Oldham Safeguarding Children Partnership

Local Child Safeguarding Practice Review

'Abdur'

January 2023

Independent Reviewer – Anna Berry

1) Introduction and summary of the learning from this review

1.1. This Local Child Safeguarding Practice Review (CSPR) was undertaken in order to find learning through considering practice and systems related to a child who required hospitalisation due to significant malnourishment and vitamin deficiency. The child will be referred to as Abdur[1].

1.2. At the time of the incident, Abdur was a child looked after on a full care order and placed at home with his family.

1.3. There is a significant history of maternal substance misuse and neglect prior to Abdur's birth with older children removed from Mothers care previously, periods of time when Abdur was subject of a child protection plan leading to the two-year period prior to the incident when he was on a full care order.

2) Key lines of enquiry and learning

2.1. The broad key lines of enquiry considered throughout this review are as follows:

- The child's voice
- Effectiveness of the care plan
- Challenges to court processes

2.2. Broadly learning was identified in the following areas by considering this case:

- Awareness of a parent's history and the impact of substance misuse
- Consideration of fathers and the role of males within the home
- Avoiding over-optimism and losing focus on the child
- Joint risk formulation and effectiveness of the care plan
- Shared approaches to neglect
- Utilising the escalation processes

3) Process

3.1. Oldham safeguarding Children Partnership (OSCP) received a referral for consideration of a child safeguarding practice review in February 2022. Partners asked all agencies known to have had an involvement with the family to provide information about their involvement for the panel to consider.

3.2. Following the rapid review processes and consultation with the Child Safeguarding Practice Review (CSPR) Panel, the OSCP identified that lessons could be learnt regarding the way that agencies work together.

3.3. A rapid review is undertaken to ascertain whether a Local Child Safeguarding Practice Review is appropriate, or whether the case may raise issues which are complex or of national importance and if a national review may be appropriate. The decision is then made along with the national Child Safeguarding Practice Review Panel.

3.4. The CSPR was conducted in accordance with the requirements set out in:

- The Children Act 2004[2] (as amended by the Children and Social Work Act 2017[3])

[1] The name Abdur was chosen by the Partnership to provide anonymity for the child and family.

[2] http://www.legislation.gov.uk/ukpga/2004/31/contents

[3] www.legislation.gov.uk/ukpga/2017/16/contents/enacted

- Working Together 2018[4]
- Local Multi-Agency Children's Safeguarding Policy and Procedures

3.5. An independent lead reviewer was commissioned to work with a panel of local safeguarding professionals from the key agencies. The lead reviewer facilitated a practitioner event analysed agency information and reports and produced this report. The lead reviewer and the panel collaborated on identifying the learning and writing recommendations from this CSPR.

3.6. The OSCP provided the reviewer with a chronology of information relating to the case. Additionally progress against various initiatives, pathways and integrated ways of working were provided throughout the review process.

3.7. The reviewer endeavoured to speak to Adbur and his family to aid the review and provide insight from their perspective. However, despite multiple attempts via the OSCP team, there has not been a response from the family.

4) The child being considered

4.1. Abdur initially lived within a Mother and Baby placement due to maternal substance use and likelihood of neglect, oversight was subsequently stepped down to universal services. Older children had been permanently removed and placed with extended family members by another Authority, this was due to ongoing drug dependency and impact on parenting.

4.2. Abdur's biological Father was not part of his life at any time and very little is known about him. His identity is known however, the relationship between mother and biological father ended before Abdur was born.

4.3. Abdur and Mother moved to Oldham and services started to have concerns about maternal drug use and neglect. Abdur was subject to a child protection plan when there was an application for a care order. A younger half sibling was born at this time (initially placed with a foster carer), and both were placed at home under full care orders. There was also another half-sibling subsequently born.

4.4. Abdur remains under a full care order at home with his mother, stepfather and two younger half siblings.

4.5. The Rapid Review found that there was a long-standing issue with maternal drug use, neglect concerns in the context of continuing and escalating concerns about Abdur's health and wellbeing and a full care order with the placement at home over a long period of time. This manifested in a number of ways, all of which provide a helpful context to consider learning from this incident.

5) Family involvement

5.1. The OSCP Business Unit have contacted the family to advise them of the CSPR process and to seek the contribution of parents and Abdur, however despite several attempts, there has not to date been a response from the family to the request.

5.2. Therefore, whilst it was the ambition and the plan for this review to thoroughly explore a range of issues with Abdur and his family members, unfortunately it has not been possible to facilitate this within the timescale of this review. As a result, there is a missing context to this review.

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

5.3. By way of mitigation there have been discussions with the relevant practitioners and in particular the insight from the school and the allocated Social Worker has gone some way to provide insight into the perspectives of Abdur and his family.

6) Summary of timeline crucial to learning

Episode	Key Points
Earlier history (from 2009)	Significant previous history- older siblings all permanently removed Continued maternal drug use (heroin and crack cocaine) Mother and baby placement at birth Moved to Oldham Allegation made by Abdur of physical abuse Child protection plan PLO
Substance use	Long term history of maternal drug use – on methadone but regularly using crack cocaine in addition Sporadic engagement with Turning Point which is the Oldham Drug and alcohol addiction help provider
Birth	Identity of biological father known but never involved Living arrangements – resident in Mother and Baby unit Stepped down to universal services soon after
Oldham	Moved to Oldham Subject to a child protection plan Public Law Outline (PLO) Application for care order Court concluded that grounds for removal was not evidenced, care order whilst placed at home Half sibling born with expert maternal psychiatric assessment informed the court that it was unlikely that mother would remain abstinent Care orders agreed with working agreement, regular testing and to return to court of conditions breached 2nd Half sibling born Concerns about dietary issues continued Concerns about dental hygiene, failing to attend appointments Concerns about ophthalmology, failing to attend appointments Concerns about School attendance Mother missed multiple appointments with Drug service Mother testing positive for crack cocaine Allegation of physical abuse made by Abdur again Abdur admitted to hospital with malnourishment and vitamin deficiencies
Multi-agency opportunities in 2021 (12 month before incident)	10 Team around Child (TAC) meetings
Significant events	Child Looked After (CLA) Health assessment Child Looked After Review, decision to seek permission to discharge care order Legal Planning Meeting (LPM), permission given to seek discharge of care orders on basis that “children’s needs were being met to a good

	standard and the family no longer needs children's social care (CSC) involvement". Hair strand drug test came back positive for crack cocaine, this demonstrated use of crack cocaine in addition to methadone plan for a 6-month period. January- attended Emergency Department (ED) due to right knee pain after fall, concluded ligament damage and crutches provided Through January/ Early February school raised multiple concerns on 38 occasions to School Health Team and Social Worker due to; significant concerns about Abdur's health, presentation, emotional wellbeing, ongoing leg/weight bearing issues, looking tired, drained and unkempt, school attendance and Mother and Step-Fathers reluctance to acknowledge that Abdur was distressed and in pain with his leg(s). They were also significantly concerned about rapid weight loss over the last couple of months and questioned whether there was a deficiency. There were ongoing issues with the contents of the lunchbox which consisted of dry bread (mouldy on one occasion) and a bottle of water. School raised safeguarding concern because Abdur has alleged that mother "stomped" on one leg because they couldn't walk properly, the allocated Social Worker did conduct a visit and spoke to both Abdur and mother. Abdur gave a different account and mum denied the incident. A S47 medical examination was not facilitated January ED attendance due to ongoing leg pain, wider context of health concerns not considered, child noted to be looked after February GP attendance due to leg pain, missed opportunity to explore wider context of health concerns February ED attendance due to ongoing leg pain, wider context of health concerns not considered, child not noted to be looked after February seen in clinic for urgent Paediatric assessment, facilitated by the Child Looked After (CLA) health team after the School Nurse raised health concerns with the Social Worker. Admitted to RO Hospital and subsequently transferred to the Royal Manchester Children's Hospital. Found to have low vitamin D, to be anaemic and to have a severe vitamin C deficiency (scurvy). Dental review, significant dental issues noted, 4 teeth extractions required

7) Positive Practice identified:

7.1. The review notes a positive and "think family" practice model by Turning Point in terms of their contributions to muti-agency meetings, persistence in engaging with Mother, multiple communications and a robust understanding of the whole family dynamics. There is a good standard of documentation and their records evidence emails, communication and attendance at TAC meetings to share their involvement.

7.2. The school input is vast and notable, seeking Abdur's voice and recognising concerns promptly. There is evidence of good communication with other agencies as concerns arose.

8) Overarching Learning

Areas of learning:
Placements at home and effectiveness of the care plan
Professional challenge/ joint management of risk, professional curiosity and disguised compliance
Escalation
Role of the Father/ male
Childs lived experience

9) Placements at home and effectiveness of the care plan:

9.1. Abdur became a Child Looked After when Oldham Local Authority made an application for a Section 31 care order[5]. The plan was for Abdur to be placed in foster care due to mothers long term drug use, and concerns regarding neglect of his safety and basic care needs. This followed a period of time where Abdur was subject to a Child Protection Plan under the category of neglect and had progressed to Public Law Outline (PLO) and an application was made to the court for a care order.

9.2. There were ongoing concern that mother was not being open and honest with professionals about drug use, engagement with drug services was poor at that time. She was also pregnant with Abdur's half sibling.

9.3. A Children's Guardian was appointed who undertook visits to the home observing positive care from both mother and stepfather. The court concluded that ground for removal was not evidenced, and care orders were agreed with a working agreement to include regular drug testing and to return to the court if conditions were breached.

9.4. During this time Abdur's sibling was born who had neonatal abstinence syndrome[6], They were removed to a foster carer for 5 months before being returned home under the same conditions of the working agreement.

9.5. A psychiatric assessment was undertaken during the court processes which concluded that it was unlikely that Mother would remain abstinent from her drug use. Mother was engaging with Turning Point and receiving methadone at this time.

9.6. From a legal perspective, a care order can be made with the plan for the child to remain at home such as in Abdur's case.

9.7. This leads to the question of effectiveness of the care plan and application of the requirements of the working agreement which raises two questions:

1) **Given that the LA had applied to the court for a care order to remove Abdur to a foster placement, did they consider appealing the court decision and if not, how did they resolve their difference of opinion?**

[5] Children Act 1989 (legislation.gov.uk)

[6] NAS is a constellation of symptoms occurring in a baby as a result of withdrawal from physically addictive substances taken by the mother

2) In view of the requirements of the working agreement, was the subsequent care plan effective and how well embedded were all agency views in the care plan in order to apply the right measures of improvement?

9.8. After a period of involvement, the Children's Guardian notes that the LA was no longer seeking removal and supported their plan for Abdur to remain at home with parents under a care order with a working agreement in place to include regular drug testing. It was required that the LA return the case to court of the working agreement was breached.

9.9. Although the application was initially to seek removal of Abdur (and sibling), the reviewer found no evidence that the Local Authority subsequently disagreed with the court decision and supported the plan to remain at home. The plan to remain at home with a working agreement could have worked with an effective care plan in place.

9.10. Regarding the care plan, agencies should have noted that concerns started to increase throughout 2021. There is no evidence of consideration of whether the working agreement had been breached and if so, returning the matter to the court.

9.11. The working agreement specified that regular drug testing was essential, however the risks and signs of deterioration could not solely depend on that indicator and measurement of safety. There was far more information that could have been used to understand what was happening in the household and the cumulative impact it was having on Abdur's health and wellbeing.

9.12. When considering the effectiveness of the care plan it raises the question of IRO oversight, however the reviewer poses the difficulty that the plan was not robust enough to start with and the measures weren't fully reflective of the experience of the child, therefore it would be difficult for the IRO to hold the plan to account if it was not focused correctly in the first instance.

9.13. The reviewer has explored the issue of the care plan and concludes that it was not well enough informed by all agencies and therefore there was never a time that all agencies accurately understood what was happening for Abdur, thus the care plan was not of sufficient quality to be effective.

9.14. In Abdur's case the care plan did not fully reflect Abdur's needs because there was not a point in time that all agencies collectively understood his needs.

9.15. The plan was not an effective reflection of the concerns held by all agencies and was too preoccupied with the drug tests thus missing crucial clues that Abdur's health was deteriorating, there were other obvious signs of neglect and in fact Mother was not fully engaging with drug services and was not being truthful about her drug use.

9.16. Neglect was worsening, there were many indicators known by agencies, missing essential appointments (dental and ophthalmology), poor school attendance, concerns about nutritional input, lunchbox content (bread and water) are all indicators of neglect and should be viewed very seriously in the context of a child on a care order at home. This is in addition to the reluctance of mother to engage meaningfully with Turning Point. These issues were as a result of neglect was not robustly pursued and there was little practical support offered to help the family manage these, for example specialist dietary input or follow up of missed health appointments.

9.17. During the course of the TAC meetings and LAC review processes, the degree to which all this information was pulled together into a coherent multi-agency plan is unclear with evidence that some services had multiple concerns and worked hard with Abdur individually, but they didn't always align with each other in terms of a common understanding of risk and development of a robust care plan.

Summary and Learning:

- The review finds that if the care plan had been more effectively jointly developed with robust measures of success, the multi-agency team around Abdur may have:

  a) Compiled a more effective care plan to consider what actions, services or support may make a difference to Abdur;

  OR

  b) informed a decision to return the matter to the court before Abdur became ill. This would have been supported with the evidence of the positive hair strand test in December 2021.

- A care plan can only be effectively implemented if it reflects all agency information.

- If there is a working agreement, the care plan should be very clear about the "threshold" that care at home is no longer safe.

10) Joint management of risk, professional curiosity and disguised compliance:

10.1. For Abdur's mother, there was good awareness across agencies of her history of vulnerability over a number of years, long term drug use, likelihood of relapse and the impact on her parenting.

10.2. Neglect, as in this case impacts directly on children's lives every day.

10.3. It was known to services that it was unlikely that mother would remain abstinent, and it was essential to note and take seriously the signs that she had relapsed and to consider this in the context of the impact on Abdur and his siblings.

10.4. Turning Point recognised some of the "red flags" that led them to ask Mother directly if she had relapsed which she denied, it was subsequently confirmed by hair strand test that she had relapsed and there was a missed opportunity for agencies to consider the likelihood of the impact of this on Abdur. It is not evident in the TAC meeting that this was discussed, and a general consensus reached.

10.5. When Abdur was subject to a child protection plan it was known that Mother was not always truthful about her drug use, and this was the reason that he became a child looked after. It stands to reason that professionals should be on high alert of the likelihood and signs when this may be happening.

10.6. Analysis of the chronological involvement with services demonstrates that the opportunities for professionals to come together were not missed, there were very regular TAC meetings, timely health assessments, LAC reviews and regular home visits by Children's Social Care, and on occasion Turning Point and School professionals. There was not an absence of contact with the family and each other.

10.7. This contrast can be demonstrated as follows;

a) The Multiagency meetings (TAC and LAC review) generally demonstrate a consensus outcome view that the family were cooperating with the requirements of the working agreement and Abdur was generally well.

b) In contrast the single agency chronologies demonstrate increasing concerns to include:

- Mother missing multiple Turning Point appointments/contacts, including urine drug screen testing.
- Parents did not opt into his school place during the COVID lockdown and thus the daily oversight of wellbeing at school was missed.
- On return to school there were ongoing concern about school attendance
- There were continued concerns about dietary intake and lunch box contents.
- Absent from school and sent home from school on at least two occasions with toothache, there was no assurance parents were accessing the dental care required.
- Not wearing glasses and had missed essential ophthalmology appointments
- Abdur made an allegation of physical abuse- "stomped on" by his Mother
- After a fall and knee injury, Mother and Stepfather were reluctant to believe that Abdur was in pain (this was in fact a symptom of severe vitamin C deficiency).
- There was rapid weight loss highlighted on multiple occasions by school.
- Abdur was distressed, emotional and complaining of painful legs and struggling to walk
- Abdur has started to look unkempt with dirty and torn clothes
- Abdur looked tired and school were concerned about rapid weight loss and a possible deficiency

10.8. It is important to highlight that there was low representation of attendance from the 0-19 Child Health Service, in fact the School Health Advisor was only present at 1 out of 10 TAC meetings. It can be seen that the Health Visitor (for the younger siblings) was present but there is no evidence that the absence of the lead health professional for Abdur was escalated and addressed.

10.9. Bridgewater Community NHS Foundation Trust (BCNFT) state that it is not uncommon for a School Health Advisor to be absent from a TAC when there are no unmet health needs. However, in Abdur's case there were unmet health needs, namely facilitation of and follow-up of dental and ophthalmology appointments, and ongoing dietary concerns that likely needed some specialist input. The reviewer concludes that the impact of these issues on Abdur was therefore not sufficiently reflected in the care plan.

10.10. In addition, contrary to the increasing concerns about Adbur's overall wellbeing highlighted by school, the "Child Looked After" annual health assessment notes very few issues. It should be noted that this assessment was done 6 months prior to becoming unwell and the weight/height were acceptable at that time. However, dietary intake was poor and there were significant gaps in ophthalmology and dental input but no plan made to address this. The assessment appeared to be based on what was seen and said on the day, rather than in the context of the full multi-agency picture, this may have bene due to the absence of his Lead Health Professional at key multi-agency meetings.

10.11. Agencies did not appear to interpret their own observations with a joint risk approach. The individual views perception from some agencies was that the situation continued to deteriorate from at least mid-2021 and there was not improvement seen. The review finds that there were missed opportunities for the care plan and the conditions of the working agreement to have been considered more robustly together, further compounded by the absence of relevant health professionals during this time. There was ample and regular opportunity to do so through multiple Team around Child (TAC) meeting.

10.12. At the LAC Review a decision was made that permission would be sought to discharge the care order and this was unchallenged by other agencies despite increasing evidence that things were deteriorating.

10.13. OSCP has developed a “Neglect Strategy and toolkit” which is an approach to neglect that captures strengths and resources. One of the guiding principles of this strategy is the child’s lived experience. The care plan in this case was agreed in together with the working agreement to reduce the risk of the dangers/harms identified but supporting the children to remain at home with Mother and Abdur’s Stepfather. It is important that there are clear bottom lines however, with robust testing of the plan which includes the skilful use of decision making and a transparent focus on risk. This should ensure that the multiagency team around the child considers evidence and reviews progress. That bottom line of what was acceptable and what was risky was not defined well enough by the multi-agency team.

Summary and Learning:

- The ways in which professionals reacted and shared their collective concerns did not lead to substantial positive action for the children
- There was not an absence of multi-agency meetings, and information was shared frequently and readily across agencies, however despite this, the multi-agency consensus was not reflective of the actual reality of what was happening for Abdur.
- Despite regular multi-agency meetings, there was not always consistent representation from agencies thus continued oversight was challenging.
- There were significant indicators of neglect in terms of Abdur’s access to health services and deteriorating health and emotional wellbeing which were not taken seriously enough.
- There was little assurance that the care plan (other than drug testing) articulated how neglect assessment tools were used to help identify escalating risks.
- Strengths based models of assessment and planning for children need to have a clear focus on risk and ensure that all available information is considered when deciding on the safety plan for a child.
- Timely application of statutory safeguarding and pre-legal/ legal threshold procedures need to be considered by professionals at key points in a case.
- There remains a need to ensure that all agencies are working collectively and curiously to apply effective and meaningful care plans that reflect all of a child’s needs.

11) Role of the male

11.1. Hidden men and invisible fathers are terms frequently used in response to the idea that male caregivers in a child’s life can sometimes be excluded from services or overlooked by professionals working with children and their families.

11.2. In Abdur’s case, biological father’s identity was known but he was never involved in his life. However, stepfather was very visible throughout the timeframe of this review. He was viewed as a “protective factor” and there is no evidence available to this review to suggest that he posed any risk, on the contrary he was a point of contact for services and often took Abdur to health appointments post incident. He was also viewed as a positive influence in terms of Mothers drug use which she also kept secret from him latterly.

11.3. It should be noted that in his role as stepfather, he does not have parental responsibility and there is no evidence that this was recognised in terms of his suitability to attend health appointments. There was a reliance that he would convey health information and plans to mother, although there is evidence that he did not often do this.

11.4. Despite Stepfather being very visible to services and with no known risk factors, there is still not a robust understanding of the functioning of the family in terms of roles. Another consideration may be the relationship between Abdur and Stepfather, although the Children’s Guardian notes a positive relationship there is little evidence of the dynamics between members of the household. These are both factors that could have been better considered and incorporated in the care plan.

11.5. In conclusion the Stepfather was a visible and significant part of Abdur's life and his daily care and there is no evidence to suggest any risk from him towards Abdur, however despite this there is little evidence that agencies worked with him in a significant way considering there was an assumption that he was a protective factor. Exploration of this may have provided good insight into Abdur's experiences and may have yielded information to inform the right support for stepfather and family.

Summary and Learning:

- The review notes that there was opportunity to engage with Abdur's stepfather in a more meaningful way and there is learning around how fathers/ males are considered within all aspects of safeguarding practice.
- Fathers/ males should not be missed or be an after-thought – at every meeting they should be considered as a potential risk or protective factor to a child, in particular when he is perceived as a protective factor- professional curiosity should be applied to test out this theory. All professionals have a responsibility to engage with fathers or question any apparent lack of engagement from other agencies.

12) Child's lived experience

12.1. The incident leading to this review has prompted exploration of how Abdur's voice was heard and whether services fully understood day-to-day life experiences. Abdur had been a child looked after at home for two years and prior to that subject to a child protection plan. As far as services are aware, mother had used crack cocaine and heroin at different times throughout their entire life, and they had statutory safeguarding input for a large part of his life. There is an absolute need to understand his experience and hear voice to inform future plans and access the right services.

12.2. The reviewer has attempted to get a sense of Abdur's personality and experiences through practitioners who knew them well.

12.3. Abdur was at an age where they could articulate what life was like for them and siblings but on the occasions when they did, there is little evidence that it informed planning.

12.4. Professionals allocated to the case from children's social care through the time frame did change on three occasions and it may be that the opportunity to build relationships with children's social workers was more limited than it could have been. To note however, the IRO was consistent throughout the timeframe of this review.

12.5. Abdur is described as a very likable and delightful child who is generally very engaging and extremely chatty. They enjoy playing Minecraft and builds good relationships with professionals. His school report that he often talked warmly and positively about mother, stepfather and siblings and this view was supported by the reports of the Children's guardian (albeit earlier than the timeframe of this review), his current Social Worker and Turning Point professionals.

12.6. School had a good perception of Abdur's mood and presentation and observed a distinct difference in demeanour and behaviour in the months leading to being hospitalised. This distinct change seemed to be from mid-2021 onwards, interestingly it was after this time that the LAC review occurred, and the plan forward was to seek permission for discharge of a care order.

12.7. How Abdur described home life was often at odds with the multi-agency perceptions, they said that neighbours would shout and throw bricks through the window which made him scared and in conversation said that they would look after younger brothers while mum

was still in bed. The extent to which this was further explored is not clear. Subsequent conversations that took place with mother would generally dismiss any comments or offer alternative explanations. Therefore, Abdur's voice and opinion was often stemmed at that point instead of providing insight into lived experience.

12.8. Abdur has been subjected to adverse childhood experiences in their short life, they have experienced a traumatic period of illness and the impact of this on longer-term wellbeing is unlikely to be fully known. Abdur is on a care order because of maternal drug use and neglect yet when trying to tell professionals what they were experiencing, how they were feeling or events that had happened, there was little weight given to views and they were overshadowed by what mother reported.

12.9. In the month leading up to being hospitalised Abdur was presenting to school looking unwell, tired, with a poor pallor and described as emotional. Abdur had a fall on the way to school resulting in a damaged ligament and requiring crutches however the pain described to parents and to school far exceeded the injury. The pain was due to Vitamin C deficiency, and Abdur could hardly stand up. They were extremely distressed because parents would not believe him, and they did express this view to school.

12.10. On one occasion when Abdur had been to a GP appointment and was made to walk, Abdur flagged down a car and got into the car with a stranger to get back to school- this not only raises multiple concerns about perception of "stranger danger" but indicates the extreme pain Abdur was in and couldn't face walking back to school. The reviewer has considered how traumatic these weeks were for Abdur; in pain and not believed, they couldn't stand or walk properly and must have been frightened. This was a particularly traumatic time.

12.11. Considering Abdur's lived experience there are other ways this can be explored. Taking the issue of nutritional intake, this was a long-standing concern and generally the perception was that he was a "fussy eater". However, this cumulatively culminated in Abdur becoming extremely unwell therefore it is essential to explore the reasons for this and how it could have been approached differently.

12.12. It was known for some time that Abdur was suffering from dental pain because they had absences from school due to that reason, this was included in his care plan. Abdur had at least 4 dental extractions. Additionally, gum pain is a symptom of Vitamin C deficiency, and this may have also contributed to pain levels. The reviewer has considered what it would be like to have constant and severe toothache and for this to be left untreated. The pain would be excruciating and something Abdur had to learn to live with, this would certainly contribute to the ability to eat. However, this was left unaddressed, and Abdur endured this pain for a prolonged period of time. There were several failed dental appointments where parents cited different reasons and Abdur was discharged. The reasons can be noted but it didn't change the fact that Abdur was left in significant pain. This is an indicator of neglect and could and should have been addressed via the care plan.

12.13. Abdur required glasses in school to enable them to see properly and learn optimally. For a long period of time, Abdur was attending school without them despite multiple attempts via school to parents to address this. There were multiple reasons given by parents, but it didn't change the fact that Abdur couldn't see optimally for a period of time. This is an indicator of neglect and could and should have been addressed via the care plan.

12.14. This raises the question of policies within agencies around discharging people when they persistently "do not attend" or fail to engage should be considered to ensure they are considered from a safeguarding perspective. Within this case Abdur was discharged from dental and ophthalmology services. Was this decision making this applied in the context of safeguarding with a child looked after?

12.15. Abdur enjoyed attending school, being a vocal and enthusiastic member of the class and well liked. Parents did not take up his school place during the COVID-19 lockdown period, this was reported to be due to parents fear of the virus, which is understandable. The extent to which this was considered via his care plan is not evidenced, nor is Abdur's views or opinions in terms of what they may have wanted at that time. Abdur did receive twice weekly visits from school during this time which was consistent and good practice.

12.16. Outside of the lockdown period, school attendance was poor with various reasons given, usually health related. Again, this is an indicator of neglect and should have been addressed via the care plan.

12.17. The 'child's voice' does not only refer to what children say directly, but to many other aspects of their presentation. The lived experience of the child includes what a child sees, hears, thinks and experiences on a daily basis, all of which can impact on their personal development and welfare whether that be physically or emotionally. The other aspects of Abdur's voice are described above in terms of his overall presentation.

12.18. The review concludes that although Abdur was using their own voice to express what was happening, and there were other indicators to demonstrate that they were suffering neglect, overall voice did not come through strongly in the care plan and in the multi-agency work that surrounded it. It did not make much difference in terms of approaches taken.

Summary and Learning:

- The review has sought to consider what life was like for Abdur in the year before he became unwell and required hospitalisation and has not found evidence that this was explored to the extent that it informed effective case management. The review has explored the research and expected practice and has identified that there is learning from Abdur case that can be applied in Oldham.
- The care plan and management of the case focused far too much on the status of mother's drug use and less on his lived experience.
- The care plan overlooked the indicators and implications for Abdur; thus agencies did not interpret their findings collectively well enough to protect Abdur.

13) Impact of COVID-19

13.1. There was no evidence to suggest that the Covid-19 pandemic directly caused or contributed to the incident although it can be acknowledged that Abdur did miss out on face-to-face education during the lockdown(s). There was opportunity to explore the decision to keep him at home in line with his own wishes and feelings and that of the Local Authority.

13.2. Abdur and his family continued to receive face to face visits and contacts during this period time.

13.3. The review has not found there to be any learning points directly related to the plan as a result of COVID-19

14) Progress against areas of learning:

14.1. Throughout the process of this review progress has been identified against some of the areas of learning and recommendations.

14.2. **Escalation:** OSCP does have an “escalation policy” to supplement the GM Resolving Professional Disagreements Policy. This policy is scheduled for review in January 2023 due to learning from other cases.

14.3. **Proactive and preventative approaches to Neglect**- the review notes the development of a Neglect Strategy and Toolkit. The OSCP annual report 2021/2022 noted limited assurance of the effectiveness and awareness of this strategy and therefore it will be reviewed in 2023 to consider effectiveness. In recognition of this OSCP has commissioned the use of the Graded Care Profile 2 tool and this is currently being embedded into practice with the support of the NSPCC.

14.4. **Training and workforce development:** Work has commenced to promote awareness of Neglect in Oldham in line with the Neglect Strategy.

14.5. **Child Voice:** In response to learning from a previous review, the OSCP conducted a multi-agency audit in 2020 to consider the “child lived experience”. This evidenced some improvements, but overall assurance was limited. Therefore, there were recommendations and actions taken. This included the launch of an annual “Youth Summit”. Further work is planned in 2023/2024 to capture the impact of the actions taken from this audit.

14.6. **The Role of the Male:** The OSCP has commissioned specific training on the “unseen male” which aligns with some of the learning from this review.

15) Conclusion:

15.1. The period of illness suffered by Abdur who is a 10-year-old boy subject to a care order was significant and potentially life threatening had he not received treatment at the time he did. The reason for hospitalisation was malnourishment and vitamin D and severe vitamin C (scurvy) deficiency, all of which are preventable. These issues went alongside a deteriorating picture of school attendance, long term poor nutritional intake, lack of dental and ophthalmology care all of which are indicators of neglect. Abdur was already subject to a care order because of neglect.

15.2. The question posed at the first panel meeting of this SCPR was *“how does a child who is subject to a care order and all the associated monitoring and support end up in hospital malnourished and with severe vitamin deficiency”?* This is the question that has guided the review process.

15.3. The review concludes that the signs were there, Abdur was telling school professionals for some time that he felt unwell and unhappy. Unlike other case examples across the country, there were regular multi-agency opportunities in the 12 months before this incident that could and should have facilitated all agency concerns to be carefully explored and risk formulation to be applied jointly to understand what was happening.

15.4. The absence of correct health input throughout this process was notable and may have contributed to a lack of emphasis or understanding of the seriousness of health concerns such as poor dental care, lack of ophthalmology monitoring and the impact of poor diet which was a well-documented concern. As a result of this, his annual “Child Looked After” health assessment completed during the timeframe of this review yielded little concern and did not alert the wider multi-agency team to the possible consequences.

15.5. With reference to the above point the reviewer notes the importance of accurate interpretation of “health” related issues so that their impact is fully understood by the multi-agency team, particularly when they may be indicators of neglect.

15.6. The review also notes that following Abdur's period of hospitalisation there were challenges within the health economy in terms of coordinating a joint medical overview (across the different providers and disciplines). It is essential for robust care planning that decisions are informed by a well communicated outcome report that is able to be understood by a non-medical professional.

15.7. The care plan was too preoccupied with the measure of success being mothers continued abstinence from drug intake, albeit a very important indicator but the wider picture did not give enough weight to the other indicators or Abdur's own voice and experience.

15.8. Abdur's voice came through strongly at school, he was telling them in different ways that he was unhappy, and they were particularly concerned about the neglect of his health needs and his general health and presentation. They went over and above their role, attending the home to bring him to school, working with him to offer healthy and appealing food choices and providing a safe environment for him. It can be seen that in the latter three months of the timeframe they made significant efforts to share their concerns with health and social care agencies, but the oversight gained little impetus until Abdur was dangerously unwell, this raises the question of escalation and how well it is applied in Oldham.

15.9. There is learning within this case about the important of all agencies contributing to the care plan and applying their knowledge, experience and expertise together to formulate a good understanding of risk, underpinned by the child's own voice. There is also learning about the use of escalation processes when one or more agencies feel that their assessment is at odds with others. The review also highlighted learning about the role of the male and understanding how their value can be best harnessed and supported.

15.10. There has been a high degree of cooperation and engagement from agencies in Oldham with the review, the reviewer has observed good reflection on this case and a recognition of the areas of learning.

15.11. The purpose of providing recommendations is to ensure that the Partnership are confident that any areas identified as being of particular concern are addressed.

15.12. There are eight recommendations made to the Partnership where assurance is required, or developments indicated.

16) Recommendations

Recommendation 1: The OSCP to make promoting the involvement of males a key focus of its work.

Recommendation 2: The OSCP to seek assurance from the commissioners of 0-19 services that delivery models allow for appropriate oversight of children with particular reference to those children known to be at risk.

Recommendation 3 The OSCP should seek assurance from the commissioners of health services that there are processes in place to ensure that medical/ health related assessments are aligned and communicated to other agencies in a coordinated way so that they effectively inform statutory processes and future planning.

Recommendation 3: The OSCP to seek reassurance that care plans are effective and informed by all agency views and the outcome measures are strongly linked to the voice of the child.

Recommendation 4: The OSCP to seek assurance that risk formulation applied in statutory meetings is realistic, consistent, timely and reflective of a full multi-agency view. Furthermore, that

when progress is not evident, and risk is increased that relevant Legal Planning threshold is always revisited and tested together.

Recommendation 5: The OSCP should examine its current position relating to neglect including analysis of data across the continuum of need, examination of audit and performance information which inform approaches to neglect. It should seek reassurance that consistent models of working are being implemented across the agency workforce including specific attention to those children "placed at home".

Recommendation 6: The OSCP should seek reassurance that agency policies that are applied when people "do not attend" or "do not engage" with services are reflective of safeguarding risk.

Recommendation 7: The OSCP should continue to promote the voice of the child and ensure that the importance of communicating with all children and young people, including non-verbal communication, so that an understanding of their lived day to day experiences can be gained, is embedded in all procedures and training provided. Assurance should be provided on how well this embedded into practice.

Recommendation 8- The OSCP should review its escalation policy and reassure itself that it incorporates supporting professionals being able to challenge colleagues within and outside their own organisation and seeks assurance that the procedure is being applied effectively.

***Albeit outside of the scope of this review, the Partnership are asked to seek assurance on the current status of this case given that Abdur remains placed at home with parents in another part of the UK.**