological distress, disclosed abuse and grooming and her education was impacted.
31. Professionals were aware that Emily was a carer to her mother and her brother.
32. CSC placed a significant responsibility on James to support the family and to undertake actions to improve the home conditions. Upon reflection, there is an acknowledgement that there was an overreliance on his ability to impact and deal with complex issues and home conditions, particularly against a decline in his health. He increased support to the family in response to requests from agencies under his own initiative.

Overall

33. Several Child safeguarding referrals were made to children's social care regarding the children from both families. These referrals did not lead to any changes to existing plans for Family B or increased support to either family.
34. The home conditions of both families were of concern. In Review A, Jessica's withdrawal meant that that extent of the living conditions were not known until the time of her death. Agencies were aware of the consistently poor living conditions throughout the review period for Family B.

35. The children were experiencing neglect, and their living conditions were, at times, very poor and unsafe.
36. Both mothers reported being depressed and struggling with their mental health.
37. Obesity was a factor for Jessica and Michelle.

Emerging Themes

38. Agencies failed to effectively capture and understand the lived experience of all family members in both reviews. There was limited engagement with children, and opportunities to address their emotional and developmental needs were missed.
39. Harry was reported to be good at signing, however, his voice was rarely heard outside of school.
40. The children were carers for their mothers from a very young age, and Emily also cared for her brother. They told different professionals about their caring roles. Both reviews highlighted inadequate recognition and support for young carers. Agencies failed to assess how caregiving responsibilities impacted the children's mental health, education, and social development.
41. Both women were significantly incapacitated by their health conditions and their ability and capacity to parent was extremely compromised. There was an over-optimism regarding the parents' abilities to manage care.
42. The extent of the impact of their mothers' incapacity on the children was not understood or explored by professionals.
43. All of the females in both families were suffering with mental health issues. It is not known whether Harry suffered any mental distress.

Linked Key Learning and Recommendations- Family A and Family B

Think Family Approach

44. There were numerous agencies involved with the families however there was no co-ordinated whole family approach in either case. A Think Family Approach would have enabled agencies to formulate a coordinated plan that addressed the known and unknown needs of the family and to identify and manage risks. The use of a multi-disciplinary team approach and where appropriate, multi-agency chronologies would have assisted agencies in understanding the family dynamics and any relevant information, for example parental trauma and health diagnosis, which could have informed plans and decision making.
45. A whole family approach to need and risk would have addressed many of the following learning themes in these two cases.
46. Agencies should promote the use of Think Family Approaches and ensure that practitioners are supported through supervision and training to do so.

The Children's Lived Experiences

47. The daily lived experience of the children in both families was not understood or explored by professionals. They were living in homes which were, at times, unsafe, unhygienic and inappropriate. Their daily needs were not always met by their mothers, and, in the case of Harry, he was not always kept physically safe.
48. For the girls in both families, caring for severely ill and severely obese mothers (and in Family B for a younger sibling with significant needs) meant that their daily lives were difficult, and their mental and physical health and their education were adversely impacted.

49. The voice of non-verbal children, as in Family B, is a recurring learning point highlighted within Shropshire reviews. The child's extreme vulnerability meant it was vital that his daily lived experience within his home was thoroughly explored.
50. Agencies must establish the daily lived experiences of all children within families with complex child/ adult needs particularly when children have caring roles.

The Mothers Lived Experiences

51. Agencies did not explore any historical trauma that the mothers had experienced. In both reviews these experiences will have had a significant impact upon their mental health and wellbeing. There were missed opportunities to explore these, particularly in Michelle's case, therefore there was no understanding of how they affected her parenting and how she engaged with services, given that she was in fear that authorities may have taken her children into care.
52. Daily life for both women was extremely difficult and their serious health conditions and significant weight meant that they could not fully look after their children or manage their home environments.
53. The unhygienic conditions in both homes would have caused them distress and embarrassment so much so that they prevented professionals from visiting. Self-neglect was an issue for both women, and this would have added to their complex feelings about asking for and accepting help.
54. Agencies must take into account the daily lived experiences of parents who have multiple needs and the impact that this has on their parenting.

Engagement

55. There was an inconsistent approach by agencies in engaging and communicating with the families. Agencies did not explore why the families did not respond to communications and the term "non-engagement" was the generally used. Agencies did not differentiate between intentional non-engagement or consider that changes in physical or mental health, daily challenges or anxiety of agency involvement may have prevented them accessing services or attending at appointments. There was an emphasis that this position was due to the family rather than the accessibility of services. There was at times a need for a more creative, determined and proactive approach to engagement.
56. Professionals should work together to maintain engagement particularly at times of increased risk and vulnerability. There should be a recognition between an intentional decision not to engage with services and where services are unable to engage with an individual.
57. There were occasions when the families were signposted or referred to supporting agencies with an expectation that the family, including the children, should take personal responsibility and a presumption that the family had progressed the referral. Most referrals and signposting resulted in minimal support to the families. Agencies should be alert to circumstances where there is a potential that individuals are unable to progress self-referrals and provide the necessary scrutiny and support. A lack of interagency communication around feedback and progression of referrals was also a factor resulting in minimal or no support.
58. Because there was little or no understanding of the reality of life for the children and their mothers the expectation that they would have the capacity and energy to follow through a self-referral was overly optimistic.

59. There should be appropriate feedback and monitoring of referrals by individuals and between agencies to ensure that they are triaged appropriately and acted upon, and where necessary escalate action to ensure appropriate support. Agency use of self-referrals for children should be particularly closely monitored and reviewed.

Visibility.

60. There were numerous occasions and time periods when the families became invisible to agencies. This included declined home visits, failure to respond to communications and non-attendance at appointments. Agencies did not show sufficient determination, curiosity or creativity in establishing contact which would enable an assessment of the family and home conditions.
61. Agencies should consider what arrangements may need to be put in place when there is a reluctance or where services are unable to engage and that this may be an indication that a child's needs are not being met or that risk is increasing. Agencies should be professionally curious when there is a lack of information and communication and offers of support are declined where necessary share this information and escalate concerns.

Young carers.

62. There was information across the system that evidenced that the three girls from both families were carers, but the identification and recognition of this role varied between agencies. There was a failure to respond to their needs as carers and particularly how this impacted upon their mental health and education. There was lack of professional curiosity by some agencies in exploring what their caring responsibilities meant daily and in Emily's case a lack of challenge between agencies in responding to her as a carer.

Neglect

Parental Assessments.

63. There is no evidence that a single agency or collectively, agencies fully understood Michelle and Jessica's capacity to parent and the extent and complexity of challenges that impacted upon this. There was insufficient assessment of pre-existing and ongoing trauma, vulnerabilities and other psychological impacts which affected how each woman was able to care for herself and her two children, each of whom had their own specific needs.
64. In each review the mothers' health conditions and weight impacted upon their ability to adequately care for their children and this should have prompted consideration of a parental assessment leading to identify support needs and risks.
65. The impact of their serious health conditions and self-neglect meant that the parenting of both mothers was compromised, and the home conditions of both families were of concern. The links between self-neglect and neglect of children is well established and was not assessed or explored in either review.
66. Parenting assessments should have considered the whole family, including the fathers, where they were involved.

Information sharing.

67. Agencies identified or were alerted to concerns in respect of both families yet there was a lack of recognition that this information should be shared. Sharing information could have prevented ongoing harm.
68. Sharing the learning from these cases will remind practitioners that sharing (or seeking) information is a vital part of their roles.

Additional learning from Family A review.

69. Schools play an important role in identifying children who are caring for adults and/ or other children within their family. The children were known to be struggling with aspects of their caring roles and support was offered to both girls but not accepted. Olivia's distress manifested itself and was described by her school as 'challenging, defiant behaviour' but there was no understanding (and none was sought) of what her life was like at home. The information provided by Olivia, Jessica and Olivia's father in 2022 to her school coupled with her distress should, at the very least, prompted a consideration of a safeguarding referral to children's social care.
70. Understanding the reasons why some women who share similar issues to Jessica in respect of weight, mobility, pain levels, self-neglect and other health conditions 'do not engage' with or may withdraw from agencies is crucial. In Jessica's case she may well have felt judged by health and other professionals particularly about her weight.
71. The impact on the children of mothers who share these complex and compounding issues and who withdraw from agencies is poorly understood but it is highly likely to be detrimental and neglect should always be considered for the children of such parents.
72. The many serious and compounding issues faced by some people who suffer from psoriatic arthritis may not be generally known however, in this case they directly impacted Jessica and the children's daily lived experiences, and their quality of life was, at times, poor and their safety compromised. Awareness of the impact of this specific autoimmune disease should be increased where appropriate. It is not known how much Jessica (or her children and wider family) understood about her condition and the co-morbidities of obesity and depression. If she had known and understood the complex co-morbidities and their impact on her weight and mental health this may have helped her and those caring for her.
73. There is little known about the impact on children of caring for a mother who was significantly overweight. She had stated to professionals that she 'done this to herself' and 'hidden herself away' and it appears she was, embarrassed. The fact that Jessica withdrew from public view compounded the difficulties experienced by the children and any shame, embarrassment or stigma they may have felt.
74. It is clear from agency records that the emotional and mental impact of Jessica's weight was not understood or explored by professionals. There were certainly no discussions with Jessica recorded by health care professionals.
75. For women who are also mothers and who are significantly obese the learning is as important for their children and the implications for them as carers and should be routinely considered and explored by professionals when they are working with families.
76. The links between self-neglect and neglect of the children resulting from Jessica's compromised capacity to parent the children were not recognised or explored despite school and children's social care knowing that the family were in distress.
77. Difficulties experienced by parents because of underlying factors can link to the neglect of children, for example:
    a. Parents lack the capacity to provide care physically or emotionally.
    b. Parents' own problems are so overwhelming or intractable that they cannot prioritise their children's needs above their own.
    c. Parents lack the knowledge or skills to provide adequate care environments.
    d. Support networks are not in place.
78. In identifying risks and concerns about risk / neglect practitioners might also consider how parents interact with support services, whether they are open to advice and guidance and

able to act upon it, or whether there is an apparent lack of engagement or lack of follow through with referrals. A multi-agency chronology could aid identification of patterns of emerging and historical concerns.

79. Accumulating and compounding risks may be identified by taking a 'whole family' or Think Family approach. Each member of the family was viewed in isolation and responded to accordingly. For example, Olivia's behaviour was seen as 'difficult' and not in the context of her family life. A further example being that the impact on the children of Jessica's withdrawal from all health care and contact with her family and agencies was not considered and therefore risks were not identified.
80. There was limited engagement with the individual family members and no engagement with the whole family which would have facilitated a 'big picture' whole family analysis of risk and need. Such an assessment would have included:
    a. Gathering information from other agencies and other family members
    b. Full parental history including parents' childhood experiences of abuse, loss or trauma.
    c. Consideration of who is part of a child's life and whether they are a protective person.
    d. Routine ongoing analysis of whether risk is decreasing/ increasing/ static particularly paying attention to patterns / capacity and willingness to change.
    e. Evidence and research including lessons from other case reviews.
    f. Routinely sharing the outcome of assessments or seeking information about the outcome of assessments particularly when there are multiple vulnerabilities and risks.

Additional learning from Family B review.

Care and Support planning.

81. Michelle was central to this family, and there was an unreasonable expectation placed upon her to adequately care for her children through the CIN process. Agencies should have recognised that this position was not adequate and that appropriate measures were in place to provide support and increase support.
82. A CIN plan continued over six years without sustained improvements to the conditions within the house or in Harry's health and development. Whilst there were small areas of improvement there was an over-optimism that the plan was effective.
83. Whilst the decision to pursue a support rather than a safeguarding approach for Harry may have been proportionate at the start of the review period, there were a number of further concerns that should have resulted in an escalation of safeguarding procedures.
84. The EHCP process during the review period was ineffective and lacked rigour. Agencies involved in EHCP should work together to contribute effectively and manage this process. The EHCP was an opportunity to regularly assess Harry's needs through a multi-agency approach and involving parents. There was no read-across into the CIN planning process despite agencies being involved in both.
85. There should be a thread running through planning, meetings and visits to ensure that objectives are progressed and monitored.

Assessments.

86. The conditions within the home were a significant factor throughout the review. There was a variance by agencies in what was an acceptable standard. CSC had an overly optimistic belief

that improvements had been made and other agencies accepted this assessment. There was information which indicated that the conditions were at least difficult and at other times unsuitable for occupation. This was even more critical against the complex health conditions of all the family and the potential for harm from infection or other hazards. Agencies should use agreed common thresholds as identified in the continuum of need framework.

Challenge and escalation.

87. There were occasions when agencies appeared to disagree with the decisions and assessment of other agencies, but there was no formal escalation or challenge. There was a lack of challenge from agencies to CSC over the effectiveness of the CIN plan. Michelle did fail to comply in a timely manner with certain actions from CIN meetings or agency requests and there was an acceptance of her intentions without questioning or scrutiny. Agencies should be professionally curious and where necessary challenge routinely and consider escalation processes.

Good Practice

88. Staff at Harry's school are practised in using methods of communication that enable Harry to communicate through the use of Augmentative and Alternative Communication. Staff also provided details of pastoral work with children and highlighted the work with Harry around bereavement. Staff at the school evidenced a good relationship and knowledge of Harry.
89. Shrewsbury and Telford Hospitals Trust (SATH) supported Michelle in moving treatment for Harry to another hospital following a missed appointment when the family were unable to find a car parking space close enough to the hospital given their mobility needs. This change in Harry's care allowed easier access for the family. SATH showed consideration and support for Michelle when Harry had left his sound processor at school and contacted a department to arrange an appointment.
90. The GP put a safety plan in place following the disclosure of self-harm by Emily.
91. Emily's college developed an effective relationship with her in facilitating conversations around her vulnerabilities and subsequently developing safety plans and maintaining regular communication.
92. CSC did provide support to Michelle during a period when Harry was struggling with transitioning from home to school transport.

Recommendations

93. The section acknowledges the recommendations from the Rapid Review process and seeks to expand upon them towards system wide learning.

Family A.

94. It is recommended that Shropshire Safeguarding Community Partnership (SSCP) seek assurance that Shropshire's new practice guidance on self-neglect (which includes a section on mental capacity and executive functioning) is embedded in the system and that it is being used by staff across agencies.
95. Partners should ensure that the links between child neglect and adult self-neglect are highlighted and explored in cases where adult self-neglect is an issue.
96. It is recommended that schools are equipped with training and resources to understand the impact of caring for others on children and how that impact may manifest itself in that child's behaviours. Schools also need an understanding of the practical and emotional support that is available to children who are carers.

97. The SSCP should ensure that the assessment process for young carers is regularly re-promoted and that schools are supported to familiarise themselves with their role in the process.
98. Partners should recognise that reluctance or inability to engage to an extent that renders a family 'invisible' must always be considered as possible neglect or as an indication that the family is at crisis point. In this case the children's mother used strategies to actively withdraw from the sight of agencies and this should trigger professional curiosity and concerns.
99. It is recommended that partners review their service, and support offers to children and young people who 'do not engage' and explore what factors could improve engagement. The use of signposting and self-referral should be included in that review.
100. It is recommended that, if possible, the SSCP facilitate confidential and sensitive conversations with family members including the children of the main parental caregiver on how to better address the impact on children of parental illness and disability including obesity.
101. It is recommended that the SSCP ensure that the link between obesity, depression and psoriatic arthritis should be shared amongst relevant health and support professionals and people diagnosed with the condition and be considered in care and support planning including psychological support.
102. It is recommended that practitioners are reminded through supervision and case management processes to undertake a whole family review where there are several risks/ needs to ensure that these risks and needs are not escalating.
103. **Single agency:** It is recommended that children's services review their response to referrals which take place during school holidays and/ or where there is no response to enquiries made to other agencies.

Family B.

1. Agencies should adopt a consistent, proactive, and creative approach to engagement, understanding the reasons behind non-engagement and addressing barriers to accessing services.
2. Agencies should improve methods and understanding to actively engage with and understand the lived experiences of all family members, including non-verbal children. This must include the lived experience and voice of the child within the home environment and consider the impact of trauma on all family members.
3. The SSCP may wish to develop awareness, understanding and methods when services are unable to engage with an individual.
    a. This should include a reframing of terminology and system wide change in responsibility and ownership of agencies.
    b. Agencies should also be professional curious where communication and contact with vulnerable people is declined or not responded to and work together to use innovative methods to enable engagement.
4. Agencies should ensure that family assessments are comprehensive and consider individual and collective risks and needs, and the abilities of parents to care for children. Assessments should adopt a multi-agency approach and where necessary, multi-agency chronologies to address the needs of all the family and provide a holistic understanding of a family's situation over time.
5. The SSCP should seek assurance that agencies are effectively:
    a. identifying cumulative trends and significant concerns across multiple incidents rather than isolated events

b. incorporating standardised levels of thresholds of risk.

6. Agencies should promote interagency awareness and responsiveness to the presence and needs of young carers to ensure that they are identified, assessed and supported.
7. The SSCP should seek assurance that agencies work together to:
    a. effectively share information to identify risk and facilitate informed decision-making.
    b. maximise opportunities to engage with and monitor vulnerable people who have become hidden.
8. Based upon the use of signposting and referrals in this case, the SSCP should review referral processes to ensure they are user-friendly, more accessible and less bureaucratic for vulnerable people. Referral processes should include timely feedback and monitoring between agencies. Agencies should be alert to appropriateness of signposting and where necessary, provide support and scrutiny for signposting and self- referrals.
9. The SSCP should seek assurance that care and support planning:
    a. monitor the progress of families and are effective in achieving outcomes.
    b. are timely, dynamic and deal with any escalation in risk.
    c. are effectively communicated with and involve all agencies who are working with families.
    d. promote the use of professional challenge and escalation between agencies and where necessary with parents.

Conclusion

104. The reviews were conducted with the Independent Authors' acknowledgement that supporting families in circumstances such as those experienced by Jessica and Michelle and their children is challenging. Whilst comments are made about practice and approaches, the Reviews are focused on a reflective practice approach and recognise the benefit of hindsight. The intention is to support agencies in Shropshire to develop and improve how they work to minimise risk and harm when working with families who share similar challenges.
105. The children were not sufficiently recognised as carers and their daily lived experience was not explored by professionals. When the children did share details of what their lives were like, this did not trigger safeguarding concerns but led to repeated signposting or referrals to other services which did not address the key issues.
106. The reviews have considered the individual aspects of each family member as well as the linked impact between family members in order to understand the broader perspective as a family. For each family member, this included either physical or emotional health and often both. Complex health needs are demanding and require additional medical, psychological and social support. Parents and professionals face a unique set of challenges and needs, especially in families where the child has a lifelong condition, and the review acknowledges the improvements in Harry's physical health.
107. In both reviews, the impact of serious health conditions, morbid obesity, immobility and self-neglect meant that the parenting of both mothers was compromised, and the home conditions of both families were of concern. The links between self-neglect and neglect of children are well established and were not considered or explored in either case.
108. Learning from this review reflects learning in the analysis of other safeguarding reviews nationally and findings from independent inspections undertaken in Shropshire.
109. It is hoped that the lessons learned in these reviews can guide future interventions to better support families with complex needs, ensuring their voices and lived experiences are central to safeguarding practices.

Glossary

ASC	Adult social Care
Bee U	Bee U (Emotional health and wellbeing service, previously CAHMS)
CSC	Children Social Care
CIN	Child in Need
EAS	Education Access Service
EH	Early Help
EHCP	Educational Health and Care Plan
GP	General Practitioner
IMR	Information Management Report
MCA	Mental Capacity Act
MHA	Metal Heath Act
MH services	NHS Trust - Mental Health Services
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
SAR	Safeguarding Adult Review
SATH	Shrewsbury & Telford Hospitals Trust
SCHT	Shropshire Community Heath Trust
SSCP	Shropshire Safeguarding Community Partnership