‘Ibrahim’ and ‘Yusuf’

Child Safeguarding Practice Review

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1. Introduction by the independent author and rationale for the Local Child Safeguarding Practice Review

This Local Child Safeguarding Practice Review (LCSPR) was commissioned by Tower Hamlets Safeguarding Children Partnership (THSCP) and is in respect of two children, Ibrahim and Yusuf.
Working Together (2023), contains the statutory guidance setting out that when a child has been seriously harmed or has died as a result of neglect or abuse, the Local Safeguarding Children Partnership should conduct a rapid review.

A rapid review was undertaken in May 2024. One of the possible outcomes of a rapid review is that a Child Safeguarding Practice Review should be undertaken. Following the rapid review THSCP concluded that a safeguarding practice review should be carried out. Reviews of serious child safeguarding cases are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that; the purpose of reviews is to:

- Identify improvements to be made to safeguard and promote the welfare of children.
- Seek to prevent or reduce the risk of recurrence of similar incidents.
- Identify local learning that has a wider importance for all practitioners working with children and families and for the government and policymakers.
- To understand whether there are systemic issues, and whether and how policy and practice need to change; this is critical to the system remaining dynamic and self-improving.

In undertaking this review names have been changed throughout the report to protect the identity of individuals.

The final report has been authored by Dr Amanda Boodhoo who was independent of the case with no actual or perceived conflict(s) of interest.

2. Summary of circumstances leading to the review

This LCSPR concerns two children. Ibrahim, who was a 17-year-old child at the time of the incident leading to this review and who presents with specific needs as a result of his severe autism. Ibrahim is non-verbal. His younger brother, Yusuf, was, at the time of the incident, aged 15 years. The children's father had called the police with concerns about their welfare, resulting in officers visiting the property where they found it in a dangerous state of disrepair. The children's father alleged that he had seen Ibrahim being restrained. The younger sibling Yusuf spoke about being subjected to physical assault from his mother.

3. A Picture of Ibrahim and Yusuf

Ibrahim and Yusuf are children of black African heritage. The two children and their family follow the Muslim faith.

Professionals describe Ibrahim as "a joyous and energetic child who loves life", "a very happy, active child, constantly moving and dancing, always on the go" and "a friendly and tactile child,

who loves his familiar adults and has good relationships with them. He expresses his happiness through movement, smiles and touching faces"

Ibrahim was diagnosed at the age of four with autism. He is non-verbal and very sensory, using PECS (expressive communication skills using pictures) as his main form of communication. He is subject to an education, health and care plan (EHCP) and his needs require round-the-clock care.

Yusuf is a child who professionals describe as "a typical teenage boy, with lots of friends", "a young person who takes great care of his appearance". Although Yusuf struggled with handwriting he is described as having no special needs. Professionals describe how he loves to play football.

The parents of Ibrahim and Yusuf separated many years ago and the two children lived with their mother in a property that they had occupied since 2012. The property was rented from a social housing organisation under an assured tenancy. The father of the children has remarried. The agencies involved in the review made limited reference to the father and there was a difference in understanding between agencies as to what contact Ibrahim and Yusuf had with him. Ibrahim and Yusuf's mother was reported to have been diagnosed with anxiety with depression since 2017 and experienced domestic abuse in 2012. Although Ibrahim and Yusuf have extended family, they do not live close to the children.

4. Learning and improvement actions from the rapid review

The learning from the rapid review was captured within the individual agency and partnerships' reports and included:

- An increased focus on learning and development opportunities and within safeguarding supervision to ensure a focus upon absent fathers and professional curiosity
- A review of systems to identify significant areas that may indicate safeguarding concerns; e.g. patterns of not being taken to appointments
- A review of current referral pathways and responses, particularly in relation to repeat referrals in relation to neurovariance diagnosis
- For families where children live with neurodiversity and/ or complexity, the future service offer to include at least one home visit as part of assessment observation and to explore options for seeing children outside of clinics to support assessment in a familiar environment
- Service-wide training for clinicians to support working with children and young people with ASD and LD who may be non-verbal to ensure the child's voice is ascertained, heard and recorded
- To offer consultation to professionals working with non-verbal children with neurovariance
- To ensure there is a review of the outcome of escalation following referrals
- Share the learning from the rapid review with practitioners involved to support their learning
- Promotion of the thresholds for stratification to ensure children are receiving the correct level of support
- Continue to highlight the importance of health assessment for school age children
- Review the partnership agreement between schools and public health nursing to ensure any safeguarding concerns are communicated to the school nursing service so that an assessment of health needs can be undertaken.

In addition to the learning from the rapid review, which is being taken forward and monitored by the partnership, a number of actions were taken as a result of the initial concerns that led to the rapid review. The children with disabilities team scrutinised all open care package reviews to ensure children had been seen, including within their home and spoken with, to provide assurance on the quality of reviews being completed. The children with disabilities team also reviewed the care package review process, in relation to timeliness, checks with relevant agencies, children being seen within the home, children's bedrooms being seen, alongside a tracking and escalation mechanism and consideration of timely referral for children transitioning to adult services.

The GP practice agreed to undertake a significant event review. This will include ensuring all staff have an opportunity to learn from the case and inform future practice.

In meeting with professionals throughout this review, it was evident that actions were being taken forward and that the partnership is monitoring progress and its impact through their partnership governance structures. Where areas of learning are identified as part of this review, any recommendations made will build upon those already being taken forward.

5. The LCSPR - Methodology and Agencies Involved

This review adopts an approach proportionate to the circumstances of the case, focusing upon the lived experience of Ibrahim and Yusuf and the potential for the system to learn and improve.

The period covered by this review is the 24 months, from May 2022 to May 2024.

Significant events, prior to this period, have been summarised to provide context.

The information available from the rapid review was comprehensive. The methodology reflects the principles of the systems methodology as outlined in Working Together 2023 and has concentrated on the specific issues identified in the terms of reference, set by Tower Hamlets Safeguarding Children Partnership, using the following stages:

I. Examination of all information submitted for the rapid review, to gain an understanding of the key practice issues, including enablers and barriers to effective practice, establishing key practice episodes and identifying what learning is already being taken forward
II. Engagement with the parents of the children (ensuring this does not adversely impact upon any police investigation), to gain a picture of the children and to understand the parents' experience of services and their perspective on how services worked with them.
III. Individual conversations with practitioners to explore the lived experience of both children, to gain a further understanding of the key practice issues, including enablers and barriers to effective practice.
IV. A table-top event with practitioners to explore emerging themes and to influence the recommendations.

The stages outlined have enabled triangulation of the information, providing the opportunity to test whether the work and any lessons about this case were/are more widely prevalent in the wider local or national safeguarding system.

The learning from these stages is summarised in this overview report, identifying key themes, areas of good practice, highlighting specific learning, and making recommendations for system-wide practice improvement.

The production of this local child safeguarding practice review has been overseen by members of the partnership.

The agencies and professionals who contributed to this review were:

- Metropolitan Police
- North East London ICB
- London Ambulance Services
- Housing
- Schools
- CAMHs
- GP
- Children's social care
- School nursing
- Hospital Trust

6. Key areas as the focus of the LCSPR

The Rapid Review in relation to Ibrahim identified three key areas where there was potential for further learning. These have formed the key lines of enquiry within this LCSPR:

1. **How was the voice of the children heard and responded to?**

- Given that child Ibrahim is non-verbal, what approaches were taken to hear their voice?
- How well did professionals understand the lived experience of both children?
- What impact did being a young carer have on Ibrahim's younger sibling and did he receive appropriate support from professionals?

2. **How effectively did the safeguarding systems respond to any indications of physical abuse and neglect?**

- How well were the needs of both children understood? Did health professionals respond appropriately to Ibrahim's experience of constipation, given this is a preventable but common cause of death for people with learning disabilities. What system learning can be taken from any elements of potential medical neglect in this case?
- What factors may have impacted upon the multiagency system responding to ensure the children received the right help, given at the right time, based on their specific needs?

- What may have impacted upon professionals identifying the early indicators of child neglect and physical abuse to enable them to respond appropriately?
- How well adopted is culturally-competent practice that fully considers the implications of intersectionality and the impact on engagement with services?
- How effectively is the system supporting families, who are caring for a neurodiverse child with learning difficulties, and who may exhibit behaviours that the family may find challenging, in preparation for transition to adulthood.

3. How effective was the assessment of parenting capacity?

- Did assessment of parenting capacity take account of mother's own health and circumstances as a lone parent and how this may have impacted upon her ability to meet the needs of her children, one of whom had complex needs? Was there evidence of a Think Family approach being adopted?

7. Family Involvement

At the commencement of the review, Ibrahim's parents were informed that the review was taking place and had explained to them the purpose and process. During the time the review was being undertaken there was an ongoing police investigation. There was communication with the police and recognition of the importance of family involvement but due to the police investigations it has not been possible for the author to meet with family members. The author has made every attempt to include evidence of a balanced perspective including that of the family where these were seen in the records of professionals.

8. Key Practice Episodes

The information is presented as two key practice episodes: the period outside the reference period and that within the two-year reference period. In line with Child Safeguarding Practice Review Panel guidance for safeguarding partners (September 2022) and in order to anonymise the case and protect the family's personal and sensitive information, the chronology for the period outside of the reference period has been redacted and summarised for publication. The full chronology will be available for professionals.

Period outside the reference period: 2010 to May 2022

Although outside the scope of the review, a summary of relevant information and themes is presented. During the period 2010 to 2021 there is a pattern of emerging concerns relevant to the review, multiagency responses, but with limited evidence of impact.

Throughout this period the family were known to Children's Social Care (CSC) and Children with Disabilities Team (CWD) with Ibrahim receiving respite care every four weeks from 2016. The Social Housing Organisation paid regular visits to the family home to undertake repairs and annual safety checks, it was noted in their records that a disabled child was part of the household.

On two separate occasions, referrals to CAMHS were made for Ibrahim, by the GP and school, Ibrahim was not taken to the majority of appointments offered and he was eventually discharged from the CAMHS service on both occasions. There is evidence of good communication between the two schools attended by Ibrahim and Yusuf and CAMHS.

Throughout this period there is a pattern of mother not engaging with services offered, a number of professionals noted that mother presented or engaged at the point of crisis. There were also several reports of mother not engaging with school, including failure to collect Ibrahim from school when unwell or injured.

Throughout this period professionals noted that mother was struggling and that Yusuf was undertaking the role of a young carer, with Yusuf himself reporting he "doesn't have much time for himself" and had to do homework before school or at break times. Professionals expressed concerns about the impact of Ibrahim's needs on his younger sibling Yusuf and his mother and on the children's academic progress. This was a particular concern during the pandemic and the school ensured they undertook regular phone check ins.

Period from May 2022 to May 2024 (The reference period)

Throughout the reference period there is ongoing involvement with the family, by the two children's schools, CAMHS, their GP and the children with disabilities team.

Between 2022 and 2023 there are ongoing reports of lack of engagement from mother, with Ibrahim's school.

May 2022

Yusuf's school were concerned about his attendance record and his parents' failure to attend meetings and planned a home visit.

July 2022

Police received an anonymous referral alleging the mother of Ibrahim was neglecting the children and leaving them in the house alone. It stated that Yusuf, then aged 14 years, looked after Ibrahim. Both children were seen, and no concerns found.

August 2022

CAMHS contacted Ibrahim's mother by letter, seeking contact and stated that failure to respond would result in the family being discharged from CAMHS. Ibrahim's mother left a message to say the GP had not issued a repeat prescription for Ibrahim's medication. CAMHS made unsuccessful attempts to return the call. A prescription was arranged but was not collected and further messages left. A follow up call was arranged with the CAMHS doctor, but Ibrahim's mother did not join the call. There were further attempts to make contact and messages were left.

September 2022 to November 2023

No repairs were requested or undertaken to the family home. This was a significant change, given the pattern of previous repairs being required and in sharing the learning of this review there is an opportunity for housing providers to consider whether their systems have the ability to flag concerns when there is a child with needs and a change in pattern. Housing partners have a key role in ensuring children are safeguarded and that a professionally questioning approach is adopted. The significance of this role is heightened where other agencies/practitioners may have limited access to the home. Housing partners may be the one agency who may have sight of early concerns.

December 2022

Ibrahim was seen by the GP. His mother reported that he was exhibiting some aggressive behaviour.

February 2023

A personal independence payment assessor reported to the GP practice that the mother of the two children had expressed some suicidal ideation. She was invited to be reviewed by the GP on several occasions and booked an appointment for May 2023.

April 2023

GP referred Ibrahim's mother for assessment of her suspected ADHD. The referral indicated Ibrahim's mother's history of anxiety and depression for which she received prescribed medication and the completed ADHD questionnaire described her difficulties in organisation, remembering appointments or obligations, was fidgety and over active, making careless mistakes, easily distracted, unable to relax and restless. She felt she had struggled with these symptoms for several years.

At the end of April 2023, the ADHD service contacted Ibrahim's mother to inform her that the referral would be discussed in approximately 12 months and should the referral be accepted the estimated waiting time for new referrals, requiring a full assessment by a clinician, was 18 months. Information for contingency services offering support was provided with details for the 24-hour Mental Health Crisis Line.

There was no further contact between the family and CAMHS until June 2023 when a multidisciplinary team discussion felt Ibrahim would benefit from a re-assessment of ADHD. A CAMHS appointment for an ADHD review for Ibrahim was booked for July 2023.

May 2023

Concerns were noted by Ibrahim's school regarding his toileting and hygiene. The school nurse was contacted for support.

June 2023

Ibrahim's GP undertook a medication review and Ibrahim's mother reported the medication was effective and Ibrahim was well and stable.

In contrast, in June 2023 when a team around the child meeting was called by Ibrahim's school, Ibrahim's mother acknowledged that she was struggling to cope with Ibrahim's behaviour as he gets older. There were also concerns with Ibrahim's sleep. An internal multidisciplinary referral was made, plus a referral to CAMHS who again had trouble in contacting the family.

In June 2023, the school nurse service was contacted and asked to ring mother as Ibrahim had been unwell and she was asking for adult-sized nappies. The school nurse rang the mother who reported Ibrahim had been ill and although using the toilet, sometimes needed to use nappies. She advised mother to ask the school for advice on how to get these and contacted the continence service on mother's behalf. This contact gave an opportunity for an initial health review and Ibrahim would then have been stratified as universal plus, resulting in three-monthly contacts. This did not happen, and Ibrahim remained stratified incorrectly as universal.

July 2023

Following the team around the child meeting, a referral was made to MASH/early help. At the end of July the school followed up on the outcome of the MASH referral and was informed it had been de-allocated due to mother being away. Ibrahim's school insisted it should not be de-allocated due to a recent incident in which Ibrahim punched a member of the public, thereby increasing his vulnerability. The social worker confirmed it would be de-allocated at mother's request. This was a missed opportunity. Given Ibrahim's needs and vulnerability, the significant concerns raised and the challenge from the school, consideration should have been given as to how an assessment in response to the referral could be progressed, either through a visit at the home of the extended family or by diarising to be progressed at the point the family returned home.

In July 2023 Ibrahim's mother did not attend the CAMHS ADHD review appointment.

The school arranged a team around the child meeting, attended by Ibrahim's mother. Concerns were raised by both Ibrahim's mother and the school. Concerns included Ibrahim exposing himself more frequently, that he came to school with clothing that didn't fit, was dirty or soiled, that his hygiene was poor, that he used physical force, attacking members of the public, hitting his mum in public, spitting and hitting staff. Concerns were discussed in relation to the difficulty in contacting Ibrahim's mother, the missed CAMHS appointments, mother's lack of support, and Ibrahim "running rings around" his father on the occasions he took Ibrahim out.

Ibrahim's support package was reviewed. It was shared that Ibrahim's mother was awaiting her own ADHD assessment. The school made a referral to MASH for family support. Following this, the children with disabilities team recorded concerns as the mother was requesting support with her bathroom floor, which resulted in the ceiling below collapsing, Ibrahim exposing himself and poor personal hygiene. Mother shared that she had a diagnosis of ADHD and chronic fatigue. The referral progressed to a single assessment which was later cancelled as mother was reported as being away visiting relatives for the summer holidays and would not be available until September 2023.

A CAMHS appointment was scheduled for later in the month to complete an ADHD assessment for Ibrahim and discuss strategies at home. This was cancelled as Ibrahim was unwell. CAMHS planned to see Ibrahim in school as part of the assessment process.

Further contact between Ibrahim's mother and CAMHS was attempted but messages were not responded to. A plan was developed between CAMHS and the school to support Ibrahim's mother to remember appointments.

September 2023

Ibrahim's school spoke to mother on the phone to get consent for a re-referral to MASH/early help team. Mother declined saying things had improved and she no longer needed the support. At this time there is a picture of escalating concern and ongoing challenge in engaging Ibrahim's mother. The referral made In July 2023 to MASH/early help team offered an opportunity to understand what the lived experience of Ibrahim and Yusuf was and to have insight into the deteriorating picture. Had this been acted upon the school would not be in the position of having to consider re-referral. The failure to progress the July referral also had the potential to impact on professionals future judgements as to when the threshold of significant harm is met.

November 2023

The school reported ongoing struggles with Ibrahim's behaviour, particularly around toileting and using the shower. He had not been accessing off site learning as suitable clothing had not been provided. Mother had ordered a leotard, but the wrong item was sent.

Ibrahim's school made a MASH referral citing difficulties engaging Ibrahim's mother in response to phone calls or requests for team around the child meetings. A post referral social work visit was completed after 15 working days, following cancellations of visits by mother. Further visits took place in November and December 2023.

The GP reviewed the children's mother on two occasions. She reported worsening anxiety and depression symptoms and feeling tired all the time. She complained of struggling to remember things and difficulty with organisation. She was chasing up a previous referral to the Autism and Attention Deficit Disorder clinic. It was explored that this may be the cause of some of her difficulties rather than depression and anxiety alone. In addition, she complained of fatigue and investigations were instigated.

December 2023

Arrangements were established by the school to enable Ibrahim to access offsite learning. A CAMHS school visit was arranged for December 2023. The school informed CAMHS that they had made a referral to MASH which had progressed to child in need.

December 2023, Ibrahim's mother missed the CAMHs appointment for the ADHD assessment due to sickness and forgetting it. Ibrahim's behaviour was unchanged, being hyperactive, defaecating in his trousers, throwing food and objects and mother felt that she was less able to support him due to her own mental health needs. Family network support was considered but there was no immediate family nearby and they did not understand Ibrahim's mental health needs and were reported as telling her to 'stop moaning', offering no emotional or practical support.

Between December 2023 and February 2024 Ibrahim's mother was unable to attend the school for team around the family meetings. In telephone contacts she was reported as coping with Ibrahim's behaviour and hygiene needs at home. There were no further concerns raised by the class teacher.

Ibrahim's mother had some insight into her own mental health problems, and had shared with professionals how, looking back, she had at times found it hard to concentrate, felt burned out, had constant interruptions, and sometimes couldn't cook or clean.

January 2024

Mother cancelled the planned visit by the social worker, this took place two weeks later, and a Child and Family Assessment was completed, over one visit. The social worker did not observe any of the bedrooms, bathroom, or the kitchen. This was notwithstanding children's services' knowledge of the concerns raised in July 2023 about problems within the bathroom, and Ibrahim's school reporting concerns around his poor hygiene and inappropriate clothing. It was reported that Ibrahim needed two people to take him for a shower, which would cause a major challenge for mother as a single parent. No referral was made to occupational therapy to consider support.

At this assessment visit mother reported that she was struggling with Ibrahim's behaviour in the community and therefore used a wheelchair. Mother reported being diagnosed with chronic fatigue and having missed important meetings (with school and CAMHS). There were discrepancies in reporting, in that it was suggested mother was undergoing an ADHD assessment; however, the July 2023 referral indicated that she already had a diagnosis.

Despite this contradictory information regarding mother's ADHD and her self-reported mental health there were no checks undertaken with health professionals or with the school on the children's attendance and presentation, to inform the assessment and the plan considering the impact on the children's lived experience. This was a missed opportunity.

The outcome of the assessment was for an increase in personal care and in short breaks to be considered for Ibrahim and case closure for Yusuf.

Given the difficulties there had been in engaging Ibrahim's mother, this Child and Family Assessment was a significant contact, offering the opportunity to understand and respond to the needs of both children. It is not clear as to why the assessment practice missed a number of key elements, including the observation of areas of the home and exploration of the use of a wheelchair and what this may have meant for Ibrahim as a 17 year. Unfortunately, as has been previously stated, due to the ongoing police investigation it was not possible to further explore this with the relevant practitioner.

February 2024

The school emailed the MASH duty manager to follow up on the outcome of the assessment and received no response. There is evidence of the school adopting a robust approach in attempting to communicate with MASH professionals but receiving no feedback.

March 2024

Yusuf's school noted he was falling asleep in lessons and reported he had barely slept the previous night.

Ibrahim's mother did not engage with the school when called to pick him up, due to illness. She also missed the annual review. The school contacted the social work team and was informed a care package review was being conducted.

April 2024

An appointment was sent to mother requesting completion and return of an ADHD screening tool. CAMHS received no response.

In April 2024 the children's mother cancelled the planned social worker visit. The last occasion the property was visited by a professional was January 2024. As the visit in January did not result in key rooms in the home being seen it is unclear over what period the home conditions deteriorated, however following the concerns coming to the attention of agencies, Yusuf reported the home conditions to have deteriorated over a two year period. Given the needs of Ibrahim it is of concern that no professional was aware.

At the end of April 2024 the children's father contacted the emergency duty team expressing concerns regarding the condition of the home, the children's mother's mental health and that the children were being left alone. He was asked to report his concerns to the police, which he did, resulting in the police investigation.

The decision was made to find alternative care for the two children.

Following this there were extreme challenges in identifying a placement for Ibrahim and this resulted in him spending a significant period of time in police protection. This was not the right environment for a child and had significant impact upon the police service.

9. Thematic analysis of Ibrahim and Yusuf's story – Summary and Findings

The findings are presented below, aligned to the key lines of enquiry.

Theme	Content
Theme 1	The Voice of the Child
Theme 2	The effectiveness of the safeguarding systems in responding to indications of physical abuse and neglect
Theme 3	Assessment of Parenting Capacity

Theme 1: The Voice of the Child

How was this issue relevant to the review?

This review relates to two children who were found to be living in a home that had deteriorated to a level of extreme neglect and yet no adult, either in the personal lives of the children or those professionals involved with the family, appeared to have insight into the lived experience of either Ibrahim or Yusuf in their home environment and community.

Ibrahim is a non-verbal child and therefore adapting approaches to ensure his voice was heard was essential.

Yusuf was undertaking the role of a young carer and has disclosed the experience of being physically abused.

It was reported that Ibrahim was subject to restraint.

Seeing and engaging with children is important in allowing professionals to gain an accurate understanding of their uniqueness, experiences, and relationships as well as their state of health and wellbeing. It helps professionals to assess risks, needs, and protective factors effectively.

Capturing the "voice of the child" in ways that are appropriate to their individual needs, goes beyond seeking their views; it enables active participation in decision-making, ensuring their needs are the paramount consideration.

An analysis of the findings

In considering the chronology, summarised as two key practice episodes, it is significant that there are concerns, not only within the two-year reference period but for a significant length of time before. Concerns relate to mother's health and struggles as a single parent to respond to and meet Ibrahim's needs. There were times when Ibrahim presented in a way that was increasingly challenging. In reading agency information and hearing the views of professionals, it was apparent that although the life of both children whilst in the school environment is well understood, there appeared to be no understanding of the lived experience

of either child within the home or within the wider world. The voice of neither child was sought or heard to enable professionals to understand and respond to their views on these crucial parts of their lives. No professional was aware of the deteriorating home conditions. Opportunities, as part of assessment practice, to view key rooms within the home were not taken. Ibrahim was being taken out in a wheelchair. There was insufficient exploration as to the significance of this or what this meant to Ibrahim.

In agency reports there are several references that indicated Yusuf was undertaking the role of a young carer, with clear evidence this was impacting upon him, he was tired at school and his academic progress was impacted. However, this was not addressed effectively. This was a missed opportunity to hear his voice and gain valuable insight into the neglectful environment the children were living in. There is reference to him being given information on the services available for young carers, but no holistic assessment and response was evident. The failure to identify, and effectively support, young carers is likely to have significant effects on their health, wellbeing and life chances.

There was no clear understanding of the relationship either child had with their father and what role he played within their lives. There is no evidence of this being explored with either child.

Adaptations were made within the school attended by Ibrahim, which was a specialist school, experienced in meeting the needs of children like Ibrahim. School staff were very experienced in communicating with children who were non-verbal. They utilised a range of appropriate approaches to hear Ibrahim's voice including pictures, had good insight into non-verbal cues and the use of touch to comfort him. They were experienced in using language that was meaningful to Ibrahim, requiring only yes or no responses. However, such approaches were not utilised by the multi-agency system to understand his lived experience within the home. Some neurodivergent children express their emotional distress through behaviour or actions which are harmful to themselves or others and it is important to understand what lies behind the behaviour they exhibit. Given the increased vulnerability of children with learning disabilities and speech, language and communication needs, it is essential that the voices of these children are heard by all professionals within assessment and review processes.

In discussion with professionals it was apparent that, in trying to understand Ibrahim's views, it was necessary to ask questions in a direct way, which from a safeguarding perspective could appear to be "leading" and may have acted as a barrier to exploring how safe he felt.

What can we learn from local and national research?

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents.

The right of a child or young person to be heard is included in the United Nations Convention on the Rights of the Child. It is explicit in Working Together 2023 (Department for Education, 2023). that a child-centred approach, which aims to understand children's lived experiences and seeks their views about their lives and circumstances, is a core principle that underpins effective safeguarding practice.

The Child Safeguarding Practice Review Panel (2023) provides examples of best practice used to gain the voices of children with needs similar to Ibrahim, including 'Stop, look and listen to me', which uses a range of approaches including direct interview, engagement in activities, observation, and interviews with family members and professionals who know the child well.

The number of pupils with SEN support has increased by 4.7% from 2023 to 2024, and by a total of 24.9% since 2016 (DfE 2024). A number of these children will experience communication difficulties, requiring approaches to be adapted to hear their voices. Clearly, professionals who worked with Ibrahim within the school, had the skills to communicate with Ibrahim. There are opportunities to bring together the skills of different professionals to understand the world of children away from the school world, with safeguarding professionals working in partnership with the education staff who are familiar with the range of techniques that are effective in allowing the voice of non-verbal children to be heard.

The Children and Families Act 2014 and the Young Carers Regulations 2015 place a duty on local authorities to:

- Identify, assess and support any child who is a young carer or carry out on request an assessment of any young carer
- Consider whether the young carer is a "child in need"
- Align assessment processes so that there is a "whole family" approach to assessing the needs of the young carer and the individual for whom they provide care
- Provide any necessary support to the adult to ensure that the young carer is protected from excessive and inappropriate caring responsibilities.

When a young carer may have support needs, the local authority must carry out an assessment under the Children Act 1989 to establish how best they can support the young carer and their family. Section 64 of Care Act 2014 provides detail of what should be included as part of that assessment, including their desired outcomes for their daily life and the support needed to achieve this. Had this been adopted as the framework for assessment, this would have supported professionals in the identification of Yusuf's inappropriate caring responsibilities and what additional support was needed.

Within Tower Hamlets there is a Young Carers Project which offers access to weekly sessions at a youth centre, school holiday activities, residential breaks and days out. However, in undertaking this review, it was clear that this only reaches a small proportion of young carers, accessed on a voluntary basis rather than structured plans of support. Since June 2024, work has been undertaken through a Task and Finish group to map current need and provision and agree an approach for the future. There is an opportunity to consider as part of this work standardisation of the approach to ensure whenever a child has a care package, consideration is given to the impact on siblings, including caring responsibilities.

The impact of any changes will need to be evidenced.

Theme 2: The effectiveness of the safeguarding systems in responding to indications of physical abuse and neglect.

How was this issue relevant to the review?

Ibrahim and Yusuf were living in a home described as in a dangerous state of disrepair. Their father alleged that he had seen Ibrahim being restrained. Yusuf spoke about being subject to physical assault from his mother and there were frequent occasions of Ibrahim not being taken for appointments.

An analysis of the findings

In undertaking the review, it was evident that over many years a number of agencies were involved with Ibrahim, Yusuf and their family. In response to Ibrahim's presenting needs it was

necessary for Ibrahim's mother to liaise and engage with health, social care and education agencies. Yusuf attended a different school from Ibrahim and their mother needed support from different health agencies for her own health needs. The range of professionals and agencies the mother needed to engage with is likely to have been overwhelming for her.

There were numerous occasions when agencies were unable to engage the mother, the children's voices were not a central focus and over time the family transitioned between different levels of support. Assessment in relation to the father and what significance he had in the lives of the children, and insight into the lived experience of the two children at home, was not evident.

The children were of black African heritage, with their religion recorded as Muslim. As part of this review, consideration was given to disproportionality, reflecting the Social GGRRAAACCEEESSS (Burnham, 2013), and whether the children and their parents unique experience was fully understood. Professionals described the rich diversity within the Borough, which was also reflected in the workforce and service offers. For those professionals providing services to the family, culturally competent practice was well embedded. However, there was less evidence that Intersectionality, as an approach that supports professionals to consider how multiple dimensions and systems of inequality interact with one another and create distinct experiences and outcomes for individuals for whom they are providing care, had been given sufficient weight. Insufficient consideration was given to the interface and impact of religion, faith, maternal mental health, the experience of domestic abuse and the demands in terms of Ibrahim's needs.

Various religions and faiths, as well as individual families, view disability differently. In terms of both Ibrahim's needs and the mother's mental health, it is not clear what influence the family faith may have had, either in terms of providing comfort or experiencing negative feelings. Due to the ongoing police investigation, it was not possible to explore this with the family. It is recorded in professionals' records that the extended family did not understand mother's mental health needs. It is unclear whether father's limited involvement with Ibrahim may have been influenced by his view of disability and whether his religion/faith had a role in shaping that view.

Although there was evidence of Tower Hamlets having undertaken a lot of work to ensure appropriate responses to its local children and families, it should be recognised that the journey towards culturally sensitive care is an ongoing process that requires continuous learning, reflection, and adaptation (Blake 2024). In reflecting upon this specific incident there is a need for Tower Hamlets as a partnership to continually evidence that the significance of religion/ faith and the areas of inequality are considered in assessment practice.

Any child with a disability is by definition a 'child in need' under s17 of the Children Act 1989. Safeguarding disabled children demands a greater awareness of their vulnerability, individuality and specific needs. It is also important to see the child in the context of the whole family and community supports that are present. (London Safeguarding Children Partnership 2022).

Caring for a child with the level of complexity that Ibrahim presented with, is an evolving process, changing with the trajectory of the presenting needs and as the child matures. As a result of the rapid review, work has already been progressed to ensure a more robust approach to the care package review process. However, it was clear from the evidence available for this review that Ibrahim's mother was struggling to meet his needs with the level of support provided through the care package. The impact of the level of intense parenting and the multiple roles that Ibrahim's mother had to assume to meet Ibrahim's needs, is likely

to have impacted upon her own physical and mental health, in turn impacting upon her ability to respond to the needs of both children.

It is important that statutory early intervention is adopted effectively, to support vulnerable children and their families. This requires the need for coordinated assessment with clear and measurable interventions. There were occasions when concerns were identified and referrals made but were not progressed, even when there were significant concerns. This included the occasion when the mother reported the family were visiting the extended family. Despite this there was evidence of the school persevering and challenging decisions. Following referrals there was some evidence in communication not being as effective as it should be, with the school emailing the MASH manager, but receiving no response.

In considering the information available for this review, the care package in place did not appear to meet the needs of Ibrahim. It is unclear whether this issue was specific to Ibrahim or is a wider issue in Tower Hamlets. This is an area that requires further exploration. In reflecting upon the learning from this review it offers the opportunity to undertake an assessment of the current care package offer, through a process that includes, listening to families (parents, carers, young people and siblings) to understand what would work in response to their needs, as well as understanding their strengths and assets.

Given Ibrahim's needs and age, plans for the transition to adult services needed careful consideration. The children with disabilities team have identified timely referrals to adult services as an area of learning and are taking this forward from the rapid review.

Taking account of the needs that Ibrahim had, mother's health and the potential impact upon Yusuf, coordination through a lead professional arrangement and high quality multiagency assessments would have been key in ensuring Ibrahim and Yusuf received the right support at the right time, identifying the range of missed appointments, exploring the reasons and agreeing the response.

There is evidence of attempts to bring agencies together through processes including team around the family meetings; however, there are several factors that may have impacted upon the effectiveness of the system in safeguarding the children. These included a lack of understanding of the pathway and offer for young carers, the failure to join up information and expertise across agencies, changes in providers of services, insufficient robustness in using coding and flagging systems, workforce challenges, both locally and nationally including national under investment in key services, and the wrong application of level of need in terms of service provision.

Ibrahim did not receive an annual learning disability health check, which offers the opportunity for early identification of health problems. A child can be placed onto the GP Learning Disability Register at any age and is eligible for the annual learning disability health check from the age of 14 years. In the case of Ibrahim, this offered the opportunity of highlighting escalating need over a three year period, prior to the incident leading to this review.

In considering information for this review there were increasing challenges in managing Ibrahim's needs, including his behaviour, his sleep and bowels. There were concerns regarding the administration of the correct dose of prescribed medication and a number of appointments to which Ibrahim was not taken. There is reference both to constipation and smearing. In children with needs such as Ibrahim there are a number of reasons for smearing behaviour, including medical issues, constipation, communication difficulties and self-soothing. It is important to understand what lies behind such behaviour, which clearly added to his mother's challenges and contributed to the tasks Yusuf was required to undertake which were age inappropriate.

Within Tower Hamlets, a previous LCSPR undertaken (LCSPR Julie) highlighted a number of themes evident in this review including the need to improve the response to neglect, the significance of domestic abuse and non-engagement of parents. There is also a published toolkit that addresses medical and adolescent neglect. It is unclear as to how well this is embedded in practice.

What can we learn from local and national research?

Disabled children and their families are likely to be assessed many times for access to different services during childhood and as they transition into adult services. As a result, parents highlight 'the exhaustion of having to attend a myriad of meetings with professionals where the same information must be repeated over and over again.' (Clements, 2023, p.3)

The London-wide safeguarding procedures threshold document: "Continuum of Help and Support" was updated in February 2023 and provides a framework for all professionals who are working with children, young people and families. It aims to help identify when a child may need additional support to achieve their full potential. It introduces a continuum of help and support, provides information on the levels of need and gives examples of some of the factors that may indicate that a child or young person needs additional support. (LCSP 2022a). If children and their families' needs are not being identified at the appropriate level, this will result in them not getting the level of support needed in a timely way.

Neglect is the most common form of child abuse, but frequently goes unrecognised within the adolescent population. In a survey of children aged 11-17 in the UK, 13.4% described severe maltreatment (RCPCH 2022).

People with a learning disability are at greater risk of constipation. Some people with a learning disability may also find it difficult to communicate their problem. Constipation was one of the 10 most frequently reported long-term health conditions among people with a learning disability who died in 2020 (55%). In recognition of this NHSE have developed a national constipation campaign toolkit including resources for GPs that would support the annual learning disability health check (NHS England 2023).

Following the concerns that led to this review coming to light, attempts were made to find alternative care for both children. Despite the effort invested to achieve this, there were significant delays for Ibrahim, resulting in him spending almost 36 hours within a police premises, a totally unsuitable environment for a child. There is a need for partners to reflect upon the learning from Ibrahim's experience to consider what needs to happen to ensure this wouldn't happen in the future.

Theme 3: Assessment of Parenting Capacity

How was this issue relevant to the review?

In common with other reviews published nationally, there were gaps in the quality of information sought and shared by agencies, in particular in relation to the role of both the father of the children and the impact of the mother's mental health, not demonstrating a "Think Family" approach.

An analysis of the findings

In reviewing agency information that contributed to this review, there were significant indicators that the children's mother was not coping with caring for Ibrahim and Yusuf over a significant period of time. As a single parent caring for two teenage children, one with very high levels of need, who as he got older, increased in both needs and strength, would be a

challenge for many parents. In addition, mother was experiencing mental health challenges, was suspected as having ADHD and had no local family support. In considering the needs of both Ibrahim and his mother, it is possible that Yusuf, who was known to be undertaking inappropriate caring responsibilities for Ibrahim, may have also been acting as a young carer for his mother.

Individual professionals were concerned about the number of appointments that the children were not taken to, or which mother didn't attend for her own needs, but there is no evidence of attempts being made to gain a full understanding as to the "why". Without understanding the reasons that professionals were not managing to engage the children's mother, it was not possible to develop an approach to address this. It is very possible that given the multiple demands, the mother of the children felt overwhelmed. Individual professionals were aware of the missed appointments for their own service but there was no holistic view of the appointments missed across the range of services.

It was evident that the children's mother was trying hard to be a good parent. Practitioners described how despite the struggle to take Ibrahim out, due to the behaviour he exhibited in the community, she used a wheelchair in order to take him to a museum. As has been discussed earlier the use of the wheelchair needed further exploration, although it is clear that the father, in his limited contact, experienced challenge when taking Ibrahim out.

As previously discussed, assessments did not adequately explore the interface between parental factors, including the impact of maternal challenges on her ability to be the good parent she wished to be, and any understanding of the role the children's father played in parenting.

What can we learn from local and national research?

A number of national reviews show that without the right support, a parent with poor mental health can sometimes struggle to provide safe care and this highlights the need for professionals from adult and children's services to work together to safeguard children when there are signs that a parent's mental ill-health is impacting their ability to look after their child (NSPCC 2023).

A number of national studies have found that insufficient focus on the role of male carers is evident in assessment practice, Although the Child Safeguarding Practice Review Panel (2021) focus was on the safeguarding of babies, the finding that, in a society which expects women to take a disproportionate responsibility for children, opportunities to increase both the involvement of and expectations on men to assume more responsibility as fathers are missed, is transferrable across the lifespan of children.

10. Summary of Learning and Recommendations

Learning Point 1 The need to ensure the voice of children is central to understanding their lived experience, (including children who are non-verbal), particularly within their home. (Recommendation 1)

Learning Point 2 The need to ensure a robust response to neglect, both adolescent and medical by all agencies. There was wide ranging evidence of neglect including missed appointments and deteriorating home conditions. Opportunities to identify the deterioration was missed when assessment practice failed to take the opportunity to see key areas of the home. In addition there were concerns in relation to medication administration, constipation not being assessed and managed, a child undertaking inappropriate caring responsibilities, possible use of restraint and physical abuse. (Recommendations 2 and 3)

Learning Point 3 The need for a strong system of case coordination/lead professional arrangements to enable early identification of a pattern of missed appointments, understanding of the reasons and an agreed response. Within this review children not being taken to appointments was within a context of a single parent with limited support, maternal mental health challenges and possible ADHD, experience of domestic abuse, lack of clarity re the role of the father and the need to engage with multiple services/appointments. (Recommendation 4 and 5)

Learning Point 4 The need to evidence that the needs of young carers are identified and responded to. The planned changes that are underway to the young carers offer will need to be embedded and demonstrate impact. (Recommendation 6)

The rapid review and a previous Tower Hamlets LCSPR "Julie" have identified and taken forward a number of recommendations and therefore the recommendations from the LCSPR, detailed below build upon these.

The recommendations evolve from emerging learning points from the review and have been co-produced with Tower Hamlets practitioners to ensure local relevance:

	Recommendation
1	The THSCP should seek assurance that learning identified from the rapid review results in systems change in that assessments of children who are non-verbal demonstrate their voice is heard. To achieve this, there is an opportunity for safeguarding professionals to undertake assessments, drawing upon the expertise of professionals who work with those children using adapted approaches to communicate with children who are non-verbal and have learning difficulties.
2	The THSCP to review the effectiveness of the current Tower Hamlets Child and Adolescent Neglect Assessment and Action Toolkit by: 1. Seeking assurance, that partner agencies are utilising the toolkit in assessing and responding to neglect, particularly medical and adolescent neglect. 2. Undertaking a focused piece of work with partner agencies including housing to understand any barriers to using the toolkit and identifying what support individual agencies may need to ensure early signs of neglect are identified and responded to.
3.	Commissioners of primary care should assure themselves that within GP practices children are appropriately coded and the "reasonable adjustments digital flag" used to ensure any reasonable adjustment for the children and their families are made and they receive the LD annual health check.
4.	The THSCP to seek assurance that the system-wide family support case coordination model results in families being supported to ensure the health needs of children with complex needs are met. Consideration should be given to: 1. Undertaking focus groups to understand what families need from a care package to ensure the needs of children with disabilities are met and parenting stress in families with children with disabilities is reduced. 2. Implementing an approach that includes a lead health professional for children whose needs are complex.

5.	The THSCP to seek assurance that partner agencies' "was not brought" policies explicitly recognise the vulnerability of children who are non-verbal and have a learning disability not being taken to appointments and safeguarding and escalation actions are reflected.
6..	The THSCP to seek assurance that the newly developing approach to young carers can demonstrate impact, with increased numbers of young carers being identified, an assessment being undertaken that reflects the requirements set out in Section 64 of Care Act 2014.

11. Closing Statement

This review has shown the importance of professional practice focusing upon the learning from previous reviews and research. Due to the ongoing police investigation, it was not possible to hear the views of the parents or the social worker. The impact of this needs to be acknowledged.

The review has highlighted the importance of communication with children to understand their lived experience and the importance of professionals with different skill sets or focus working in a way that pools those skills to ensure assessment that adopts a think family approach.

In undertaking this review, it is important to acknowledge the impact that the experience of Ibrahim and Yusuf has had on those that knew them. The impact on professionals was evident and cannot be underestimated. All professionals involved in this review held open, honest, and difficult conversations. This review has highlighted examples of good practice across the partnership as well as areas for development. Professionals engaged fully with the review, demonstrating personal reflection and willingness to change their practice. It has been through the positive engagement from agencies with this review process, that has enabled identification of the learning.

12. References

Blake., L. (2024). *Delivering person-centred care for the UK's culturally diverse communities*. National Children's Bureau: Research in Practice.

Burnham. J. (2013) Developments in Social GGRRAAACCEEESSS: visible invisible, voice unvoiced. Cultural Reflexivity. London: Karnac.

Clements, L. (2023). Draft Guidance Assessing the Needs of Disabled Children and their Families. https://www.lukeclements.co.uk/wp-content/uploads/2023/11/Final-Draft-Guidance-July-2023.pdf

DfE (2024) Special educational needs in England Academic year 2023/24. London DfE

London Borough of Tower Hamlets Child and Adolescent Neglect Assessment and Action Toolkit: structured judgement tool. London Borough of Tower Hamlets Child and Adolescent Neglect Assessment and Action Toolkit: structured judgement too

London Safeguarding Children Partnership (2022) London safeguarding procedures, 7th edition. LSCP

London Safeguarding Children Partnership (2022a) Threshold - Continuum of need matrix LSCP.

NHS England (2023) Learning from lives and deaths - People with a learning disability and autistic people (LeDeR) Action from learning report 2022/23. London NHSE

NSPCC. (2023) Parents with a mental health problem: learning from case reviews. London NSPCC

RCPCH (2022) Child Protection Evidence Systematic review of teenage neglect. London RCPCH

The Child Safeguarding Practice Review Panel (2021) “The Myth of Invisible Men” London CSPRP

The Child Safeguarding Practice Review Panel (2023) “Safeguarding children with disabilities and complex health needs in residential settings” Phase 2 report, London CSPRP