

The purpose of serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. They should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account. Sharing from the learning of these reviews is vital for all practitioners to reflect on to ensure practice is continually evolving in the best interest of children, young people and families.

Introduction

Child AE was a 9-year-old child who has experienced significant neglect throughout their life while in the care of their mother. The family's history includes numerous safeguarding referrals from various services and anonymous members of the public, dating back to 2016. There have been periods of Early Help, Child in Need (CIN) and Child Protection. In 2024, due to ongoing concerns across physical, emotional, health and educational domains, Child AE and Sibling 3 were removed from their mother's care and now live with a paternal family member. The family history includes unexplained injuries, maternal aggression, sexualised behaviour, hidden males in the home, maternal mental ill health, unsafe home conditions, and exposure to adverse childhood experiences including domestic abuse and substance misuse.

Context

Child AE is one of four siblings, with two older siblings (one now an adult, one not included in the review) and one younger sibling, Sibling 3. Both Child AE and Sibling 3 were also open to the Disabled Children's Service and have a "Child with a Disability" flag on the Local Authority's database. Both children had significant developmental delay, though neither has a formal disability diagnosis.

At 18 months old, Child AE was hospitalised following a serious seizure and respiratory arrest after reportedly banging their head on a cupboard.

Child AE's complex health needs include epilepsy, soiling, incontinence, delayed development, and challenging behaviours. There were significant periods where essential medical appointments were missed, resulting in repeated hospital admissions for seizures.

Child AE did not attend school despite being offered a place.

Areas of Good Practice

- Professionals recognised that Child AE would require an Education, Health and Care Plan (EHCP) to access education and support on an equitable basis.
- Regular strategy meetings were held as concerns escalated, resulting in decisive safeguarding action with the children remaining within the wider family.
- Safeguarding teams across hospitals communicated effectively, leading to timely referrals and opportunities for information sharing.
- On receipt of a referral about missed epilepsy appointments for Child AE, The MAST identified ongoing concern, and so the referral was screened with information taken from by Police, Health, and Children and Families Service, with cumulative risk considered during the process.

Resources & Further Information

All NYSCP Practice Guidance / OMGS

[NYC Schools and Fair Access Protocols](#)

[NYSCP Learning for Professionals and Safeguarding Practice Reviews](#)

[Further links to videos and NYSCP resources within this briefing](#)

Areas for Development

- **Holistic Recognition of Neglect.** Focus on all types of neglect. The review found that this wasn't always the case and cumulative harm was not always recognised.
- **Effective Multi-Agency Working.** Information was not always shared between services, and key agencies sometimes missed meetings, leading to missed opportunities to identify and address risks.
- **Continuity During Service Transitions.** Transitions between services (e.g., Early Help, Disabled Children's Service) sometimes lacked supervision and clear handover, resulting in gaps in support.
- **Education Access and Monitoring.** Child AE became "invisible" to education due to poor follow-up, especially under the Fair Access Protocol.
- **Timely Medical and Specialist Assessments.** Delays in child protection medicals occurred, and reasonable adjustments for complex needs were not always made.
- **Workforce Development and Challenge.** Staff needed more training in communication (especially for disabled children), cultural competence, and professional challenge. Opportunities for curiosity, capturing and acting on the Voice of the Child didn't always happen.

Recommendations

- T&F Group to create a campaign to spotlight the issue of intrafamilial neglect. This campaign will include the development of a Neglect Strategy which will support practitioners and managers in understanding the NYSCP's approach to neglect.
- T&F Group to create a toolkit to support practitioners in evidencing concerns, understanding context, and applying a tiered response model.
- Review the process for partner invitation and attendance at multi-agency meetings, ensuring the right agencies are present and information is triangulated. Improve timeliness and communication of meeting outcomes.
- Promote the use of guidance for managing different professional perspectives and escalation policies, ensuring early and effective use.
- Convene meetings between relevant services to create pathways for children with complex needs and safeguarding concerns, ensuring reasonable adjustments are made.
- Share and promote the "Voice of the Child" toolkit, ensuring children's views are respected and communication needs are met, especially for those with disabilities and complex health needs.
- Review and improve processes for children missing education, particularly for those with Education, Health and Care Plans, ensuring appropriate follow-up and support.

Questions for Reflection

1. Which tools do we use to assess cumulative risk?
2. How do we ensure that the child's voice is heard and acted upon, especially for those with communication difficulties?
3. What strategies do I use to keep my knowledge and skills up to date, particularly in areas such as cultural competence, neurodiversity, and safeguarding
4. When was the last time I challenged or was challenged by a colleague in a professional and constructive way? What was the outcome?

Next Steps

Share the key learning from this review with your team and discuss how it applies to your practice.
Use the reflective questions provided to review your team's processes, identify specific areas for improvement, and ensure any new or updated guidance is disseminated and understood within your service.