Nottingham City Safeguarding Children Partnership Local Child Safeguarding Practice Review

LCSPR Lisa

October 2025

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Independent Reviewer

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A. Who was Lisa?

Lisa was a 17-year-old child. She is described '*as a ray of sunshine.'* She was '*such a happy person.' 'She had big energy, and she was super cool, smart and very funny.'*

Lisa looked up to her sibling. For enjoyment, Lisa loved watching cartoons, and she loved playing drums, especially with her sibling. She loved having her hair done*. 'She was a sociable and friendly girl.' 'If anyone felt unhappy around her, she would try and make them happy.'* Lisa had a wish to make her own food and drink and be able to use a bike unaided.

Lisa's voice: (taken from a document)

"I have special needs and health complications, but it has not stopped me from living a happy life. I have an older sibling who is my best friend. When I started school, I was happy…I love to dance and sing. I loved dancing and singing with my sibling a lot…'

'She was a vibrant and inspiring young woman'.

B. Ann, Lisa's Mother

Lisa's mother, Ann is described as an '*independent woman'* by a family member. She did not like to ask for help, she was very reserved, and she liked to keep her life private. She wanted others to believe that she was fine, and to think that she did not have any issues or needed help because she was independent.

Ann was one of 8 children, and she was the third child. She grew up in the Catholic faith and was born and lived in an African country. When her older siblings got married, she looked after her younger siblings from a very young age. Ann's mother ran a business in the city centre where they lived in Africa. Ann raised funds to attend university by working hard in the family hotel, she trained as a midwife.

After coming to the UK, Ann did not have many friends; she had one friend whom she was close to. She spent time at home with Lisa and She had a beautiful voice. Lisa and Ann loved to go shopping. Ann liked travelling and loved having her hair done and look smart. Ann enjoyed cooking for her daughters and made fresh food every day. She was very affectionate towards her daughters, giving them hugs and kisses.

1. INTRODUCTION.

1.1 This Local Safeguarding Practice Review is an analysis of the professional practice focussing on work carried out by agencies prior to the profoundly tragic death of Lisa. The reason for the LCSPR is to set out the work carried out by agencies and review their involvement with Lisa, before her death. The aim of the review is to learn from what happened and to consider how safeguarding policies and practices were applied to support Lisa within the multi-agency partnership.

1.2 Lisa lived with her mother and for some time, with both her mother and her sibling. The 'Think Family' approach is critical for analysing the work carried out with Lisa and her family. This approach recognises that a child's safety and wellbeing is deeply connected to the family's dynamics. The model is predicated on family assessment and collaboration by multi-agency partners to explore meeting the needs of the family as a whole to protect children.

1.3 The Nottingham City Safeguarding Children's partnership established a review panel (hereafter referred to as 'the panel') to oversee the work of this review. The panel agreed the review should focus on the period between 01/11/2022 and 23/05/2024.

1.4 This review was initiated following an incident in May 2024, when police were contacted by a concerned neighbour regarding Lisa and Ann. Officers attending the address forced entry because there was no reply and Lisa and Ann had not been seen for a while. When they entered the property, officers discovered a distressing and tragic scene that sadly both Lisa and Ann, had died. They noted that, considerable time had lapsed from their death to when they were discovered.

1.5 The reviewer offers condolences to Lisa and Ann's family. This is a difficult review for Lisa's family and those involved in working with Lisa and Ann. This is a particularly challenging because not only did Lisa and Ann sadly died under tragic circumstances, but Lisa's death was preventable. Therefore, the reviewer is aware that this is a difficult review for practitioners, the agencies involved and wider community. The panel has noted that all agencies and practitioners involved in working with Lisa are committed to ensuring that there is learning from the review to prevent future tragedies.

1.6 This review aims to establish learning to honour their memory (as shared by a family member) and to learn from their experience as to serve as a reminder of the importance of robust, child focussed practice with tenacity, vigilance and effective communication.

Background

2. Reason For This Local Child Safeguarding Practice Review (LCSPR).

2.1 The review is conducted in line with the statutory guidance - Working Together to Safeguard Children (2023). The reviewer, in agreement with the review panel, pursued a systems methodology. This approach outlines how professionals worked together to safeguard and promote the health and well-being of children and their families. It seeks to outline critical areas for improvement of practice with children and their families.

2.2 The Nottingham City Safeguarding Children Partnership made the decision that with the agreement of the Child Safeguarding Practice Review Panel,[1] this LCSPR should be commissioned. The purpose of a Local Child Safeguarding Practice Review (LSCPR) is to reflect on the safeguarding response to the specific set of circumstances and to consider if improvements or examples of good practice can be embedded locally or nationally.

3. The Methodology for this Review.

3.1 The systems approach adopted for this review, focuses on how different systems operated to meet Lisa's needs, risks and circumstances. It considers various elements and stakeholder perspectives. For example, family members, communities, organisations and policies. This root cause analysis focuses on identifying underlying issues that contribute to safeguarding, rather than the symptoms. The systems approach can provide insight and analysis about what happened. To inform the systems approach, the reviewer has included the voices of the family, practitioners, senior managers and members of the community who share Lisa's black African and disability background.

3.2. Analysing these different perspectives provides an opportunity to understand the strengths in practice and identify gaps to prevent future tragedies. The outcome and suggested recommendations will be provided to the Nottingham Safeguarding Children Partnership, to develop a SMART Plan to improve

[1] An independent panel commissioning reviews of serious child safeguarding cased based in the Department of Education.

practice comprising of learning from this LCSPR. It is important to note that the partnership has implemented the recommendations from the Rapid Review.

3.3. The independent reviewer is aware that what happened to Lisa and Ann has received considerable media interest because of the circumstances surrounding their deaths. Therefore, the panel and the reviewer are mindful that the family needs to be safeguarded from the potential negative impact of this attention.

3.4 The Nottingham City Safeguarding Children Partnership commissioned an independent author to complete the report – Kanchan Jadeja - an independent social care safeguarding consultant. She has authored Local Child Safeguarding Practice Reviews. She is currently a reviewer for the National Child Safeguarding Practice Review (Department of Education). She is a Department of Education approved Improvement Adviser for Local Authorities - Children's Social Care. Kanchan is a qualified social worker and at various points in her career worked at leadership and improvement roles in Local Authorities, regional government and national government.

4. PROCESS OF THE LCSPR.

Information available to the review.

4.1 Rapid Review and agency reports, chronology.

4.1.1 Following the Child Death review, the partnership produced a Rapid Review with agencies providing 'agency reports' to inform the joint Rapid Review. These reports were available to the reviewer to inform this LCSPR.

4.2 EMAS – East Midlands Ambulance Service - Report PSII Patient Safety Incident Information Report.

4.2.1 A key issue in this review is a phone call that was made by Ann to the ambulance service requesting an ambulance to be dispatched to her home, as she was feeling unwell. The call was answered but later abandoned and no ambulance was dispatched. Following their death, EMAS identified early that an individual agency report was necessary to establish the circumstances surrounding Ann's 999 call and the subsequent lack of response by the service.

4.2.2 This resulted in a Patient Safety Incident Report (PSIR). EMAS commissioned a PSII which was shared with the reviewer to inform the LCSPR. The PSII report provides the details of the investigation into the 999 calls from Ann on the 2nd of February 2024.

4.2.3 EMAS participated in the multi-agency practitioner event held on the 24th of February 2025. Their engagement provided for a critical opportunity to review what happened with the wider partnership in the context of learning to improve practice in future.

4.3 Feedback from Practitioner Event.

4.3.1 The reviewer led a practitioner event on 24th February 2025 for practitioners who were either directly involved in working with Lisa, or their representatives, who had access to Lisa's records. The representatives came prepared with a good understanding of the work that was carried out with Lisa.

4.3.2 All agencies involved in working with Lisa were represented at the practitioner event. It was particularly beneficial and advantageous to hear from practitioners, who had worked directly with Lisa and her mother, to inform this review. The input from practitioners was very productive and valuable. The findings from these discussions have been incorporated in the body of this report.

4.4 Senior Management Event - LCSPR Panel Event to review findings.

4.4.1 The chair of the panel agreed with the reviewer that a senior leadership discussion should follow the practitioner event. The reason for this was to gain a more comprehensive understanding about what happened and to have a senior management and strategic lens on agency involvement, to maximise and analyse the learning from the practitioner's event. The engagement of the senior leadership illustrates the commitment of senior managers to engage in the review process and contribute to findings and learning for this review.

4.5 Community meeting - Feedback from Communities like Lisa and Ann.

4.5.1 Systems approach considers and incorporates a range of stakeholders including children and families. In order to understand and appreciate Lisa's lived experience in the context of her family and community, the chair of the panel, the panel and the reviewer agreed that voices of those who have a similar background to Lisa and Ann is a key component for this review.

4.5.2 With a community worker's support, a session was held with parents of similar demographic to explore their needs, risks, and circumstances when raising a

neurodiverse child with disabilities. These discussions were anonymous and contributed to the findings of this review.

4.5.3 In order to maintain confidentiality of the review and the subjects, no aspect of the review was discussed within the community meeting. The focus of the discussions was on understanding the experiences of families in accessing support, good practice and any barriers they faced in accessing their children's needs, especially for children of African background with disabilities.

5. FAMILY MEMBER INVOLVEMENT.

5.1 The LCSPR reviewer, a senior member of Nottingham City Council children's social care, and the bereavement nurse met with Lisa's sibling. She is aware that what happened to her family was of interest to the media, and she is concerned about being identified in this review. Her voice and experience will be redacted in the published report. For the rest of this report, she is referred to as Lisa's sibling.

5.2 Lisa's sibling described her as a funny, loving, and caring young woman who cherished her family and enjoyed school. She noted that Lisa was unhappy when she couldn't attend school. Lisa loved to eat and she loved food.

5.3 Lisa's sibling portrayed their mother as a strong, independent woman who maintained a spotless home, provided daily homemade meals, and was devoted to her daughters. She said that her mother was not keen on either of her children having much contact with the world outside the home. Lisa's sibling believed that her tendency to be overly protective stemmed from concerns regarding potential risks and harm in the world.

5.4 This was key to understanding how Lisa's mother negotiated with and accessed services for Lisa. Lisa's sibling is more independent and wanted to explore the outside world and develop her own relationships and career. She and her mother had clashed on their different approaches to their lifestyles. Lisa's sibling left the family home and was not living in the family home at the time of Lisa's death.

5.5. The family dynamic was a complex one for Lisa. Lisa's sibling left the family home after a disagreement with her mother. Lisa's mother had experienced trauma and abuse, and this is likely to have impacted on her care of Lisa and her sibling.

5.6 During the meeting with Lisa's sibling, she shared memories of happier times as a family. She is strong independent minded young woman who is navigating life without her sister and mother.

During this difficult time, she is well supported by a network of support in the UK. The reviewer is grateful to her for taking the time to provide her views for this review.

6. FAMILY CONTEXT.

Family living arrangements at the time of the Lisa's death and context of family background.

Family member	Relationship to Lisa	Accommodation
Lisa (subject)	Lisa (subject)	Living in family home
Ann	Mother	Living in family home
Sibling	Older sibling	Not living in family home
Father	Birth father	No contact.

6.1 Lisa was of African heritage. She was born in a European country, and she identified as Black British. Lisa died when she was just 17 years old. Lisa was a young person with Downs Syndrome, obesity, peri membranous ventricular septal defect, (this is a hole in her heart which was reported not to be causing her any clinical problems), hearing and visual impairment, and intellectual disability. Although she did not attend school, she often went on shopping trips with her mother. Lisa was often seen out in the community with her mother.

6.2 Lisa's mother, Ann, had experienced her own adverse experiences through some childhood trauma and was a survivor of domestic abuse as an adult. Practitioners commented on how she was finding it challenging to navigate life in her new home in the U.K. For example, she did not understand how to access services when she needed them.

6.3 Some practitioners were concerned about Ann's needs and presentation when they met with her. For example, she had experienced physical ill health. There were growing concerns that Ann was suffering from poor mental health. This may have impacted on how she cared for Lisa and some of her decision making about attending appointments and prioritising Lisa's needs.

6.4 Ann shares the same African background as her daughters. She was born in Africa; she attended university in her country of origin and is described as a confident and independent woman.

6.5 Ann relocated to a European country when she married and worked long hours to provide for her family.

6.6 In the U.K, she became a full-time carer for Lisa. Ann spoke English and has been described as an intelligent woman.

6.7 On one occasion, Ann was admitted to hospital with acute respiratory distress and was found to have a chest infection and anaemia (low haemoglobin levels). This was a serious medical illness and was potentially life threatening without a blood transfusion. Ann's friend agreed to look after Lisa, but Ann did not want Lisa to stay at her friend's home. The hospital agreed to accommodate Lisa and Ann's friend in the hospital hotel. This is good practice.

6.8 Lisa's father, who is of African heritage, resides in a European country. Ann had moved to the European country to live with him after she married him. The family reportedly lost contact with him after they moved to Nottingham in 2016. For a long time, he was absent from Lisa's life and records indicate that there was a history of violence by him towards Ann. There are suggestions that he may have harmed Lisa and her sibling and also that the siblings witnessed the violence towards their mother as young children.

6.9 The family relocated to Nottingham because Ann had determined that she and her daughters were not safe in the European country due to her husband's behaviour, despite being divorced.

6.10 During the period of this review, there was no contact with Lisa's father and his family. There was a thorough discussion with the review team about the engagement with Lisa's father to gain his views. The conclusion of these discussions was that as he was absent from Lisa's life, no contact was to be made for him to contribute to this review. The National Panel provide guidance and a framework in how to engage with fathers in reviews. The panel in this review decided not to engage with Lisa's father due to the history of domestic abuse, the fact that he had been absent for a number of years and to respect the wishes of Ann and Lisa's sibling, who did not wish to have any contact with him.

6.11 Whilst Lisa's father had not been involved with the family since they moved to the UK, it is important to recognise the impact the experience of domestic abuse continued to have in influencing some of Ann's responses and behaviours of overprotection of her daughters.

7. ANALYSIS - SIGNIFICANT INFORMATION AND EVENTS.

Relevant information prior to the timeline

7.1 This section of the LCSPR sets out the timeline, key interventions and challenges highlighted by practitioners in safeguarding Lisa.

The family was first known to children's social care when they were facing housing instability in Nottingham in 2016. They had become homeless due to eviction. Housing appropriately referred them to children's social care. The outcome of the referral was no further action.

7.2 In July 2017, Ann contacted the Disabled Children's Team independently to seek assistance for Lisa's needs arising from Downs Syndrome and other disabilities. Although safeguarding concerns were not documented at this time, there was insufficient clarity sought regarding the scope of the support needed by Lisa. Also in 2017, a subsequent referral by a Key Worker mentioned concerns about Lisa exhibiting behaviours described as 'aggressive'.

7.3 This led to a Child and Family assessment in December 2017. This assessment recommended engagement with CAMHS, SEN services, and short breaks for Lisa. Despite these proposed interventions, there was no meaningful change for Lisa. This was partly because Ann was not confident in accessing the support and there was less than assertive practice by practitioners to encourage her or overcome the barriers to engagement in supporting Lisa.

7.4 In 2018, good practice was demonstrated by the SEN team when they commissioned a specialist school placement tailored to meet Lisa's educational needs. This was appropriately followed up by the finalisation of Lisa's EHCP plan in March 2019. While these developments signify progress, there was a two-year delay from Ann's initial request for support in 2017 to the completion of the EHCP. It is important to note that this experience was echoed in the community meeting indicating that this may be a systemic issue for the partnership to consider.

7.5 In July 2019, the family encountered further housing instability, facing eviction and subsequent homelessness. It is not known why they were evicted from their home. After a period of time in housing for homeless families, they were housed by Nottingham City Council housing. There is evidence that if there is mould in a home where a child lives, mould inevitably impacts on a child's health and wellbeing. This presented a potential risk to Lisa and could have impacted on her overall health and wellbeing. Despite good intervention from housing services to secure a house, timely support was not provided to address the mould and key repairs required within the property. Although there is no evidence that Lisa died because of mould in the house.

7.6 In February 2020, concerns were raised by the school regarding Lisa's reported hunger, necessitating further investigation to determine if neglect or underlying medical conditions were contributing factors. The issue of Lisa feeling hungry was particularly concerning as, during the COVID-19 pandemic in March 2020, she did not attend school despite provisions being made for vulnerable children. Ann's decision to keep Lisa at home may reflect her protective instincts.

However, the lack of follow up suggests the absence of a collaborative approach to understand and support Lisa accessing school. There was a lack of professional oversight over Lisa's needs, during this challenging period.

7.7 The concerns for Lisa accelerated in April 2021, when a safeguarding strategy meeting was convened. An enquiry under Section 47[2] of the Children Act 1989[3] was agreed, this was single agency. This was due to concerns regarding Lisa's missed medical appointments and her exceptionally low school attendance rate of 4.7%. The response to her needs, risks and circumstances at this time was that disability services were offered.

7.8 These needs are not clearly identified and suggests a limited understanding of child neglect. This is further explored in the findings section of this report. The Section 47 enquiry concluded that there were no safeguarding concerns. At the senior leader's practitioner event, there was a robust discussion which indicated that the G.P and the social worker knew Lisa well and the social worker attempted to enter the home for visits. However, at times entry was not secured and overtime, she was not able to engage meaningfully with Lisa. It is unclear what support disability services were going to offer to Lisa.

7.9 In May 2021, Domestic Violence Services received a referral about Ann's behaviour towards Lisa's sibling, which was disclosed to a college counsellor by her. Lisa's sibling stated the issue was resolved, and so it was closed. Another domestic incident occurred in December 2021. The police involvement resulted in no further action.

7.10 A referral was made to children's social care about how this may have impacted Lisa, and the outcome of the referral was no further action. No immediate safeguarding concerns for Lisa were identified at the time.

7.11 In April and May 2022, when concerns arose regarding Lisa's school attendance, the social worker sought the support of police to access the property to carry out a safe and well check as well as conduct a home visit. A joint visit was carried out to the family residence, leading to a referral to the Education Welfare Services. It was reported that Ann was not cooperating with school authorities to support Lisa to attend school.

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[2] A statutory duty for local authorities and the police to investigate when there is a reasonable cause to suspect that a child is suffering or likely to suffer significant harm.

[3] The children Act 1989. Crown. 1989.

7.12 In July 2022, Children's Social Care received a referral from Lisa's siblings school alerting them that Ann was planning to travel abroad and was not intending to take Lisa with her. Professionals advised Ann against leaving Lisa unaccompanied during her absence. It is unclear what work was carried out with Ann to understand the purpose of her trip and how best to work with her to provide short break for Lisa while she was away. Some practice with Lisa was not impactful or purposeful to support her and sometimes there was insufficient or inaccurate information.

7.13 An example of how little was known about what was going on in the family is that one agency believed that Lisa and her mother had gone to Kenya, another believed they had gone to Cameroon and another to Rwanda. A Section 47 was held because of concerns that Ann might leave Lisa home alone, these were concluded in August 2022 as Ann took Lisa abroad with her for six weeks.

7.14 Lisa and Ann returned to the UK together. Lisa's sibling assured professionals that Lisa and her mother were back from abroad and they were safe and well and Lisa was in her mother's care. A subsequent home visit revealed that there were no immediate safeguarding concerns for Lisa.

7.15 In October 2022, Ann contacted Police to discuss 'personal matters.' She told police about the abuse she experienced from her husband in the European country she lived in prior to coming to Nottingham. She said that she was having bad dreams about him abusing her.

7.16 Police were concerned and so submitted an Adult Public Protection notice for review and consideration by Adult Social care. Police officers noted that Ann may be experiencing stress, potentially post traumatic. This is an indication of Ann not understanding the role of agencies, what support they provide and how she can access support she needs. It is unlikely that those who understand the role of police would go to a police station and explain that they had bad dreams about domestic abuse in another country.

7.17 The preceding events highlights the critical need for timely, knowledgeable, and skilled interventions, alongside integrated housing solutions and inter-agency collaboration to support Lisa at an earlier stage including when mould was found in her home. This objective could have been attained through early assistance and proactive support for Lisa and her mother. Given that there were complexities and vulnerabilities in the family, it would have been helpful to have considered a 'Think Family' approach which would have assessed the situation for the whole family. Child in need meetings were held to discuss Lisa's needs but the impact of these was not known fully.

8. Summary of Events within the Scope of the Review - (November 2022 – May 2024).

8.1 In November 2022, concerns for Lisa escalated as she was not attending school and she was not being brought to medical appointments. A strategy discussion[4] and Section 47 enquiries led to an Initial Child Protection Conference (ICPC)[5], placing Lisa on a child protection plan for child neglect.

8.2 There were delays in scheduling the ICPC and there was poor communication with the police which is likely to have hindered effective safeguarding for Lisa in line with Working Together to Safeguard Children 2018.

8.3 In December 2022, the Child Protection Chair and their Service Manager agreed not to go ahead with the ICPC because there was outstanding information required. Also in December 2022, legal advice was sought to test threshold for legal proceedings because it was assessed that Ann was not engaging however threshold was found to not be met.

8.4 As Lisa was approaching adulthood, the concerns continued as there was ongoing unsuccessful engagement with Ann with little impactful intervention and approach about what work could have been carried out to address this. Initial discussions took place with legal services, and it was noted that Mental Capacity and Court of Protection should be pursued in due course, if non engagement by Ann persisted. This was good practice.

8.5 When legal services advised that evidence would be required to demonstrate child neglect, the social work team interpreted this to mean that the threshold had not been met for child protection measures. Greater rigour should have been applied to ensure the ICPC proceeded, and as recommended by legal colleagues, evidence should have been gathered regarding the neglect and its impact on Lisa in order to assess the threshold appropriately.

8.6 In February 2023, a home visit was carried out by the social worker who told Ann that housing services were attempting to contact her. This was in relation to her tenancy, which was at risk, with possible eviction, if she did not respond to housing officers.

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[4] Strategy discussion – the purpose of a strategy discussion is to decide whether the threshold has been met for single agency or joint child protection investigation.

[5] ICPC – Initial Child Protection Conference is the first meeting in the child protection conference, a meeting where professionals assess the safety and well-being of a child.

8.7 Also in February 2023, education services attempted to enter the home and did not manage to do so, they called for police attendance and noted that there was no heating in the family home. During this visit, Lisa and Ann were speaking in a European language, children's social care indicate that an interpreter should have been used because '*English was not the family's first language.'* [6] This is explored further in the report. Ann took Lisa to a paediatrician appointment but was not comfortable in agreeing to an Occupational Therapist visiting. These were indicators of child neglect, for example not meeting Lisa's health needs, further action should have been taken to increase to daily visits. As a result of these concerns, a discussion was held within children's social care about the potential use of the Court of Protection, this is good practice.

8.8 At the end of March 2023, an ICPC was held, and the outcome was a Child Protection Plan under the category of neglect.

8.9 In March 2023, health practitioners contacted Ann because Lisa had missed her annual health check. In addition, housing colleagues contacted her about unresolved housing repairs which were noted but not completed. There were missed housing management visits and there was a lack of communication which led to no repairs being completed. The housing department had attempted to gain access, but this was not achieved because Ann did not allow access.

8.10 It is likely that this added to Ann's stress levels and potentially impacted on her care of Lisa. The delay in any action being taken was to suggest that it was because of Ann's refusal to 'engage.'

8.11 The Nottingham City Housing colleagues were aware that there was mould in the home, and it was in a poor state of repair but could not engage with Lisa's mother to address the repairs and when access was not agreed, no further action was taken.

8.12 In May 2023, the housing patch manager contacted the social worker and told her that the gas had been capped because they could not enter the family home. The social worker did not follow this up with housing until 10 days later.

8.13 In June 2023, there was good practice by the social worker on a visit when she had a brief discussion with Lisa and offered support to Ann to complete Lisa's college application. Ann declined informing the social worker that she has approached the G.P to support her with this. The lack of gas in the home and the college application was addressed by the social worker.

[6] Taken from Children's Social Care Child and Families Assessment.

8.14 In July 2023, there was a further discussion between social work manager, legal team manager and social worker. At this time Lisa was travelling abroad with her mother. The social work manager noted that a Mental Capacity Assessment should be completed when Lisa returned from abroad. This was good decision making but unfortunately was not pursued when Lisa and her mother arrived from abroad. No practitioner knows where they went, there are different countries mentioned in agency reports.

8.15 In October 2023, a Legal Planning Meeting was held to consider whether any action through the Court of Protection might be required to safeguard Lisa. Information shared during the meeting indicated that there were no safeguarding concerns regarding Lisa's care. It was advised that the G.P and Adult Services should be contacted to undertake a capacity assessment to determine Lisa's ability to consent to and access services independently as she approached adulthood.

8.16 In October 2023, a Review Child Protection Conference was held. All agencies except children's social care agreed that Lisa should remain on a child protection plan, the chair disagreed with children's social care and Lisa remained on the child protection plan.

8.17 This was good practice demonstrated by the chair as there were concerns about Lisa not being supported to access services. In November 2023, there were two unsuccessful home visits. Police were requested to support access to the home, but they declined as there were no immediate concerns for Lisa.

8.18 In January 2024, Ann went into hospital with severe respiratory issues. After receiving some treatment, Ann was keen to leave the hospital, and she was discharged. The discharge was a 'pragmatic' discharge from hospital. Ann's symptoms had improved significantly and whilst the doctor would have preferred Ann to stay in hospital, she had responded well to treatment and there were no concerns that she was at any imminent risk; A follow up appointment was made for a few days later and the hospital arranged transport for Ann to attend the appointment, ensuring the appointment was with a clinician that she knew well. However, it would have been even better practice if the hospital had known what would have encouraged Ann to attend, At the time of discharge, the hospital had assessed that there were no concerns that Ann's ill health would impact on her care of Lisa.

8.19 Ann's discharge is relevant for Lisa, because had she stayed in hospital there was no carer for her, and Ann was keen to be discharged to care for Lisa.
The ward contacted the social worker, and she was told that Lisa was cared for by Ann's friend overnight in the patient hotel.

8.20 It is clear from children's social care chronology that more contact was made by ward staff with the social care team. Ward staff sought advice from their safeguarding children's team and were advised to contact children's social care. They did this and there was good information sharing between the ward staff and children's social care. This was good practice.

9. THE INCIDENT.

9.1 The circumstances that led to the death of Lisa and her mother occurred between February 2024 and May 2024. Ann was asked to ring for an ambulance or medical support if she felt unwell when she was discharged from hospital. There was a follow up plan in place for her to come back for clinical review. In February 2024, Ann made a call to the ambulance service seeking medical support. The call was triaged by a call handler at East Midlands Ambulance Service using NHS Pathways which achieved a Category three disposition. [7]After about 10 minutes, the call was stopped and removed from the system. No ambulance was dispatched to the family home.

9.2 The transcript from the call indicates that there were communication difficulties during the call. Queries were raised about whether there was a possible language barrier during the call. Ann's communication may be linked to Ann's medical condition at the time of the call. There was no response to her request for an ambulance, and no ambulance was dispatched. It is understood that Ann sadly died soon afterwards and Lisa died sometime after her.

9.3 In May 2024, A neighbour called Police because they had not seen Lisa and her mother for some time. Officers responded to a welfare check initiated by a neighbour's call and discovered Lisa deceased in an upstairs bedroom and Ann deceased downstairs. Officers concluded that sadly a considerable time had lapsed from when Lisa and Ann had died before they attended. This will have been distressing for officers who attended the family home.

10 ANALYSES OF KEY LEARNING AND THEMES.

10.1 Key Themes 1: How well was Lisa's voice and lived experience understood by agencies?

[7] A Category 3 call refers to an urgent, but not immediately life-threatening, situation that requires ambulance assistance or clinical assessment at the scene.

What was known about Lisa's communication needs and how well was this used in communicating with her? How well was this understood by professionals working with her and how did this impact on Ann accessing support for Lisa?

10.1.1 The searching question for this review is that if Lisa's communication needs were better known and understood by agencies and if this information was shared, would she have been able to communicate her distress prior to her death? At the practitioner event, there was a robust discussion about Lisa's needs and how these were understood and responded to. Many practitioners noted that Lisa's needs were known, however, while working with her, there was little consistent intervention. Lisa's sibling said that engagement and communication with Lisa required a nuanced approach to communicate with her. The case recordings do not adequately demonstrate how services sought to seek her views and understand her lived experience.

10.1.2 Disability impacts on a child's development, education, and overall well-being. It is worth reiterating Lisa's needs in this section to understand how her physical heath and intellectual disability impacted on her quality of life. Lisa was diagnosed with Down Syndrome, obesity, peri membranous ventricular septal defect, hearing and visual impairment, and intellectual disability. Lisa faced challenges that affected her understanding, social interactions, behaviour, and communication abilities. Whilst some practitioners were aware of her conditions, there was less understanding about how this knowledge and information should be used in safeguarding, intervention decision making and analysis.

10.1.3 *Lisa's life was significantly impacted by her disabilities which restricted her participation in educational and social activities. Lisa mainly communicated non-verbally through facial expressions, gestures, and body language*." [8]

10.1.4 Furthermore, Lisa's mother, Ann, did not send her to school nor take her to medical appointments, a decision that professionals working with Lisa did not fully address appropriately.

10.1.5 Practitioners, especially the social worker had made attempts to engage with Ann but on most home visits she did not succeed in entering the family home, often requesting police engagement for entry into the home. Other methods could have been employed, for example, joint visits with another social worker or education,

[8] Document from Nottingham City Children's Social Care.

health practitioners. A request could have been made to the G.P for the social worker to meet Ann at the G.P surgery because the G.P was a trusted professional.

10.1.6 Lisa is described as a joyful and empathetic personality, who positively impacted those around her. Lisa was reported as someone who wanted others to be happy and often would not share how she was feeling to protect other from her needs and circumstances.

10.1.7 Lisa's G.P described her as *'a pleasant young lady, happy and smiling'* and records suggest that although she refused examinations, health professionals did not have concerns about Lisa's presentation.

10.1.8 When the children's social worker visited Lisa with a colleague from adult social care in January 2024, Ann told them that she did not need any support. However, when she had met the G.P also in January 2024, Ann discussed her concerns and worries about Lisa not securing a place at college and Lisa's future. She asked the G.P to support her to fill the relevant applications for Lisa's college placement. Although many practitioners suggested that Ann was 'not engaging' she was seeking support from her G.P indicating that she trusted some practitioners and was more than willing to engage with them and seek support. The partnership may want to consider whether there is any learning regarding what allowed Ann to trust some professionals and how those trusted professionals can support other partners to engage more effectively with the family to meet the needs of the child.

10.1.9 Despite agency involvement, Lisa's daily life was not fully understood. It is likely that she faced substantial barriers that prevented her from accessing opportunities for '*stimulation, and learning*,' and interpersonal connection. Observations of Lisa's living conditions revealed insufficient opportunities for stimulation, including limited toys and restricted access to functional equipment, such as a television.

10.1.10 It is hard to appreciate what, if any, reasonable adjustments were suggested and offered to Lisa and her mother in response to her being non-verbal in order to maximise her communication and enable her to participate more fully. As Lisa was mostly at home, her mother was her primary carer. Therefore, it was incumbent on practitioners to attempt to understand Ann and be able to communicate with her so that Lisa's voice and lived experience was heard and responded to.
This is important in all areas of work with Lisa - referrals, assessments, plans and reviews. This was not evidenced in records.

10.1.11 Practitioners in all agencies attempted to work with Lisa, but there were barriers to her receiving services. The main barrier was the relationship between Lisa's mother and some practitioners. Her mother's experiences had led her to be distrusting and wary of professionals. Agencies and practitioners need to be mindful of not persistently resorting to Ann '*not engaging'* as a means of not having

access to provide support for Lisa. Practitioners did not demonstrate curiosity and understand why Lisa felt unable to work with them; had this been understood professionals could have worked creatively to help her feel able to engage.

What is known about Lisa's lived experience is:

Restricted Access to Education:

10.1.12 Lisa's school attendance was recorded at only 4% on one occasion. Her Education, Health, and Care Plan (EHCP) does not appear to have had meaningful engagement with her. Lisa's attendance was consistently low. The SEN team reported that the last time that Lisa contributed her views to the service was in March 2021. The service report also highlights that Lisa's lived experience was unknown to their team. When she did attend, she enjoyed it and was reported to be happy in school. Ann's views, that the school was not meeting her daughter's needs, further impacted on Lisa. This left Lisa mostly deprived of the educational and social opportunities essential for her development. The question is who was able to make sense of her mother's concern and build a relationship that might have enabled an increase in attendance?

10.1.13 When Lisa was on a child protection plan, the social worker did not often get access into the family home. At other times she knocked, waited and then went back when Ann opened the door but was unable to gain access into the family home. When she did gain access to the home, she observed that there were limited opportunities for Lisa to have appropriate level of stimulation. She understood that the T.V may not be working. However, Lisa had access to an electronic tablet and would use this frequently.

10.1.14 Lisa had a few dolls, some art equipment and some balloons. She often watched cartoons and loved them. In work with children with disabilities, observation is important, however, child focussed interventions can be employed. Research in Practice [9] highlights the importance of practical engagement and intervention with children with disabilities and has developed a practice tool to support this. This approach could have been considered in work with Lisa.
Knowing the child's communication needs is key in understanding their voice and lived experience. Lisa was not seen alone, and the communication was primarily through her mother.

10.1.15 Practitioners observed that Lisa's mother cooked fresh meals for her children every day, her home was clean, and Lisa was wearing age-appropriate clothes.

[9] Supporting children and young people with communication needs. Research in Practice June 2024.

10.1.16 When the reviewer interviewed Lisa's sibling, she said that Lisa was overeating because her mother had let her eat as much food as she wanted to, this often resulted in her vomiting during the night because she had overeaten. It was unclear whether she linked this with the overeating, or whether she had an eating disorder. Lisa's sister sharing that she was overeating was not known to professionals working with her and has only come to light as part of this review.

Social Isolation:

10.1.17 All records indicate that Lisa's lived experience was one with limited interaction with others. Lisa's absence from school and lack of stimulation contributed to her isolation from peers and any structured activities. Consequently, Lisa had very little social interaction and she was restricted in her ability to form relationships, enhance her communication skills within her ability and gain emotional support to do so.

Dependence on Caregivers:

10.1.18 Lisa was solely dependent on her mother Ann for her daily physical care and to meet all her other needs. Practitioners concluded that Ann had provided consistent good enough care for Lisa. However, her mother's mistrust of agencies prevented her from having relationships outside the family home. This was a barrier to Lisa receiving services and accessing the support that she needed.

10.1.19 Lisa's dependency became critical when her mother fell ill. Lisa had no means of communicating to others and therefore was unable to call for help.

10.1.20 Further work could have been carried out to understand how Lisa could be supported by being curious about the barriers that may have contributed to Ann being reluctant to access services for Lisa. Had Lisa had access to other services and the opportunity to build relationships with others, this may have afforded Lisa the opportunity to better communicate her needs within the capacity she had irrespective of her individual circumstances. It is important to recognise that it is for the professionals to take the lead on engaging with and developing communication through creative strategies with a child with disabilities.

10.1.21 All agency reports highlight that they did not sufficiently understand her voice and lived experience and that more work could have been carried out to be more tenacious and persistent in gathering her voice and lived experience to inform work with her.

10.1.22 Lisa's family faced obstacles in their interactions with housing and social care agencies. These agencies struggled to establish trust and maintain Ann's trust to work with them. Agencies reached out to support Lisa, but there is little evidence

of impact and often concluded that support and care was refused, placing the onus on the family to engage rather than professionals.

10.1.23 The absence of relational, restorative and Think Family[10] approaches further hindered the support provided to the family. Lisa's experiences illustrate the wider systemic issues and multi layered barriers that children with disabilities can encounter if agencies do not focus on involving them in meaningful ways and seek to understand their lived experience. Without this. interventions will continue to be limited in their impact on children's lives.

KEY LEARNING

To address findings from Lisa's narrative, it is essential to prioritise the voices and lived experiences of children with disabilities.

- **Understanding Individual Communication Needs:** Practitioners should make nuanced and tailored efforts to recognise and adapt to the diverse communication methods of children with disabilities.
- **Practitioners should use** non-verbal techniques and personalised approaches to ensure every child's voice is heard and lived experience understood to inform assessments and plans for the child.
- **Consistent, Coordinated Multi-Agency Engagement**: Effective safeguarding requires persistent collaboration and information-sharing among all agencies involved in a child's life. Regular multi-disciplinary meetings help maintain a coordinated and proactive approach.
  This is especially important where there is a trusted professional within the multi-agency partnership.
- **Creative and 'thinking outside the box' Approaches to Family Engagement**: Practitioners are often under pressure from workloads and agency expectations when working with families like Lisa's.
  However, where families are hesitant or 'difficult to engage,' practitioners should pursue alternative strategies, such as joint visits with trusted professionals or meetings in neutral settings, to build trust and understand the child's circumstances.
- **Direct Work and Observation with the Child:** Direct engagement with children, especially those with disabilities, is crucial. Observing their environment, behaviours, and methods of communication supports practitioners to understand their lived experiences beyond what is reported by parents and carers.

[10] The Think Family approach is a way of working that acknowledges the interconnectedness of family members and their impact on each other's well-being.

- **Addressing Social Isolation and Access to Opportunities:** Children with disabilities may face barriers to education, social interaction, and stimulation. It is essential to identify and mitigate these restrictions to support their wellbeing and development.
- **Impact of Caregiver Relationships:** A child's access to services and support is greatly affected by the caregiver's relationship with agencies. Building trust and understanding with parents and carers is essential in overcoming barriers to care for children with disabilities.
- **Persistent Professional Tenacity:** Practitioners should continually seek ways to involve children in decisions and plans affecting them, ensuring their voices and experiences inform safeguarding actions, even when challenges arise.
- **Systemic and Multi-Layered Barriers:** The case highlights how a lack of relational, restorative, and 'Think Family' approaches can hinder safeguarding efforts for children with disabilities, underlining the need for more inclusive and persistent interventions.

10.2 Key Theme 2: The impact of migration on Lisa and her family

What was the impact of migration on Lisa and her family? How well was this understood by professionals working with her and how did this impact on Ann accessing support for Lisa?

10.2.1 Ann moved her family to Nottingham in order to keep her children safe. The move was a difficult one and started with housing needs not being met, an eviction and then delay in accessing SEN support for some time. The family was isolated and were having to navigate a new set of systems to seek support for housing, education and health.

10.2.2 Ann's understanding and use of the English language was misunderstood by some practitioners. Although Ann had a degree, was educated to university standard and had previously worked in the family hotel speaking in English, some practitioners believed that she did not speak English. The NCSCP will want to consider learning from this and support practitioners to be more curious about their understanding about the English language by people from diverse backgrounds.

10.2.3 Ann spoke to Lisa in a European language when the social worker visited. She spoke her own African language, the European language and English. This will have impacted on their communication.

10.2.4 Professionals attended the home with interpreters to enable Lisa to communicate with them, as Ann spoke to Lisa in a European language when professionals attended the family home. The purpose of the interpreters was to enable professionals to understand the discussion between Ann and Lisa to safeguard and support Lisa. This is good practice. However, there was some misunderstanding about Ann's ability to speak English amongst some practitioners.

10.2.5 For example, in discussions at the practitioner event, some practitioners believed that Ann did not speak English. This was not the case. Practitioners need to be mindful of stereotyping and making assumptions about whether someone speaks English and the use of English. The evidence provided from her G.P (who attended the practitioner event) was very clear that Ann spoke English well and could communicate her own needs and the needs of her daughter.

10.2.6 There is a clear contradiction and highlights the failings in some organisations. As the "It's silent" Race, racism and safeguarding children report (HMG 2025) notes, when working with diverse families, consideration of bias, cultural competence should always be considered as good practice.

10.2.7 US research refers to migration as a form of trauma for many children, and it often impacts on child development. [11] The process of migration for Lisa from a European country to the U.K is not sufficiently understood. However, research on migration suggests that the changes in circumstances and the lack of information and knowledge about the new country that the family were living in, would have impacted on the children and their mother. In particular, Ann's ability to understand, navigate and access resources for Lisa.

10.2.8 The practitioner event highlighted that Ann's perception of being seen as 'the other' in the community may have contributed to her being overly protective of her daughters.

10.2.9 It is likely that Ann's relative unfamiliarity with the United Kingdom's social care and support systems and her potential mistrust of agencies may have limited her ability to access necessary services. Significantly, she did engage with her G.P (who was South Asian).

[11] https://doi.org/10.1177/1534765610388304

10.2.10 Ann's engagement with her G.P, highlights the importance about partners knowing which practitioner or agency Ann had confidence in. Although the G.P did not know Ann well, her willingness to speak to her could have been leveraged to enable Ann to access other support. For example, from Housing and children's social care. For example, when the social worker asked Ann whether she could support her to make Lisa's college application, she declined informing the social worker she will go to the G.P. This is a question that the Partnership will want to explore and learn from to improve practice with disadvantaged families.

10.2.11 As Lisa's primary carer, Ann's wellbeing and trust of professionals was key to Lisa's wellbeing*. "People in Britain from BAME communities face fundamental inequalities in access to treatment, experiences of care and outcomes from services."*[12] The practitioner event identified this as an issue linked to social capital, highlighting the absence of robust social networks that could have provided practical and emotional support for some communities. Ann sought out the G.P to ask her about education, and other areas of need that were outside of her remit, whilst she avoided support from children's social care.

10.2.12 Furthermore, the broader context of policies described as fostering a '*hostile environment'* for people who have moved to the country and referred to as '*migrants'* is likely to have influenced Ann's decisions and her mistrust in some professionals. This is evidenced when the family experienced racial attacks in their previous home in Nottingham, including a severe incident involving a neighbour setting fire to their back garden. The fire brigade was called, and the fire was extinguished.

10.2.13 Relationships are predicated on trust and understanding, with often new migrants going to those who either share common language or experience. Initially Ann's prior experience and ill health may have predisposed her to engaging with the G.P whilst struggling with others especially when there was a lack of response or fears about authoritarianism whether perceived or real.

10.2.14 The research, feedback from practitioners and Lisa's sibling suggests that the family was isolated as a choice based on fear by Ann of any potential threats from the outside world to her daughters. Ann is likely to have considered some aspects of support from children's social care as a potential threat to her and her daughters. However, at times Ann did have positive interaction with the family's social worker.

[12] Robinson, Williams, Buck, Breckwoldf. June2021, Ethnic Health inequalities and the NHS. NHS Race and Health observatory.

10.2.15 The session with the community group highlighted that there is a gap in service access for people from African background. More work needs to be carried out for services to support children in these communities and engage with their parents. Families feared that their children's disability was not always understood, and consequent treatment was not available to them, and this caused the parents anxiety and distress. Others were concerned that their children were treated differently because of their status as being from a minority background. These fears and worries shape the ability of parents to confidently engage with services. In seeking to explain this, evidence is often sought about why, for example, Ann did not engage.

10.2.16 The reviewer has found that no agency involved with Lisa was able to evidence why Ann did not engage with some agencies but did with others. Records suggest non engagement but do not sufficiently analyse their hypothesis about why this was the case. As a result of this Lisa did not receive services. If agencies are to provide services to all, then more sensitive, culturally appropriate, assertive and creative approaches are required to understand and work with parents who are considered to '*not engage'* in order to safeguard children, especially children with disabilities.

10.2.17 The practitioner event had clear, open, and nuanced discussions about cultural competence, race, and racism. The discussions were held to enable learning from the case, and to help the panel understand the wider issues. In order to support all children, a more knowledgeable approach is required about the lived experience of those who feel or are made to feel like outsiders, as is the case of this family, when someone set fire to their garden.

10.2.18 In addition, there is no evidence of using tools such as a culturagram.[13] Practitioners agreed that the review highlights areas for further work to understand families from diverse backgrounds. Not doing so continues to perpetuate the one size fits all approach to service delivery.

10.2.19 Parents at the community event were distressed and tearful about the lack of support for their children and knowing how to voice their concerns or having their concerns heard. The support they did receive was from individual teachers who were committed to pursuing support for children with SEN needs. It is positive that there are individuals within the system who actively seek to engage with parents of children with disabilities who are from a disadvantaged background.

[13] A culturagram is a family assessment tool used in social worker to understand how cultural background impacts on family life.

10.2.20 However, this appears to be a systemic issue requiring a systematic response. The concerns raised by members in the community about their challenges in accessing support for their children has been raised with the senior leader's event and has now been followed up by senior managers in children's services. This is good practice and indicates the willingness to build trust and follow up on areas of concern for disadvantaged communities.

10.2.21 As sole carer for Lisa, Ann's engagement with services was critical in meeting Lisa's needs. Ann may have been reticent in accessing services and may have needed support to engage. Without meaningful discussion and finding methods of engaging with her, progress in assessments and plans for Lisa was difficult. For example, her sibling told the reviewer that Ann did not trust the school to care for her daughter in the way that she did at home. A discussion with Ann about what she needed for her to support Lisa to attend school could have led to a more nuanced approach to break the stand-off between Ann and the school and education services.

10.2.22 Examining how past trauma, the impact of migration, and the intersecting identities of a black child with disability and their single black mother combine to create a complex experience of disadvantage – influencing their engagement with professionals – represents an important area of learning and reflection for the partnership. Dynamics of migration are often closely linked to race and racism for some communities.

10.2.23 Unconscious bias and issues of race and racism are often difficult to assess and can be met with resistance to acknowledging this issue, without 'evidence.' The reviewer would suggest that these are issues that the partnership may consider and be curious about learning from this review.

10.2.24 This reflects some of the findings from the Race Health observatory report "We *Deserve better: Ethnic minorities with a learning disability and access to healthcare (2023)*[14] *which noted from LEDER (2018-21) analysis," People from ethnic minority groups had a significantly lower median age at death".* In their summary they have gone onto say
"*Within health and care settings, reasonable adjustments are not always adhered to …. Through a combination of such factors, people from ethnic minorities with a learning disability experience worse care and ultimately die at a younger age.*"

10.2.25 From the parent's perspective, there is a strong desire for practitioners to better understand their standpoint. Parents often question, *"Can I trust services, given my past and present experiences?"* In contrast, organisations frequently struggle

[14] https://nhsrho.org/wp-content/uploads/2023/05/RHO-Executive-Summary-LD-Report.pdf

with a lack of understanding of these lived experiences. From both community and individual viewpoints, some parents and communities may perceive engagement with agencies as discriminatory—particularly on the grounds of race. The complexity of these interactions is shaped by the intersection of multiple factors, including disability, communication needs, ethnicity, and migration status, all of which contribute to the challenges faced by parents and their families.

10.2.26 The experiences of those who attended the community meeting reinforced this point. They reflected that when practitioners reach out, attempt to understand their perspective and lived experience and communicate effectively trust is built and sustained to support them and work with them to meet their children's needs. Lisa's degree of intellectual disability is likely to have meant that she always needed support in accessing services and even with reasonable adjustments, would not have been able to do so independently.

10.2.27 The National Panel's analysis highlighted that *too often reviews miss opportunities for capturing the learning about the many ways that race and racial bias influence multi-agency practice",*[15] In this case the success of some whilst others struggled, can only lead one to conclude that these issues need some consideration.

10.2.28 These factors highlight the importance of multi-agency frameworks in proactively addressing barriers, fostering inclusivity, and ensuring families are aware of and able to access available resources, by use of cultural competency work and Social GGRRAAACCEEESSS.

(BASW [16] Social GGRRAAACCEEESSS is an acronym. The term 'Social GGRRAAACCEEESSS' was first developed by Burnham (1993) and refers to a range of social differences. It was later further expanded to include gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality (Burnham, 2012).

KEY LEARNING

- **The impact of migration was not sufficiently considered.** Practitioners need to understand the impact of migration, including feelings of isolation, disconnection, and hostility felt by newly arrived migrant parents. Community discussions also highlighted these issues.

[15] Child Safeguarding Practice Panel 2025, It is Silent – Race and Racism. HMO

[16] www BASW 2020 social graces and cultural competence.

- **Practitioners need opportunities to openly support and challenge** (and in supervision) to better understand the impact of migration, race and racism on families and how this may shape their responses to services provided.

10.3 Key Theme 3: Robust child protection processes, child neglect and transition arrangements.

How effectively were Child Protection Processes used to support and safeguard Lisa? What was known about the impact of Child Neglect on her?

What understanding did professionals have of Lisa's voice and lived experience? How did this influence their decisions?

10.3.1 The chronology below maps child protection processes and concerns, how they were raised and the responses from agencies.

- In February 2020, concerns were raised by the school regarding Lisa's reported hunger.
- In April 2021, a safeguarding strategy meeting was convened due to concerns regarding Lisa's missed medical appointments and school attendance. The outcome was to convene an ICPC.
- In May 2021, there was a referral with concerns raised about an incident relating to Lisa's sibling. A referral was made to children's social care, it appropriately concluded that there were no concerns for Lisa, and the outcome was no further action. In April and May 2022, concerns arose regarding Lisa's school attendance.
- In November 2022, a strategy discussion and Section 47 enquiries were initiated, this led to an Initial Child Protection Conference (ICPC), being planned but this was then cancelled by the chair because Ann did not have enough notice to attend.
- In December 2022, there was a discussion within children's social care that further information was required and that the ICPC should not go ahead. The ICPC should have gone ahead.
- The procedures for ICPC were not followed as it is unusual for the discussion about level of risk to be taken outside of the multi-agency partnership.

- Another incident occurred in December 2022, with Lisa's sibling, no immediate safeguarding concerns were raised for Lisa at the time. As Lisa's sibling was an adult in December 2022, her decision not to pursue further was respected. However, the question remains about what considerations was given to Lisa witnessing what happened to her sister. It was assessed at the time that no further action would be taken to safeguard Lisa and this decision was appropriate.
- In March 2023, there were further concerns raised by health. The combined health agency report for the Rapid Review suggests that Ann had dis-engaged by not bringing Lisa for her appointments and that further investigation was required to understand why this was the case. They appropriately raised concerns with Children's Social Care.
- In March 2023, an Initial Children Protection Conference was held. It was agreed that Lisa be placed on a child protection plan at the end of March.
- In January 2024, the Child Protection Plan was ended. A home visit was made in January 2024, Ann came to the window, Lisa was not seen. There were several visits made at the end of 2023, when Lisa was not seen. She was last seen in October 2023.
- The decision to end a child protection plan is a multi-agency decision. Housing attended the review conference but did not inform the conference that gas was switched off at this time. There was no meaningful engagement by adult social care within the review conference, and this was reflected in the minutes. Furthermore, there were no discussions about transition to adult services for Lisa. Housing had attempted to engage with Ann prior to the gas being switched off, however, this was not successful, and Ann did not feel able to engage with housing. This is likely to have caused difficulties for both Ann and Lisa.
- This was a key missed opportunity because of Lisa's age and level of need. The plan should have continued until there was sufficient evidence that there was support around Lisa and for Ann so that she could care for Lisa as she had been unwell.

Child Protection.

10.3.2 The Nottingham City safeguarding procedures describe the purpose of the Child Protection Plan "*to ensure a child's safety and prevent further harm by supporting their strengths, addressing vulnerabilities and meeting their unmet needs'*[17].

10.3.3 In order to prevent harm and address vulnerabilities, a Child Protection Plan should be driven by regular statutory visits (at least every two weeks) and intervention (carry out activities set out in the plan).

[17] Nottingham City Safeguarding Children Partnership Procedures.

10.3.4 In the time that Lisa was on a child protection plan, she was due to be visited every two weeks in line with local child protection procedures and processes. This meant that Lisa was due 29 visits, 6 visits were made where she was seen. There were attempts made but on one occasion two weeks had lapsed from an unsuccessful visit to the next attempt.

10.3.5 Other attempts were not successful. There was home visits made where entry was not gained into the home. When Lisa was seen, there is little information about what direct work was carried out with her. Recordings suggest that intervention was mostly superficial. The decision to end the Child Protection Plan was a multi-agency decision, and the decision was not sufficiently evidence based. The partnership has reviewed child protection processes to seek reassurance that this is not a systemic issue in child protection practice in the City.

10.3.6 The social worker and police attempted to make contact, and visits were made jointly to see Lisa. However, there is little evidence of how the child protection plan made any meaningful change in Lisa's lived experience. The partnership has been proactive in reviewing and working to ensure that visits are purposeful after the rapid review was completed. The partnership has also carried out meaningful work on ensuring that a child's lived experience is understood on social work visits.

10.3.7 The child protection plan did not have a meaningful impact for Lisa because Ann had not been involved in the child protection core group meetings, and she was reported not to be accessing support. It is concerning that the multi-agency team was not able to understand the reason for non-engagement and to find creative and trauma informed methods to engage with Lisa and understand the barriers to engagement for Ann. As a result of this, Lisa did not receive the CSC assessment or sufficient safeguarding support.

10.3.8 Further work could have been carried out to review thresholds when there was disagreement about whether Lisa should be on a child in need or a child protection plan, escalations processes could have been used, and professional meetings called to work through barriers to engagement, visits and to understand what life was like for Lisa. There was no legal advice sought at this time.

Child Neglect.

10.3.9 Lisa was on a Child Protection Plan under the category of child neglect. Child neglect is the most pervasive form of child maltreatment. *It is characterised by a caregiver's failure, to provide for a child's basic needs, including physical care, emotional support, education, and medical attention.*

Unlike other forms of abuse, neglect can often be passive, resulting from inaction rather than deliberate harm. [18]

10.3.10 Lisa experienced intermittent health neglect because she was not brought to health appointments. However, due to the limited intervention, observation, and opportunities to assess and understand Lisa's lived experience, further work was required to analyse the risk of neglect and make an evidence-based decision about its impact on Lisa and the necessary interventions.

10.3.11 Whilst the CP plan was not based on home conditions but on neglect of health and education needs, work with child neglect requires a thorough assessment of all domains, in order to understand the child's needs, risks and areas for support and intervention.

10.3.12 The Child protection notes suggest the focus was on the presentation of the home, with lack of heating and mould that had not been addressed by housing. The child neglect was seen superficially; records suggest that the house was clean and there was food in the freezer.

10.3.13 The records do not adequately illustrate the impact of the non-attendance at school or for health appointments (areas that were of concern on the child protection plan).

10.3.14 On one occasion, there was a 10-day delay from when Ann told the social worker about the mould in her home, lack of heating and no hot water and the social worker contacting housing to follow up on the mould and repairs required in the property. This 10-day delay suggests that not only were Lisa's needs neglected by Ann but were exacerbated by agencies. There appears to be a lack of urgency to address the home living conditions. At the time, the social worker was not responsible for reporting on housing issues, but home conditions are an important part of a child's lived experience. This has now been changed in relation to Awaab's Law.

10.3.15 A comprehensive understanding of Lisa's needs was required including the causes, manifestations, and consequences of child neglect. In implementing the CP plan, a more nuanced child focused response was needed in meeting Lisa's needs and working with Ann to do so.

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[18] Eavan McKay, August 2024, Too little, too late NSPCC.

10.3.16 Difficulties in engaging with Ann resulted in minimal intervention from children's social care. There was limited evidence of proactive or innovative attempts to overcome these barriers and build a more effective working relationship. Nottingham City Safeguarding Children's Partnership (NCSCP) should consider whether this reflects a wider systemic issue in ensuring multi-agency, child-focused interventions for children on child protection plans.

10.3.17 Nottingham City Safeguarding Children's Partnership (NCSCP)'s Neglect strategy states "*child neglect has a lifelong impact on a person's well-being, and it is vitally important that as a partnership we do all we can to prevent it"* [19]. There is a neglect toolkit in place for practitioners to understand and work with child neglect. The expectation is that it is completed to inform referral, assessment and decision making on child neglect. This was not completed for Lisa.

10.3.18 The partnership has a current neglect steering group looking at how recognition and response to neglect can be improved across the partnership. Completion of the child neglect toolkit for all children on a child protection plan under the category of neglect has been identified as learning from this review and children's social care has put in place measures to reinforce this expectation.

10.3.19 The decision to end the plan in January 2024 was based on the questionable assessment and assumption that there was sufficient support provided to Ann, by her friend to care for Lisa. This decision was not evidence based and was overoptimistic, given that there was little evidence that the plan had made significant changes to Lisa's outcomes or lived experience.

10.3.20 The social worker visited the friend's shared house, but she was not in. Although a couple of visits were made, no contact was made with Ann's friend to understand what support she could provide to Lisa and to Ann to care for Lisa. Evidence should have been sought as to whether support from the friend had a positive impact on Ann's ability to meet Lisa's needs and Lisa's lived experience, as well as ensuring that the offer of support was sustainable overtime. Therefore, the decision to end the children protection plan was poor practice as it was not fully assessed, analysed, or tested.

10.3.21 The Child Safeguarding Practice Review Panel's report has been critical of the lack of robust and forensic review of the needs, risks and circumstances for children. The Child Safeguarding Practice Review Annual report (2022) suggests that:

"*Assessments and plans for support are framed by underlying assumptions that remain unchanged in spite of continuing or spiralling risk…. This is particularly so*

[19] Nottingham City Safeguarding Partnership Neglect Strategy.

where there has been intervention over years (or in Lisa's case ineffective intervention)*. These circumstances are often combined with a lack of challenge between professionals and a reluctance to escalate concerns.*[20]

10.3.22 There was little change for Lisa and a continuation of risk that had remained unchanged. The lack of thorough work prior to step down was later reinforced by information found by Police. Police found that Ann's friend had blocked her phone, and it is likely that she was not able to care for Lisa or support Ann to care for Lisa. Ann was offered a Child in Need plan which requires consent, and no consent was gained therefore the case was closed.

10.3.23 Agreement to discontinue with the Child Protection plan was a missed opportunity to carry out work with Ann to safeguard Lisa. Attempts would have been made to visit the home even if Ann did not provide access, giving some oversight of Lisa's well-being. There is further learning about the initiation, progress and completion of child protection plans from this review. For example, for Lisa the ICPC was cancelled without multi agency input. Other agencies could have followed an escalation process to challenge this decision.

10.3.24 Professionals are expected to observe, assess and review, and work with each other to understand the child's lived experience and apply their professional knowledge about the child's circumstances. There is little information about the work that was carried out with Ann to understand the reason for step down of the child protection plan.

10.3.25 This information was not tested or triangulated with what was known about the friend e.g. how often she visited Lisa, what was her input into Lisa's daily life and how did she communicate with Lisa.

10.3.26 Nottingham Children's Social Care has put processes in place to avoid early closure of Child Protection Plans since Lisa's death and is revising the child neglect strategy. The needs of children with disabilities should be reviewed in the revised neglect strategy and tested by carrying out a multi-agency audit to assess whether this practice has been implemented systematically across the whole partnership.

10.3.27 This review highlights the need for purposeful visiting, ensuring that access is gained, that direct work is carried out with children and young people and ensuring that interventions have a positive impact on a child's lived experience. In some cases, visits made life more difficult for Lisa, for example when housing failed to gain entry, the gas was cut off, this will have impacted on Lisa's lived

[20] Child Safeguarding Practice Review Panel Annual Report 2022.

experience especially in the colder months. This is an important area of learning from this review.

10.3.28 Child protection plans should be guided by appropriate thresholds, with the level of monitoring proportionate to the level of concern. In Lisa's case, the decision to cancel the Initial Child Protection Conference (ICPC) and subsequently end the plan was not consistent with these thresholds.

10.3.29 At the Review Child Protection Conference (RCPC) in October 2023, children's social care recommended that the child protection plan be stepped down. However, decisions at review conferences should always be evidence-based and underpinned by a current, comprehensive understanding of the child's needs, risks, and circumstances. In this case, the evidence did not sufficiently support the decision to end the plan.

10.3.30 Before ending a child protection plan, it is essential that all protective factors and sources of support are fully tested — for example, in Lisa's case, assessing whether Ann's friend could provide safe and appropriate support to help keep Lisa safe.

10.3.31 Where a plan is not leading to meaningful change in the child's lived experience, further action should be considered, including seeking legal advice. Any such decision must be based on a robust, multi-agency evidence.

10.3.32 Overall, the decision-making around thresholds and the management of the child protection plan lacked sufficient rigour and did not adequately protect Lisa.

Consideration of Measures Through the Court of Protection.

10.3.33 In February 2023, a manager in Children with Disabilities Service provided oversight of work with Lisa and appropriately assessed that professionals continued to struggle to gain access to Lisa to provide her with the support she needed. The manager noted that consideration should be given to convening a strategy discussion and to seek legal advice about legal routes to safeguarding Lisa. The purpose of this was to consider whether threshold had been met for legal proceedings because of a pattern of non-engagement by Ann.

10.3.34 In March 2023, there was a pre-legal planning meeting to explore the route of pursing legal proceedings and possible Court of Protection application.
The convening of a legal planning meeting for Lisa was both appropriate and good practice.

However, they were not underpinned by a stepping up of work with Lisa, for example, increased visits to the home and calling additional professionals' meetings to review work carried out with her. Prior to this decision, there was no evidence of work carried out to assess Lisa's capacity to consent to the services offered to her. There was an insufficient process in place in response to the established increase in risk.

10.3.35 The request for legal advice was undertaken by email. The response from the legal department was that as Ann had started to engage, no legal action should be sought.

10.3.36 It was agreed that further legal planning should be convened if this changed. Given that there were concerns about professionals not being able to adequately assess Lisa's needs, risks and circumstances, not seeking further legal advice was an oversight. It is unclear whether input was sought from professionals with expertise in learning disabilities at this time. This approach was not proportionate to the concerns that were raised about Lisa at this time.

10.3.37 In the absence of Lisa being seen and the legal threshold for statutory safeguarding intervention not being met, advocacy services could have been employed to give Lisa a voice. This would have supported her transition into adult services and advocated for her to access education, health services and social and recreational activities.

An assigned independent advocate could have supported Lisa (as she was due to turn 16 years) her mother was not felt to be acting in her best interests to ensure she was accessing support she needed. It is concerning that this was not discussed at the RCPC in January 2024.

Transition Planning for child with a disability.

10.3.38 Lisa was 17 years old at the time of her death, although the exact date has not been determined because of the circumstances of her death. Transition work involving Lisa's move to adult social care began in January 2024, with both the children's social worker and an adult social care social worker visiting her home. Lisa was not seen, and Ann was seen from the window.

10.3.39 There was no evidence of appropriate transfer plans. The Whole Disability Service held Children's and Adults Teams, allowing for a smooth and collaborative transition. The practitioner from adult social care attended the RCPC and it was agreed that the transfer process should be streamlined. The lack of a written transfer document was a missed opportunity to provide detailed and thorough information about Lisa's needs, risks and circumstance into adult services.

10.3.40 In late January 2024, it was noted that the Lisa's children's social worker was worried about Ann because when she spoke to the nurse in hospital, she was told that Ann's health risk was very high. When Ann returned home, a joint home visit was carried out between the children and adult social care social worker. When Ann was asked how she was, she said she is 'ok.' The adult social worker said she was worried about Ann too. Ann said she is fine.

10.3.41 This was followed up with a call by the children's social worker to the hospital enquiring about Ann's health but there was no response. A message was left for the consultant but there is no further information about Ann's health and there is little information about why this is the case. There was a follow up appointment made within three days of discharge from hospital for Ann. This was a critical time to understand how Ann's health impacted on Lisa and although Ann was saying that she was fine further information about her health was not sought. For Lisa, work on transitions was not sufficiently progressed with rigour.

10.3.42 When Ann said that she will ask her friend if she needed further support, this was not tested either. This time was critical for transition planning. It was not clear how Ann's recovery from the hospital appointment would impact on her care of Lisa, nor the detail of the support that her friend was willing and able to provide to both Lisa and Ann.

KEY LEARNING

- Child protection plans should be thoroughly reviewed before closure to ensure they have positively impacted the child's well-being.
  The partners involved must critically evaluate whether the plan's goals have been achieved prior to its conclusion.
- Senior leadership advice and oversight should be sought for children where there are child protection measures in place, but the plan is felt to be ineffective or where professionals are struggling to effectively engage families in the work.
- Where safeguarding concerns meet a Legal Planning threshold, the work carried out, and safeguarding concerns identified in Child Protection Plans should be considered to provide a thorough and nuanced understanding about the child's needs, risks and circumstances.
- Whilst initially there was some good practice on Deprivation of Liberty Safeguards this did not continue. Children's social care staff need to be confident in gathering evidence to inform their DOLs decision making meetings and not by email or electronic communications.
- Age appropriate and disability aware consent for children with intellectual disability to access services.

- The Mental Capacity Act should be used when there are concerns about accessing services for young people aged 16 and over (as Lisa was) to protect and empower them to make their own decisions about their care and treatment.

10.4 KEY THEMES 4: How did agencies work with Lisa and her family as single agencies? How did they work together? What was the impact of these interventions? What have agencies learnt from this and how has practice changed?

Children's Social Care.

10.4.1 There was historical Children's Social Care involvement with the family when a referral was received in November 2016 from Housing Aid to seek support for the family for housing because there was a 10-year-old (Lisa) and her 13-year-old sibling and the family was homeless. The outcome of the referral was no further action. The rationale for this was appropriate as there were no concerns and the family later secured housing.

10.4.2. The family was open to children's social care because Lisa was presenting with distressing behaviours: hitting, spitting and throwing. Support was provided with behavioural strategies, SEN support identified and CAMHS. At this time, Lisa was open on a Child in Need from plan July 2017 until December 2017.

10.4.3 In April 2022, a referral was made by education welfare because, Lisa was not seen since January 2022. Also in April 2022, the family were evicted from their home. The referral was progressed to social work assessment.

10.4.4 In July 2022 Lisa had not attended school for months and it was reported that professionals were not able to engage with Ann to understand the reason why this was the case and what support was needed for Lisa to attend school. Lisa was on a Child in Need Plan, at this time.

10.4.5. In September 2022, a referral was made by a medical professional about Lisa's home conditions. In particular there was mould in the property and Lisa would not be able to use the bath as she could not fit into the bath to bathe in. Her mother used a bucket for her to bathe with. This was indication of environmental child neglect where Lisa's mother was not supported to meet her basic needs. Children's social care involvement does not appear to have considered the pattern of child neglect over time. That is non-attendance at school, poor housing, eviction and Ann struggling to engage with professionals.

10.4.6. Between September and October 2022, there were two home visits by the social worker. One was successful where Lisa was seen, and her sibling told the social worker that Lisa and her mother had returned from their time abroad and that they were well. Lisa was seen in passing on this visit and this was through a door. She was not seen alone, her wishes and feelings were not sought. There was a reported bad smell in the house and there was no curiosity about this especially as there were previous referrals about the state of the property and it was known that there was mould in the house.

10.4.7 This practice appears to be limited and does not evidence thorough and curious practice to understand the child's lived experience and the reason for her mother's reticence in engaging with the social worker. In the agency report for the Rapid Review. Children's social care assessed that more frequent visits should have taken place, and these should have been planned in line with the areas of concern: Lisa's well-being, the state of the property and to work with her mother to find creative methods of engagement.

10.4.8 In November 2022, another unsuccessful home visit was followed by a strategy discussion. This was not in line with practice expectations and was delayed four days instead of being conducted within forty-eight hours, the outcome of the strategy discussion was an Initial Child Protection Conference (ICPC). The ICPC was cancelled. This decision led to the service overlooking safeguarding concerns and reverting to expected practice for a child in need plan, that is visiting the child at a minimum frequency of monthly.

The decision to cancel the ICPC was not proportionate to the safeguarding concerns highlighted in the strategy discussion and a safety plan to visit more frequently then would be expected for a child on a child in need plan in the intervening period. This could have been challenged by other professionals in the multi-agency partnership and have oversight by senior managers in children's social care. There was no senior leader oversight of the decision to cancel the ICPC – this practice has now changed in the service.

10.4.9 In December 2022, legal advice was sought, which represents good practice. However, there was a misunderstanding among social work colleagues that no legal route was available to safeguard Lisa. The legal team had advised that if legal intervention through the Court of Protection were to be considered, evidence of child neglect and its impact on Lisa would be required. They also suggested that, before making a Court of Protection application to seek injunctions to compel access for assessments, further efforts should be made to encourage Ann's cooperation, as court proceedings should be a last resort. A more robust approach by the social work team could have been taken to gather evidence of neglect.

10.4.10 In March 2023, another strategy discussion was convened with the outcome of Initial Child Protection Conference. This was held in late March 2023, and child protection measures were introduced in respect of under the category of child neglect. There was a missed opportunity to invite housing to the ICPC as housing was a key issue for Lisa's lived experience. In April 2023, during a home visit following the ICPC, the social worker noted that there was food in the fridge that Lisa appeared to be happy, there was no heating but there was hot water.

10.4.11 It is not clear whether the bath had been adapted for Lisa, or she was still bathing with a bucket. The engagement with housing to address the home conditions was neither swift nor timely. Further child protection decision making appeared to be misinformed by what life was like for Lisa and a multi-agency decision was made in January 2024 to end the child protection plan based on support received by Ann from a friend. This was agreed by all professionals present at the meeting.

10.4.12 The social worker had not met the friend; no meaningful safety plan was agreed with either Ann or her friend. No updated Child and Family Assessment had been carried out to inform the end of safeguarding concerns noted at the start of the Child Protection Plan. Another key consideration that was not considered, was that housing had not yet resolved the absence of gas in the family home, there was no meaningful engagement with adult services, and it was not clear whether adult services would enable Ann to engage with their service or transitions for Lisa.

10.4.13 Since the rapid review was published children's social care have made improvements in their work on child protection ensuring that visits are purposeful, meaningful and provide clear understanding of the child's lived experience.

Education.

10.4.14 Ann first contacted SEN team in January 2017 when she approached them for Lisa's education, health and care assessment for Lisa. This was declined in February 2017. Another referral was made by Ann in July 2017, but the SEN team believed that Lisa had moved abroad with her mother and therefore this was not progressed.

10.4.15 A school place was commissioned in 2018 for the duration of Lisa's education as a child. This was terminated in July 2022, and a place was sought at college. Lisa was first referred to Education Welfare Service in March 2022; there was a delay in making the referral. It was not made until three months after Lisa had not attended school.

10.4.16 The records suggests that Ann was concerned about trying to access support for Lisa's learning and later for a college place.

It is not clear what she said about Lisa's non-attendance at school, and Ann said that Lisa was refusing to go to school. A letter was sent which resulted in court action in date, this is while the case was open to the service. This would have further alienated Ann and fuelled her mistrust of agencies and is not good practice. Sending a letter is considered good practice, however, this should be carried out as an action after a case has been closed.

10.4.17 Lisa's attendance at school was reduced to 4.7 %, in the academic year 2021 and 2022 (COVID Pandemic). There was an EHCP in place, but it is unlikely to have had any meaningful impact on Lisa.

10.4.18 Lisa's sibling said that the reason for Lisa not going to school was because Ann felt that she was not well cared for with her toileting and other needs and that Lisa found it distressing at times. The school has suggested that Lisa seemed happy at school and feedback from a family member suggests that she enjoyed school and she wanted to attend.

10.4.19 It is concerning that Lisa was not attending school and her sibling reported that she was distressed about this. Lisa's own views about school were never ascertained. The mistrust that Ann had about agencies does not seem to have been addressed. As wider partnership learning from this review, consideration could be given to how agencies can work together to overcome the barriers that are in place to prevent children from attending school.

Lisa did not receive education for long periods of time, and this will have made her unhappy as well as prevent her from being with other children and receive appropriate education.

Housing

10.4.20 Since the family's arrival in the city in 2016, Lisa's mother, Ann had difficulties with housing. Lisa and her family were evicted by a private landlord. They were offered temporary accommodation and then a house from the city's housing stock.

10.4.21 The question is what Ann understood about her responsibilities as a tenant and how she could achieve what she needed to within the home? This is not a question that the reviewer has a response to, but it is evident that while Ann had contacted housing about repairs, she did not feel confident in allowing repair workers to access her home to complete the requested repairs.

10.4.22 The housing agency has reported that they attempted to gain access to the home because they needed to undertake safety checks in order to issue the gas safety certificate which is a requirement for them to complete by law.

When access was denied by Ann, the gas was cut off, in line with housing regulations and safety standards. However, the impact of this on the family was not sufficiently considered.

10.4.23 There was a need for some advocacy for Lisa and her family in respect of their home conditions. The social worker contacted housing but there was a delay of 10 days after a visit and there were no trusted individuals who could have communicated with and supported Ann to understand the impact of her denying access to the home.

10.4.24 Little time was spent to support her to understand the impact of non-engagement. Children's social care contacted housing about this and other housing issues, however, work with housing would have improved if a more robust advocacy approach was taken by children's social care to resolve the housing issues faced by the family.

10.4.25 At the practitioner event, one practitioner commented on the windows being covered in the family home. It is not known why this was the case.

10.4.26 Changes have now been put in place by housing for tenants to provide evidence about damp and mould without a housing officer having to visit the home. For example, any evidence of damp and mould can be provided by using a phone to take a photo or video evidence. This is good practice.

10.4.27 In working with vulnerable children and their families, it is important that all agencies take account of the responsibilities set out in Working Together 2023 that safeguarding is everyone's business.

10.4.28 Although housing agency practitioners followed protocol, it had unintended consequences for Lisa and her family. The learning for housing from this review is that a more flexible approach is needed in order to meet their regulations and the needs of vulnerable children and adults in the household.

10.4.29 The housing agency carries out regular tenancy visits to ensure the property's safety. The significance of this practice, considering Lisa's vulnerabilities, was not fully understood. Following the Rapid Review, the housing agency has updated its policy to include engagement with children's safeguarding to better understand house safety within the context of child safeguarding. The housing agency has developed a vulnerability policy and established a multi-disciplinary group to understand non engagement by some tenants and how this can be approached through a more relational and restorative approach. A post has been developed to address this so that the needs of tenants are better understood and there is

improved communication to understand and respond to tenants needs, risks and circumstances.

10.4.30 Housing officers, like many other agencies had difficulties in gaining access to the family home for maintenance. The housing agency has subsequently established that this approach is not appropriate for families where there are vulnerable children or adults. "*The proposed outcomes will be to ensure a robust escalation process with a menu of supporting activities, performance measures and appropriate and proportionate risk-based intervention actions that reflect an agreed new vulnerability policy"*[21]. Future gas caps will be reviewed with children's social care to ensure that there are no unintended consequences of following the procedures set out for gas safety.

10.4.31 The housing agency has developed an action plan which includes the development of a vulnerability policy, and other actions from this review and put processes in place to improve practice. Developed, nuanced and person focussed communication with tenants is a positive step towards addressing understanding of tenants and reasons for non-engagement.

East Midlands Ambulance Service

10.4.32 Towards the end of her life, Ann made a 999 call for an ambulance to come to her home. Previously, she had been in hospital with a serious illness, and she did not attend her follow-up appointment.

10.4.33 Little is known about why this was the case; it is likely because Ann was the sole carer for Lisa. It is understood that her medical condition deteriorated, and therefore she called 999 requesting an ambulance.

10.4.34 When Ann called the ambulance the call handler found it difficult to understand what she was saying with very few words being recognised. The call handler appropriately checked if an interpreter was required. This is good practice. Ann did not respond to this question.

10.4.35 However, they did not assess that the difficulty to understand Ann may be because she was struggling to speak due to an underlying medical cause rather than a language issue. During the call, very few words were recognisable. Ann's inability to communicate was likely to be because of her medical condition at the time. It is important that the ambulance service call handlers appreciate the nuance and difference between language and medical difficulty in being comprehended.

[21] Housing agency report. June 2023.

10.4.36 Due to unclear communication (which may have partly been due to her health issues), the service concluded that the call had been abandoned. The Hunt line which maps calls was not accessed, and guidance from a senior colleague should have been sought. This did not happen, and the call should not have been marked as abandoned. If the call was not abandoned, this would have meant that the call would be on the call stack, and an ambulance would have been dispatched. The ambulance service has identified this as learning in the patient safety incident investigation (PSII) report.

10.4.37 The service review suggests that if there was a clinical marker on Ann and Lisa's home address, this would have alerted the ambulance service to establish where there are vulnerable children and adults. This is especially important for children and adults who like Lisa, have a disability, are primarily non-verbal and potentially not able to move to safety and would therefore be unable to follow up on a call. In Lisa's case no alert was requested by children's social care, because at the time she was not open to the service.

10.4.38 In the ambulance service, safeguarding alerts are added by the safeguarding team. Clinical alerts used to be added by one practitioner. Revised governance arrangements are now in place with a dedicated email address for clinical alerts to be processed. Since the rapid review, all adult and children's social care departments across the East Midlands have been contacted to remind them the process of how to add a clinical or safeguarding alert to patient's home addresses. A safeguarding or clinical alert enables EMAS to be notified that a patient is living at an address and they may need additional support if their main carer becomes unwell as they are unable to care for themselves.

10.4.39 The report recognises that changes need to be made, and this is significant learning that will need to be shared nationally, so that all paramedic and ambulance services have the opportunity to review their processes. The coroner found that if an ambulance had been dispatched on the night of Ann making the 999 call, Lisa's death could have been prevented, and this is a significant finding from this review.

Police

10.4.40 The contact with Nottinghamshire Police was limited and intermittent. Ann believed and reported that in July and August 2022, while she was away police had broken into her home, smashing a window to gain access. However, Police provided information that in fact, this was a Safe and Well check which was requested to ensure that Lisa and Ann were safe. Local officers made a number of enquiries starting with attendance at the property to which they had no answer. They then spoke with neighbours, contacted Lisa's sibling, the Emergency Duty

Team (there was no answer from them) and re attended the property and gained access via Section 17 PACE '*to save Life and Limb'*. The address was searched, and no signs of life were found and the police requested boarding up services from housing.

10.4.41 Police had an initial concern came in from Ann who said that she was going away and was planning on leaving Lisa at home. Children's social care called a strategy discussion in July 2022 with partners and in that strategy plan it was discussed that mum had it in hand, but social workers were not sighted on the plan by mum.

10.4.42 From the strategy discussion, Police then created a safeguarding concern, but it was to remain single agency and for social care (to whom Lisa was open to) to check the address and assess the situation.

10.4.43 Also in July 2022, children's social care reported that they had been unsuccessful with their visit and there was no answer at the address. Children's social care asked for boarder checks and an alert for when Ann and Lisa returned from abroad.

10.4.44 Police contacted EDT and Lisa's sibling and passed this information back to the MASH. There were continued efforts to ensure that Lisa was safe and well. To aid the situation, an Investigation was allocated to continue checks with the boarder agency and start searching for the family as they appeared missing.

10.4.45 Police then conducted a Joint Visit with social care at the home address and whilst there was no answer spoke with Lisa's sibling who confirmed that she had gone abroad with her mother.

10.4.46 Police then passed this information to Children's social care to monitor when Lisa returned. When they returned, Children's Social Care then updated police that Ann was not engaging with them. Information sharing between police and Children's Social care was good practice.

10.4.47 In March 2023, Ann went to a police station to discuss matters that she was concerned about and potentially to ask for help and support. She told police officers that she was having bad dreams about her ex-husband. The police agency report indicates that in their communication with Ann, they assessed that her behaviour presented as someone with either mental health needs, under considerable stress or depression.

10.4.48 During her visit to the Police station, Ann was changing subjects as she spoke to officers, and she said that she did not need support with her mental health. Police completed a Police Protection Notice and shared information with Children's

Social Care. The sharing of information with Children's Social Care following this visit was in line with expected practice.

Health[22]

10.4.49 Health services in the Nottingham City had contact with Lisa dependent on her health needs. Lisa was open to universal services and other parts of the health service relating to her disabilities. For example, Lisa was open to City Care Children's Public Health 0-19 Nursing Service in 2017, she was receiving a standard service and an enhanced service. It is not known whether the universal service was sufficient to meet Lisa's needs or whether an enhanced service should have been provided.

10.4.50. Ann took Lisa to some medical appointments. However, when the family first moved to Nottingham, Ann took Lisa to most of her health appointments. In 2022, this engagement changed to Lisa being taken to fewer appointments. The reason for this is not known. However, records show that Ann took Lisa to most of her G.P appointments, although she did not take her for her annual review at the G.P practice. Practitioners made several attempts to contact Ann by making phone calls to encourage her to attend the G.P annual check-up with Lisa.
None of these attempts were successful. The consequences for Lisa were that routine surveillance screening for associated conditions (such as diabetes and thyroid disorders) were not checked. [23]. Little is known about why she did not take Lisa to some appointments and not others.

10.4.51 The amalgamated health agency report acknowledges that at this time; a professionals meeting should have been held to further explore the reasons why this was the case and what support was required by Ann to re-engage.

10.4.52 When Ann took Lisa to her hospital appointments, she did not always attend at the allocated time. The hospital staff were curious about whether Ann's health impacted on how she could care for Lisa. Lisa attended Nottingham University Hospital in September 2022 when she was seen by a paediatric cardiologist. The cardiologist contacted the G.P to notify them that future appointments would be with an adult cardiologist.

10.4.53 The referral was accepted by adult cardiology, and an appointment was made for two years later in November 2024. The heart condition further illustrates Lisa's

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[22] 'Health' is used as a generic term relating to agencies who provide health services. Information is drawn from 'health' agency report for the rapid review report.

[23] Taken from Children's Social Care chronology

complex physical and mental health needs and vulnerabilities. Her heart condition was not having a clinical impact and was under routine surveillance.

10.4.54 It is not clear whether any further attempts were made to understand why Ann had not brought Lisa to appointments and whether there were any trusted practitioners that Ann would work with. Discussions at the practitioner event suggest that Ann had a good relationship with her G.P. and they communicated well. Practitioners and the G.P could have worked together to encourage Ann to take Lisa to appointments and leverage the good relationship between the G.P and Ann to improve access to medical support for Lisa.

10.4.55 When Lisa was on a child protection plan, a ‘Child at risk’ alert was recorded on Lisa’s Primary Care health records dated May 2022. There was also a CP-IS (child protection information sharing) alert on Lisa’s record. Child Protection Information present on the national spine which is seen when the CYP attends urgent care settings such as Emergency Department of hospitals. This is good practice and provides critical information to health professionals that Lisa was on a child protection plan and there were safeguarding concerns for Lisa. A national limitation of this system is that is can only be seen in urgent care settings.

10.4.56 There was variability in Ann’s engagement with health appointments and attendance at follow up appointments. It is unclear why there was a change in engagement and attendance over time.

The impact of this on Lisa is that she was left with health needs being unmet. This highlights the importance of addressing barriers to engagement, unfortunately there was no information about why Ann did not engage with health professionals and what the barriers were for her to engage.

10.4.57 The practitioner's event emphasised the importance of vulnerable children and their parents having trusted professionals. For Ann her G.P was her trusted professional, she shared her difficulties about wider areas of concern in her life, for example Lisa’s application for continued education.

10.4.58 The practitioner event highlighted the importance of health sector practitioners understanding who Ann was most likely to trust and work with. They could have considered the good relationship she had with her G.P and support to bridge gaps of mistrust and non-engagement.

KEY LEARNING

- **Relational and Restorative Approaches** A recurring theme is the need for relational and restorative practices to build trust with vulnerable families. Agencies must prioritise proactive communication, empathetic engagement, and advocacy to address mistrust and ensure that services are accessible and responsive.
- **Trauma-Informed Practice** The analysis highlights the importance of trauma-informed practice across all agencies. Understanding the long-term impact of domestic abuse and adverse childhood experiences is crucial in tailoring support to meet the unique needs of individuals like Lisa and Ann.
- **Strengthening Multi-Agency Collaboration**
  The lack of cohesive multi-agency collaboration in Lisa's case highlights the need for more systemic improvements, regular professionals' meetings and shared frameworks for communication. For example, the multi-agency use of the child neglect toolkit, when used effectively can ensure that agencies work together effectively to recognise neglect and respond accordingly.
- **Child-Centric Decision-Making**
  Ensuring that children's voices and lived experiences inform safeguarding practices is paramount. Agencies must actively seek the perspectives of children and prioritise their well-being in all decision-making processes.
- **Building Trust** Families must feel confident in collaborating with agencies and safeguarding support systems. Transparent communication, relational frameworks and Think Family approach can foster trust and encourage active engagement.

10.5 KEY THEMES 5: DOMESTIC ABUSE AND LONG-TERM IMPACT ON CHILDREN AND THEIR MOTHERS.

What was known about Domestic abuse in the family home in the European country and its likely impact on Lisa? What does this tell us about the lingering impact of domestic abuse on survivors of domestic abuse when assessing parental vulnerabilities?

10.5.1 The impact of domestic abuse on children and families is profound, extending far beyond the immediate harm in abusive homes. Research has increasingly demonstrated that children exposed to domestic abuse are not mere witnesses; they are victims in their own right. The trauma associated with living in such conditions can severely disrupt the development of the nervous system and neuropathways, as evidenced in studies emerging since the Domestic Abuse Act 2021.

10.5.2 For survivors like Lisa, these disruptions often manifest in mental health challenges such as anxiety, depression, and even symptoms akin to post-traumatic stress disorder (PTSD). The ripple effects of domestic abuse can extend into physical health, eating disorders, and a diminished sense of self-worth.

10.5.3 Ann was a survivor of domestic abuse in another country. She had left her husband and remained in the same town in a European country. Her ex-husband-maintained family time with their two daughters. Both daughters are reported to have experienced the trauma associated with domestic abuse and adverse childhood events. Ann assessed that she and her children were not safe living in the same country and relocated to the U.K.

10.5.4 Social isolation was a key feature of Lisa and Ann's lived experience and is evidenced in records from most agencies. Lisa's sibling mentioned that she had no friends both in the U.K. nor when they lived in a European country or Ann's country of origin. She was isolated and had minimal support.

10.5.5 There is evidence to suggest that her own experiences of abuse might have influenced her efforts to be overprotective of her daughters. Practitioners were aware of Ann's history of domestic abuse, and therefore employing a more trauma-informed approach would have been beneficial to engage with her. Further evidence of the impact of domestic abuse on Ann is when she attended the police station to tell police, she had bad dreams about her husband abusing her.

10.5.6 The lack of connection to supportive networks both in their country of origin and in the U.K. will have impacted on the family's vulnerability.

Isolation often exacerbates feelings of helplessness and internalised isolation not wanting to engage with others. This can perpetuate cycles of trauma, particularly when survivors experience feelings of powerlessness and hopelessness. Families like Lisa's require trauma informed, tailored support systems that not only address immediate safeguarding concerns but also wider perspectives such as community integration and building resilience.

10.5.7 The need for holistic care is central to mitigating against the damaging and long-term effects of domestic abuse and adverse childhood experiences. *"For non-engagement" It is important to understand the underlying issues giving rise to reluctant or sporadic engagement particularly where professionals are 'working with consent'* [24]

[24] Multi agency Safeguarding and domestic Abuse Child Safeguarding Practice Review Briefing 2 September 2022.

10.5.8 Researchers and practitioners alike have highlighted how a caregiver's trauma can inadvertently inhibit their ability to support their children effectively. For Ann, the lingering effects of domestic abuse, coupled with the challenges of social isolation, could potentially have reduced her capacity to address Lisa's needs.

10.5.9 The experiences of Lisa and Ann highlight the critical need for a trauma-informed, intersectional approach that considers the nuanced complexities of migration, disability, and social isolation. The impact of domestic abuse on survivors needs a robust support approach from agencies working with children who have lived in abusive homes. The systemic learning here is for agencies to work towards a more trauma informed practice and to tailor multi-agency work with families like Lisa's.

10.5.10 A relational and restorative approach layered with trauma informed practice is key to responding to the complexities that Lisa and her family experienced.

KEY LEARNING

- **Impact of Domestic Abuse**: Recognising trauma for children exposed to abuse as victims, addressing its effects on their physical and mental health, and implementing tailored interventions to meet her needs.
- **Addressing Social Isolation**: Supporting families in overcoming social isolation through community integration and resilience-building efforts often evidenced in survivors of domestic abuse.

10.6 KEY THEMES 6: INTERSECTIONALITY

How well was the notion of intersectionality, race, disability, health needs of Lisa including behavioural needs known? How well was intersectionality understood as vulnerable factors and related risks about Lisa?

10.6.1 The Child Safeguarding Practice Review Panel guidance for safeguarding partners (September 2022) states that: *Intersectionality is the interconnected relationship of social categorisations such as race, gender, and sexual orientation together with individual vulnerability and adversities suffered by the individual. It is important to consider the potential to learn from issues of 'intersectionality' at each stage of the process – particularly when considering the usefulness of an LCSPR.*

10.6.2 The challenges faced by Lisa have been addressed in other parts of the review. The issues relating to disability, health, education, and so on were examined individually and separately. Records and discussions from practitioner events, as well as information from her family member, indicate a limited understanding of how the intersectionality of these needs impacted on Lisa's overall vulnerability. It appears there was insufficient recognition of how her multiple vulnerabilities interconnected. An assessment and analysis of this would have provided a more rounded understanding about Lisa's needs and therefore information about responses to her needs.

10.6.3 The dimensions of disability, migration, and trauma presents unique challenges that demand an intersectional approach to safeguarding. Lisa's case exemplifies how interconnected factors - abuse, race, gender, health needs, and social status shape the lived experiences of survivors and their families. Recognising these relationships allows practitioners to create a more effective framework of care that provides children and families with tailored support for and mitigate against systemic inequalities and individual vulnerabilities.

10.6.4 The Child Safeguarding Practice Review Panel guidance highlights the importance of applying intersectionality to every stage of intervention, ensuring that complex needs of children like Lisa are addressed comprehensively and empathetically. "*Understanding intersectionality can provide a powerful framework and tool to support practitioners to better comprehend the lived experiences of children and families from Black and other minoritised ethnic groups. (Practice Supervisors, 2020), including in addressing the adultification of Black children (Davis, 2019)."*[25]

KEY LEARNING

- **Consideration of Intersectionality and culturally appropriate Practice**: Addressing interconnected factors such as disability, migration, race, gender, and health needs to develop comprehensive and empathetic support interventions.
- **Practitioners need to be aware of the impact of intersectionality** when working with children and their families who experience multiple disadvantages and be supported to response with robust interventions to improve outcomes for children, young people and their families.

[25] It is silent. 2025. Race and Racism. Child Safeguarding Practice Panel HMO.

11. CONCLUSION.

11.1 Lisa was described as a delightful happy child. She was a child with disabilities and from an African background. Lisa's death was preventable. Agencies made attempts to respond to her needs, but these attempts did not lead to an impact on her lived experience. Work with Lisa required a proactive and empathetic multi-agency approach which worked with rigour, persistence, determination, tenacity and empathy when Ann was reported not to engage. Holistic understanding of their history and lived experience, and an approach shaped by nuanced trauma informed practice.

11.2 There was good practice when concerns were identified, referrals were made to children's social care, a child and family assessment was carried out which illustrated Lisa's life at the time. The child and family assessment sets out the home circumstances, the lack of stimulation that Lisa was living within the family home. There is evidence of good information exchange between children's social care and health when Ann was in hospital and children's social care and police. It is positive that there were discussions about stepping up to legal proceedings because there were concerns that work with Lisa was not having the impact that was needed.

11.3 This review has concluded that attention should be given to the actions which could have reached Lisa, to offer her support and understanding and respond to Lisa's needs and lived experience.

11.4 These are the building blocks of good safeguarding practice. Practitioners and their managers attempted to work with Lisa with care. She and her mother came to Nottingham because her mother wanted to keep her safe and 9 years after they arrived, she has sadly died. It is a tragedy that could have been prevented, and Lisa could correctly observe "*why was I not seen or heard"?*

12. RECOMMENDATIONS.

These recommendations are based on themes identified in the review for single and multi-agency SMART action plans to be refined and developed by the partnership. Please note Appendix 1 sets out recommendations from Rapid Review, these have been completed.

1**. Local Learning and System Improvement** – East Midlands Ambulance Service (EMAS):
Nottingham City Safeguarding Children Partnership (NCSCP) should seek assurance from East Midlands Ambulance Service (EMAS) that learning from this review and the Patient Safety Incident Investigation (PSII) has been reviewed and embedded through local system improvements and staff learning.

NCSCP should also ensure that this learning is shared with relevant local partners to strengthen joint understanding and responses in similar cases.

2. Child Protection Review Processes:
NCSCP should review its Review Child Protection Conference (RCPC) processes to ensure that:

- Information shared at conferences directly informs safety planning and subsequent decision making.
- Decisions to maintain or end a child protection plan are evidence-based and grounded in:
    - Effective multi-agency information sharing.
    - A shared and current understanding of the child's needs, risks, protective factors, and family circumstances.
    - Robust analysis of evidence of engagement and sustained change, rather than reliance on thresholds alone.

3. Strengthening Child Protection Practice:
Develop and deliver service-wide training for children's social care practitioners to reinforce:

- The purpose and process of convening and progressing Initial Child Protection Conferences (ICPCs).
- The evidence base required to justify a decision to step down or close a child protection plan.

4. Purposeful Home Visiting:
NCSCP should review expectations around home visits to ensure they are purposeful and proportionate.

When there is “no access,” there should be an expectation for creative approaches to enable professionals to see children, including:

- Increased frequency of visits.
- Joint or multi-agency visits.
- Reflective supervision to explore alternative engagement approaches. A tenacious and child-focused approach should be maintained to ensure that the child is seen.

5. Think Family Approach:
Reinforce the ‘Think Family’ model when working with children from diverse backgrounds and children with disabilities, ensuring that the whole family’s circumstances and needs are understood and addressed.

6. Equality, Diversity and Inclusion:
Provide partnership-wide training on the impact of race, racism, disability, and intersectionality, focusing on how these factors influence families’ engagement with services.

7. Relational and Restorative Practice:
Deliver training on relational and restorative approaches, including the Social GRACE framework, to build trust, strengthen professional relationships, and foster collaboration with families.[26]

8. Language and Professional Reflection:
NCSCP should consider how professional language (e.g., “non-engagement”) shapes how services perceive and interact with families.
The focus should shift from a “family deficit” model to one of “service adaptation.” Practitioners should reflect on how the offer of support is being experienced by families, and whether it aligns with their priorities, capacity, and sense of safety.

9. Culturally Informed Assessment:
NCSCP should explore the use of the Culturagram model to support culturally informed assessment and planning when working with families from diverse backgrounds.

10. Housing Involvement:

[26] Social GGRRAAACCEEESSS – Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, ethnicity, Education, Employment, Sexuality, Sexual Orientation, Spirituality. Social Graces: A Practical tool to address inequality, R Pierre BASW 2020.

Ensure that Housing Services are invited to Child Protection Conferences and Reviews when the family is a tenant of Nottingham City Council, to support effective multi-agency planning.

11. Neglect Strategy:

Recognising that neglect remains an area for improvement across the partnership, the Neglect Steering Group should be made aware of the learning from this review. NCSCP should ensure that:

- Learning informs the ongoing development of the local neglect strategy and toolkit.
- The impact of the strategy is assessed through a partnership audit within a reasonable timeframe after implementation.

12. Transition to Adulthood:

When a child with disabilities approaches 18 and is not in education or training, a robust transition process must be followed.

A transfer summary document should be developed to support effective transition from children to adult services. NCSCP should seek assurance that the impact of this process is reviewed once implemented and embedded.

13. Escalation and Professional Challenge:

NCSCP should strengthen and evaluate the use and effectiveness of the partnership's escalation policy to ensure timely and appropriate decision making for children. This should include:

- Applying escalation procedures when there is professional disagreement about the application of thresholds or decisions relating to a child's care and support planning.
- Analysing data on escalation activity (including cases involving children with disabilities and those from global majority backgrounds).
- Assessing the impact of escalation on outcomes for children to determine whether it leads to the right decisions being made at the right time.
- Developing a quality assurance process, such as incorporating mandatory escalation-related questions into audits and dip-sampling referrals to review outcomes.

13. APPENDIX 1: ACTION TAKEN SINCE THE RAPID REVIEW.

Following the tragic deaths of Lisa and her mother Ann, a rapid review identified several critical areas for improvement in safeguarding practice. Since then, a series of targeted actions have been implemented across Nottingham City Children's Integrated Services and the wider partnership with a clear focus on strengthening safeguarding, professional curiosity, transition planning, multi-agency collaboration, and operational procedures.

1. Strengthening Responses to Non-Engagement and Disguised Compliance

The partnership recognised that previous procedures for managing non-engagement were insufficient. Safeguarding policies were revised to embed guidance on disguised and non-compliance throughout. Practice guidance was issued to all Children's Integrated Services staff, and learning sessions were delivered to fieldwork and whole life disability teams. Monthly quality assurance audits now include a focus on engagement. This area continues to be a priority for ongoing learning and improvement.

2. Promoting Professional Curiosity, Triangulation, and Challenging Barriers to Engagement:

Staff were reminded that visiting frequency should reflect the seriousness of concerns, with guidance updated to require frequent attempts to visit families where engagement is poor (up to daily if necessary). Senior management oversight has been strengthened, with daily monitoring of outstanding visits and children not seen.

Importantly, social work teams have been reminded of the need to triangulate information with other professionals, rather than relying solely on self-reported information from family members. This ensures a more accurate understanding of the child's lived experience and family circumstances. Additional learning sessions have focused on professional curiosity, and further activities are planned to ensure this remains a central theme in safeguarding practice.

3. Improving Understanding of Mental Capacity and Legal Planning:

Weaknesses in understanding mental capacity were addressed through new guidance on Deprivation of Liberty Orders (DOLS), developed and shared by the

Legal Team. Staff received learning sessions and an expert-led workshop facilitated by a barrister.
Thinking tools were distributed and tracking systems now enable fortnightly reviews of cases requiring DOLS consideration, ensuring timely and appropriate action.

Practice guidance has also been updated to clarify the appropriate use of duty legal advice and when full legal planning meetings should take place, supporting robust decision-making in complex cases.

4. Enhancing Transition Planning for Children with Additional Needs:

A transfer summary document and protocol were developed to support best practice in transition planning, with clear timescales for referrals and joint working between children's and adult disability services. The protocol includes guidance on information to be shared between current and new workers and was co-developed between the Head of Service for Fieldwork and Head of Service for Whole Life Disability.

A transition panel now reviews all children aged 16 and 17, with adult services involved to identify roles and actions. Written guidance and joint visits at handover points are now standard, and further work is underway to introduce adult workers earlier in the process. The Children with Disabilities Service's move into the Children's and Education Directorate will further embed consistent practice and regular quality assurance activity focused on transitions.

5. Strengthening Professional Challenge and Escalation Processes:

The escalation process was revisited and confirmed to be appropriate, with clear inclusion in the Threshold of Need Document. Team meetings have reinforced awareness of escalation procedures, and evidence shows improved decision-making for children in cases where escalation has been used effectively.

6. Addressing Housing Needs for Vulnerable Tenants and Operational Improvements:

Nottingham City Housing is now represented on the Safeguarding Partnership, with refreshed policies ensuring participation in core group meetings for children under protection plans.

Operational improvements include:

- **Gas capping**: The Housing department now contacts Children's Social Care and Adult Social Care prior to gas capping a home where access has not been gained, ensuring the gas remains on until a resolution is found.

- **Damp and mould**: The previous rule of closing cases after three unsuccessful attempts to gain access has been removed. This issue is now included in a wider review of non-access, with the use of physical evidence (video/photos) to illustrate damp and mould.
- **Tenancy review**: Where access is not gained, cases are escalated to a senior member of staff through a multidisciplinary group, in line with findings from the rapid review.
- **Vulnerability policy**: The vulnerability policy is being reviewed to ensure it aligns with the findings from this and previous reviews.

7. Ensuring Use of Interpreters and Addressing Language Needs:

Social work teams have been reminded of the importance of using interpreters for families where English is not the first language. This requirement is now part of regular case discussions and referral processes, ensuring language needs are identified and addressed from the outset.
However, it is recognised that Ann could speak English, and the report notes that the use of translators was sometimes unnecessary and even criticised. The approach has been refined to ensure interpreters are used only when genuinely needed, based on the family's actual language proficiency.

8. Improving Handover and Information Sharing Between Children's and Adult Services:

Transition policy and practice guidance now require safeguarding information to be shared at handover.
Adult social workers are invited to child protection meetings, and the transition panel identifies children needing adult support earlier. Child protection policies have been reviewed, and audit activity continues to focus on threshold application and decision-making.

9. Embedding the Neglect Toolkit in Practice

All social work teams have been reminded to complete neglect toolkits before review conferences. An education neglect policy has been developed. Strategic and internal quality assurance activities have highlighted further work needed, particularly in management oversight. Practitioner events are planned for the policy's launch, ensuring continued focus on improving outcomes for children suffering neglect.

10. Reviewing the Occupational Therapy Waiting List

A review of the Occupational Therapy waiting list has been initiated to establish the level of demand, current wait times, and the impact on children whose needs are not

being met while awaiting allocation. This ensures that service gaps are identified and addressed proactively.