Cumberland Safeguarding Children Partnership

Local Learning Review Neglect

Cumberland Council

CUMBRIA CONSTABULARY

NHS North East & North Cumbria

What is a Local Learning Review?

A Local Learning Review (LLR) is undertaken when a child or children have suffered abuse or harm, but the circumstances do not meet the full criteria for a Rapid Review or Local Child Safeguarding Practice Review. However, the three safeguarding partners believe there is learning about the way in which local professionals/agencies work together to safeguard children, that could strengthen safeguarding practice locally and improve multi-agency working to better safeguard and promote the welfare of children.

The Local Learning Review

This briefing summarises the key learning from a recent local learning review involving two young children aged two years and a nine-month-old who experienced chronic neglect. The case highlights the importance of recognising cumulative harm, professional curiosity, effective information sharing, and timely escalation when concerns persist. These background factors have been noted recurrently in a range of reviews locally and *nationally over a significant period of time.

The review identified several missed opportunities to recognise and respond to neglect at an earlier stage. The key theme throughout is the need to understand the cumulative impact of recurring concerns rather than viewing incidents in isolation.

Once information was shared effectively and brought together, agencies responded appropriately, resulting in improved outcomes for both children.

Background

The family were not known to Children's Services prior to June 2025. Between June 2025 and January 2026, multiple concerns were raised regarding:

- Poor home conditions.
- Hygiene concerns.
- Feeding and nutritional concerns.
- Failure to thrive.
- Neglect indicators.
- Missed opportunities during pregnancy.
- Domestic abuse concerns.
- Parenting capacity.

There were referrals that were anonymous and individually resulted in "No Further Action" decisions. Whilst agencies held pieces of information, the overall picture of escalating neglect and risk was not consistently recognised.

It was not until January 2026, when concerns escalated significantly and information was brought together through safeguarding processes, that decisive action was taken.

July 2026 *Child Neglect: A thematic analysis Briefing Paper: Responding to cumulative harm Safeguarding unborn babies and pre-birth planning

Good Practice

Through the review agencies identified good practice but this was once risks were fully identified which included:

- Agencies acting swiftly.
- Children's safety being prioritised.
- Multi-agency working improved significantly.
- The children's circumstances improved rapidly.
- Persistent attempts were made to engage the family.
- Concerns were escalated appropriately.
- Information was actively shared.

Key Areas of Learning

- Cumulative harm was not recognised early enough.
- Multiple concerns over a prolonged period were viewed separately rather than as part of an emerging pattern of neglect.
- Appropriate referrals were not made to Cumberland Children Advice and Support Service (CCASS).
- Information sharing was inconsistent.
- Some professionals were unaware of wider concerns held by other agencies.
- Agencies were unaware of anonymous referrals.
- Historical concerns not routinely linked to current risks.
- Missed opportunities to seek information.
- Midwifery involvement not always evident within safeguarding discussions.
- Delayed Escalation and challenge.
- Reassess risk when circumstances changed.

The review found that agencies did not have a sufficient understanding of the child's daily lived experience. Gaining a clearer picture of what life was like for the child on a day-to-day basis may have enabled earlier identification and recognition of neglect.

Taking Multi Agency Learning into Practice

Implementing the learning from this review will support earlier identification of risk, stronger multi-agency practice, and better protection for vulnerable children and families.

It is important as a practitioner to take the issues identified into your supervision, team meetings and group supervision.

All practitioners should consider:

- How can I be more professionally curious? What do I need to ask or observe?
- Identify and explore patterns of concern over time and escalating risks.
- Small concerns, when repeated or combined, can cause significant harm
- To question explanations that do not fully account for presenting concerns.
- What may not yet be known about a family and question who may know.
- Recognise cumulative harm, look beyond single incidents.
- Family history.
- Recording concerns accurately and chronologically
- Repeated low-level concerns can indicate significant neglect when viewed together.
- Pregnancy and the arrival of a new baby should trigger renewed assessment and planning.

Single Agency Learning

Action plans to address key findings and ensure practice improvements have been developed by the individual agencies which the partnership will monitor.