West Glamorgan Safeguarding Board
Child Practice Review Report

West Glamorgan Safeguarding Board
Extended Child Practice Review

Re: WG N63 2021

Brief Outline Of Circumstances Resulting In The Review

An Extended Child Practice Review was commissioned by West Glamorgan Safeguarding Board on the recommendation of the Practice Review Management Group (PRMG) in accordance with Part 7 of The Social Services and Wellbeing Act (Wales) 2014, specifically Volume 2 Child Practice Review Guidance.

The criteria for this Review were met under section 7.1 of the above guidance namely:

A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has –

- died; or
- sustained potentially life threatening injury; or
- sustained serious and permanent impairment of health or development; and

the child was on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –

- the date of the event referred to above; or
- the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

Circumstances leading up to this review

The six children, who are the subject of this review, are a sibling group, and for the purposes of this review will be referred to using the following pseudonyms from oldest to youngest and are all the children of Mother. Child A is a half sibling to Children B, C, D, E & F. Children B and C are the Children of Mother and Father 1. Children D, E & F are the children of Mother and Father 2.

In June 2018 Mother, Father 2 and all 6 children moved into the area. Prior to the move, the children had all previously been on the Child Protection Register, in the originating Local Authority 1 area between July 2016 and February 2018. The reason for registration was due to poor supervision of the children, poor school attendance, missed health/dental appointments and instability in living arrangements.

The family moved to Local Authority 2 area in June 2018. It is noted that Mother had been offered a care and support plan by Local Authority 1 but declined and therefore the information provided was for information sharing only. Father 2 however stated that the family had been encouraged to move to South Wales on a temporary basis by the Local Authority 1 children's services, in order to protect Child A. This was due to Child A's substance misuse and disputes in their home area with other individuals, which led to concerns that Child A would be the victim of violence if not relocated.

Agencies were advised that Child A was known to have Additional Learning Needs and at the time of the move, a suitable school placement was being sought. At this time four of the other five children were also of school age. Documentation analysed during the review indicated that Child A spent most of his time in the previous Local Authority 1 area, travelling back and fore on public transport alone. The other children also spent a lot of time travelling between the two areas, accompanied by Mother. Statutory agencies noted concerns in respect of the children's health and well-being, with all children noted to have dental caries, significant episodes of head lice, causing sores to their scalp, particularly in the case of Child D & Child E.

Child A's Additional Learning Needs added further vulnerabilities and increased the risk of exploitation. He frequently travelled between two different Local Authority areas which added to the difficulties experienced by agencies, to fully assess his needs and provide appropriate support. The geographical distance between the two authorities totalling 60 miles and across England and Wales added further complexity.

Child C had specific dietary needs due to a diagnosed medical condition, which were not being met by Mother or Father 2. The children have since reported that food was scarce in the household, and that they often prepared their own meals.

The older children have also indicated that they were responsible for the care of the youngest child, preparing Child F's bottles and changing nappies. The children had little access to clean clothing, and they have reported wearing the same clothes for several days, and often sleeping in them also.

The children were exposed to significant harm, including parental substance misuse, significant domestic abuse between Mother and Father 2, leading to his incarceration, chronic neglect of health needs, limited access to food and appropriate clean clothing, and lack of a stable home environment. The children lacked opportunities to socialise and learn from their peers due to limited school attendance, and no access to

appropriate toys or other forms of stimulation. Children D and E reported that there were no toys or other sources of stimulation within the family home, and that they "made up games" to entertain themselves.

Information reviewed within the timeline demonstrated a chaotic and challenging picture within the family home, illustrating that both Mother and Father 2 had unmet needs, along with the significant neglect and health needs of the children, which created competing demands and priorities for all professionals involved.

Timeframe for the review and key events

The time period for the review was agreed at the first panel meeting as 01.10.18 – 30.11.20. Given the level of concerns, extending the time period allowed the review to consider all agencies involvement with the family from the time they moved into the area.

In March 2019 the children's names were placed on the Child Protection Register under the category of Neglect, with their names subsequently removed when the children were accommodated by Local Authority 2, with (Family) Court proceedings commencing and Interim Care Orders being obtained (in relation to Children B, C, D, E & F). This followed police protection powers being exercised in November 2020.

Within the review period there were 6 Child Protection Conferences held and 23 Core Group meetings held (every 4-6 weeks). It is also noted that from November 2019, the children were considered under Public Law Outline (PLO) processes, due to ongoing concerns in relation to the parenting that they were experiencing and despite attempts, no improvements or indications that circumstances were being addressed by parents. It is apparent that the trigger for the Child Protection processes increased concerns in relation to the relationship between the parents following a domestic incident in February 2019.

It is evident following review of Local Authority 2 information, that six main specific outcomes were discussed within these meetings. These included

(1) The children not being exposed to inappropriate adult behaviour (Father 2's substance misuse and domestic abuse)

(2) The children to have a positive relationship with their education (acceptable school attendance)

(3) The children to be healthy (health appointments made, attended and advice followed through)

(4) The children to live in a stable home (maintain a tenancy)

(5) The children not to come to harm due to their environment (appropriate supervision at home)

(6) The children not to be harmed and appropriately cared for (basic care needs met).

Local Authority 2 were concerned about the wellbeing of the children and balancing this in relation to 'good enough' parenting, the potential impact on the children of separation, Family Court proceedings and the legal threshold/context. It is evident the children were regularly discussed within Legal Surgery meetings, comprising of the assigned Social worker, their Team Manager, Principal Officers and the allocated

Solicitor and Principal Lawyer. The first Legal Surgery was held in April 2019. The outcome was that further support and assessment was required, with mother indicating that she was no longer in a relationship with Father 2 and having only recently moved to the area would require further time to demonstrate their parenting ability. With limited progress at the first Review Conference in June 2019, Legal Surgery was convened again in July 2019.

Issues in relation to inconsistent attention to the children's presentation, such as recurring head lice, and occasionally presenting as grubby and unclean, fluctuating home conditions with drawings on the wall, limited bedding and poor general upkeep, and inconsistent school attendance, ranging between 64-84%. Poor oral hygiene was noted with extractions identified as likely but the children were not reporting to be in pain, and despite repeated requests from professionals the children had not been registered with the dentist. A further Legal Surgery was held in October 2019, which highlighted ongoing tenancy issues brought upon by poor upkeep of the home and rent arrears, which were subsequently paid for by Local Authority 2 on two separate occasions. The family's frequent movements between the two local Authority areas continued to impact on health and dental appointments as well as school attendance and engagement with support services. It remained an ongoing concern that the children's needs were not therefore always being prioritised or met on a consistent basis, despite services offering support and advice. There also had been another domestic incident between parents in the presence of the 5 younger children. It is noted that the outcome was to progress to the Public Law Outline process as a result of the catalogue of concerns.

Separate parenting assessments were completed in relation to Mother and Father 2 and were shared at Legal Surgery in February 2020. The assessment highlighted that a further period of assessment was required. Under the Public Law Outline process, it is noted that there had been some stability in relation to living arrangements, with temporary but stable accommodation identified for the family. The Working Together service, who provide parenting support for families where there is a concern in relation to recurring neglectful parenting, commenced their involvement in January 2020. Also at this time, Maternal grandmother was seeking to move to the area, which would offer mother further support and Father 2 had been released from HMP, after conviction for an assault in September 2019 on Mother, Whilst Father 2 was reported to be working with services, it remained to be seen how this would impact on the situation and care of the children.

With the onset of the Covid 19 Pandemic and the potential impact on service provision, a further extension was sought in June 2020. At the time, it appears that professionals believed the situation was predominantly stable, however, with concerns that the situation was not improving a PLO interim report was completed in July 2020 by Social Services. Home conditions were generally noted as acceptable, with no specific safety issues, although still limited toys and stimulation were highlighted. Mother was noted as not consistently engaging with all professionals. Some health appointments were attended for immunisations but professionals advised and observed that Mother did not always proactively act on health advice, for instance in returning health matters to the GP or when special shampoo for some of the children had run out. Child D and E had been noted as complaining of tooth ache occasionally to school but it would appear that professionals weren't concerned that Mother did not pursue an appointment, instead choosing to potentially act on the advice to monitor if it was a recurring issue.

In the Review Child Protection Conference in May 2020, it was highlighted that the children were likely to feel some pain the majority of the time, due to their tooth decay, only being more aware of it when under acute pain. They had accessed specialist provision when in originating Local Authority area 1 and despite the delays in accessing advice in Local Authority area 2, appointments in October 2019 indicated that in the future, tooth extractions were likely for all of the children. Child B – 4 teeth, Child C – 2, Child D - 6, Child E – 11, Child F – did not open their mouth. This would be seen as an emergency appointment, if the children were regularly complaining of toothache. Some improvements, although not consistent, in relation to the children's presentation in school was noted during Social workers involvement. Generally, during visits the children did present with limited clothing. There were specific items that the children were regularly seen in, such as school uniform or summer dresses. Child F was often observed to be in a nappy. It is noted that advice and support was offered from professionals in November 2019 in relation to toilet training. Visits were often at the end of the day when the children had been in school. Mother would regularly report bathing the children nightly and this was monitored through the Care Plan, with school professionals seeing the children the most often. The children's school attendance had been affected further by the pandemic, with the situation only improving when transport was provided.

Legal Surgery was convened again in July 2020 with specific tasks to be completed, including a meeting to be held between the Principal Officer and Mother in order to be clear with expectations and the support available. The matter was reviewed in Legal Surgery in late August 2020, where it was felt again, that a further period of assessment was required within the new school year, with services and expectations returning to some normality from the impact of the pandemic.

It was noted in the learning event that professionals conceded, that as is the case with many families where neglect is a factor, care fluctuates between 'good enough' and poor, with some parenting tasks and skills being met only sometimes. However, it was clear that certain expectations were changed during the pandemic, for instance, school attendance and the availability of health appointments. Whilst practitioners had to support and encourage attendance and the engagement with services, equally with service provision changing, such as School Hubs, and support services using video calls, unless a specific issue or complaint was being regularly identified or highlighted, routine and regular appointments, like Health, became just for emergencies. It is noted that a further addendum assessment would have been due to be completed in December 2020.

Children's and parent's perspectives during the review

Unfortunately, there have been logistical challenges and barriers to obtaining the views of the children and the parents in this review. Child A's Father sadly passed away prior to the events which led to this review. Neither Mother nor Child A felt able to engage in the review. Child F is still considered too young to engage in the review process but he has settled in his new placement and is making positive progress in his development.

Father 2 has been spoken to. He stated that the family had been encouraged to move to South Wales on a temporary basis by Local Authority 1 Children's Services, in order to protect Child A. This was due to Child A's substance misuse and disputes in their home area with other individuals, which led to concerns that Child A would be the victim of violence if not relocated. He felt that Local Authority 1 had "offloaded

them" to some extent and they were "left to fend for themselves" when arriving in South Wales for quite a long period of time and that this was only supposed to be temporary and never a long-term option.

He stated that he worked away in the week and would generally only be home on weekends throughout the majority of the relationship and did not believe it was his responsibility to maintain home conditions. He recognises now that home conditions fluctuated between sometimes acceptable and sometimes unacceptable and agreed that they could have been categorised as neglectful conditions during the unacceptable periods.

He described that having a lack of money played a role in the level of care they were able to offer the children stating that they were not able to buy a car. He stated that he would often have to walk all of the five youngest children to and from the multiple different schools they attended, and that this contributed to the children's low school attendance.

Father 2 confirmed that there was substance misuse during the period in question and recognises that money spent funding these habits, could and should have been spent on the children and their care.

He confirmed that when children's services became involved in the Local Authority 2 area, to his knowledge home visits were often unannounced but he could not recall whether the children were ever spoken to or observed on their own. He felt that his relationship with the lead social worker was very poor. This was due to his belief that the social worker would offer negative observations when attending the Child Protection Conferences or other Strategy Meetings, that hadn't been said previously to him and this annoyed him as he felt ambushed. He confirmed that his relationship with the family social worker was therefore strained and that he stated he had threatened and attempted to intimidate them also.

In relation to the children's dental health and other health requirements, he stated that the responsibility for registering all of the children with dentists and also at their General Practice surgeries had been left to him and he found this difficult when working away also. Father 2 was asked about his views on dental health and he believed that this was really important and more should have been done.

Father 2 confirmed there was conflict within the relationship leading to domestic violence issues and his subsequent incarceration in HMP.

The reviewers were also given an opportunity to visit the current home address of Child B and Child C and discussions were held with family members. The children were not spoken to at this time at the request of family but there was an opportunity to understand their experience and progress made since they were placed there.

Both Child B and C have settled within their new home and are both thriving in this new environment. Child B is described as very responsible and this was reflected within the review and corroborated below when Children D and E were visited. Child B still continues to take the lead and protect Child C. He is very confident in comparison to Child C. Both have a rich appetite for learning and both enjoy football. They are also learning how to play musical instruments with Child B playing the guitar and Child C playing the drums. Both also attend two martial arts sessions every week

and this has boosted them further contributing to their confidence, social interactions and discipline.

Child C's dietary needs are now met and his health has improved. He takes an active part in cooking and baking his own gluten free food with grandmother and they have a "Coeliac App" on their mobile device, which allows them to scan and select appropriate foods, which Child C thoroughly enjoys. His iron levels were low when first arrived but have risen to normal levels.

Child A maintains contact and they both have an excellent relationship with him. Child A attends the scheduled visits with mum, of which there are currently six arranged per year and has requested to visit more often.

Child B and C have also been on holiday with Child D and E whom they see more frequently than Child F. They have however visited Child F and where logistics permit, these visits are encouraged and accommodated between current carers to strengthen the relationship.

Reviewers had the opportunity to meet with Child D and Child E, at their current foster placement. Child D and Child E have settled well into their placement, with both children presenting as happy and comfortable in their new surroundings. Both children underwent significant dental treatment following their placement, but are now attending regular check-ups and have good dental hygiene routines. Both children were very proud of their teeth now, and were happy to show the reviewer their improved "smiles". Child D is currently undergoing an assessment of their educational needs, after displaying signs of developmental delay, which despite regular school attendance has not improved.

Although Child F was too young to engage in the review process, his foster carer reports that he has settled really well into his placement. He has started in a new school and is progressing well and although he is still a little behind his peers, the school are confident with some additional support he will catch up educationally.

Child F is reported to be very sociable and talks about his friends in school. His confidence has really increased, with others supporting Child F also remarking on how much he has "come out of his shell". His foster carer said that Child F is a lovely character who enjoys being active and being outdoors, but is equally happy sitting on the sofa with a blanket watching TV. Child F is said to enjoy contact with his siblings, and also Father 2, however contact with Mother is very sporadic and she often cancels last minute.

The children recounted how life was with Mother and Father 2, stating that they didn't have toys to play with, or a TV to watch, and often had to make up games to amuse themselves. They recounted that Child B would often be the one to make food for the children, cooking things like packet pasta with cheese, or pizzas. They also stated that they would be responsible for the care of Child F, changing his nappy and making his bottles.

The children spoke of an incident of domestic abuse between Mother and Father 2 which frightened them describing how they had cowered on the floor as a result of the fear. There were also accounts of physical abuse towards all the children, including a description of being thrown in the air and allowed to drop to the ground,

at the hands of Mother's new partner shortly before being accommodated into foster placement.

The children obviously experienced a lot of trauma during their time living within the family home, and are still being supported to overcome the long term impact of these experiences.

Practice And Organisational Learning

Cross Border Working

A significant issue for practitioners involved in providing services for this family centred on the movement of the family between two different areas. At the time of their move, the children were no longer subject to Child Protection Registration, and Mother declined support from Social Services in Local Authority 1. Delays in sharing information with Local Authority 2 did add to the difficulties experienced by professionals, as their knowledge of family history and previous concerns was limited.

The Wales Safeguarding Procedures 2019 outline that where there are disputes between authorities in respect of the case responsibility for children who are moving between areas, ensuring appropriate safeguards are in place and that protection planning manages all identified risks is paramount, and agencies have a duty to work together to ensure this. Guidance for children on the child protection register outlines that in such cases, "Team managers must ensure appropriate communication between agencies, and escalate to senior managers if any issues arise when children are subject to registration". In such cases collaborative working is essential to safeguard the child/young person. While this matter was not in the child protection arena, where there has been recent safeguarding involvement with the family then good practice would be to follow a similar approach to information sharing to ensure any effective decision making can be made.

The complexity of family's situations and the large volumes of information held can impede the identification of the risks faced by children. At the learning event, it was noted that historical information held by Local Authority 1 wasn't fully known by Local Authority 2.

In these circumstances the reviewers recommend that it would be for the originating authority to provide all relevant information including information on previous risk factors, and the current support in place with parental consent to do so. This will provide assurances that receiving Authorities are fully informed when undertaking assessments ensuring that the safety of children is at the centre of decision making. "When Information is not shared in a timely and effective way, decisions about how to respond may be ill-informed and this can lead to poor safeguarding practice and leave children at risk of harm" Wales Safeguarding Procedures 2019.

The reviewers recommend that Local Authorities have clear policy / practice guidance to ensure safe and timely sharing of information when children's names

are not on the Child Protection Register, and the use of the Resolution of Professional Differences Protocol is used if this is not being complied with.

Neglect of Neglect

All practitioners involved with the family acknowledged that the needs of Mother and Father 2 were significant. Many professionals were focused on supporting Mother and Father 2 to address issues such as housing, rent arrears, Father 2's substance misuse, maternal mental health and domestic abuse to indirectly improve the circumstances for the children in the home, rather than focusing on their capacity to parent and the impact of this on the children.

Farmer and Lutman state where parenting capacity is impaired due to complexities such as domestic abuse, or substance misuse which in turn leads to neglect of the child/children, practitioners can become focused on parental needs, rather than the needs of the child. They noted that where supporting parents to "parent" becomes the priority there can be a failure to consider if this is improving the outcomes for the child (Farmer E. and Lutman E. ,2014).

In the learning event, practitioners were aware of the impact of parents care on the children however, what was not fully understood was the capacity or motivation to change and the timescales of this.

It is recognised that characteristics of neglect may make it harder for practitioners to recognise the chronic nature of this form of maltreatment over a period of time, which can result in practitioners becoming used to how the children were progressing and either fail to question a lack of progress or accept minor progress. Unlike physical abuse for example, the experience of neglect rarely produces a crisis that demands obvious and immediate action. The complexities already alluded to, in respect of the parental needs, the existence of domestic abuse, and aggression demonstrated by father, whilst ongoing in some part during the pandemic, contributed to this challenge.

There was evidence of 'false optimism', where practitioners noted parental engagement but do not appear to have placed enough emphasis on whether the change was happening in a way that made a significant difference to the experiences of the children. There was also evidence to some extent of 'disguised compliance', where mother gave the appearance of co-operating with services to avoid raising suspicions and allay concerns. It is important to establish the facts and gather evidence about what is actually occurring or has been achieved, in order to not lose objective sight of what is happening.

The term "disguised compliance" is attributed to Peter Reder, Sylvia Duncan and Moira Gray who outlined this type of behaviour in their book Beyond blame: child abuse tragedies revisited: "Sometimes, during cycles of intermittent closure, a professional worker would decide to adopt a more controlling stance. However, this was defused by apparent co-operation from the family. We have called this disguised compliance because its effect was to neutralise the professional's authority and return the relationship to closure and the previous status quo." (Reder, P., Duncan, S. and Gray, M. (2010) Beyond blame: child abuse tragedies revisited. London: Routledge, pp 106-7)

A recurring theme throughout the review was the difficulty in establishing the parental willingness or parental capacity and capability for change and an expectation or reliance on the parents by practitioners to take the necessary actions, when their history indicated that this was repeatedly not happening. Was it a case of that Mother and Father 2 were incapable and couldn't provide the required care or make and keep appointments or just that they often did not wish to and prioritised other things. Practitioners should draw on knowledge and experience of managing change when working with families with multiple areas of concern, utilising methods such as Motivational Interviewing, to gauge parental motivation to change, and to set achievable targets. Such approaches can instil parental confidence and therefore lead to sustainable change. Although practitioners are skilled in using such methods the review did not see evidence, either through documentation or at the learning event that this was implemented when supporting the family.

Extra Familial Harm

The complexities surrounding Child A, moving frequently between two different local authority areas, involvement in criminality and possible exploitation, added to the difficulties in ensuring his safety. This in turn led to Child A often "missing" when considering the needs of the children, and particularly in care planning.

Following the learning event, it was highlighted that Child A could have benefitted from his own Social worker rather than a single family Social worker due to his personal circumstances and the concerns of extra familial harm. The reviewers recommend that Local Authorities consider each child's circumstances fully when allocating workers to ensure the risks of extra familial harm are not absorbed within the wider family dynamic. Additionally, it is felt that better use of supervision in such cases would support allocation of multiple workers where there is extra familiar harm.

Voice of the Child & Advocacy

The under pinning principle of the wellbeing (Social Services and Wellbeing (Wales) Act, 2014) is 'what matters' to citizens therefore, in practice it is essential that children's voices are listened to in order to achieve the right outcome at the right time for them including safeguarding them from harm.

There is limited evidence whilst the children remained living with Mother and Father 2 that they were asked about their wishes and feelings. Given the ages of the younger siblings this is understandable. However, the older siblings were old enough to share opinions about their daily lives and activities. It is apparent that the opportunity for them to share their thoughts was not consistently provided to them, despite them being in contact quite frequently with different professionals.

It appears all of the visits conducted, were done when Mother was present. Practitioners need to constantly seek to understand the lived experience of the child. Best practice recommends children are seen on their own by practitioners, away from parents and carers, in an environment where they feel safe, so that the child can speak about the impact of the circumstances which have prompted safeguarding concerns. Providing time and space to listen directly to children supports a system which is child-centred and promotes good safeguarding practice. This could have resulted in disclosures from the children relating to their ongoing neglect, and may have provided evidence for further action at an earlier opportunity.

As all children were on the Child Protection Register they were entitled to an active offer of advocacy from a statutory Independent Professional Advocate (IPA) (Part 7 of the Social Services and Well-being (Wales) Act 2014 and Section 47 of the Children Act 1989). It is noted in the Initial Child Protection Conference held in February 2019 and the subsequent Review Conferences that independent advocacy services were considered and many of the children were deemed too young to qualify or benefit from their use.

The Reviewers recommend that each organisation considers advocacy through a broader lens such as non-instructed advocacy which may have been of benefit had the services been approved. The four currently recognised approaches to non-instructed advocacy are briefly set out below. It is acknowledged that an integrated approach is most effective in delivering non instructed advocacy.

Rights based Approach

With this approach, the role of the advocate is to ensure, using a variety of means, that the basic human rights of the children are promoted, defended and where necessary used to take affirmative action on behalf of them. Where the advocate believes that the injustice being done to the service user may be illegal, they should seek appropriate legal representation for the person.

Person-Centred Approach

In spending time with the child/children and may be others who the child knows and trusts, the advocate builds up a picture of their lifestyle, preferences and needs. The advocate can independently represent the person's views 'as if they were the advocate's own' (O'Brien 1981). In doing so the advocate is raising the profile of the child's unique perspectives, and as such is promoting a person-centred approach to service delivery and decision making.

The Watching Brief Approach

This approach centres around 8 quality of life domains which are used as the basis for a series of questions that the advocate can put to the decision maker or service provider on behalf of the child. Watching Brief provides a framework for questioning and challenging the decision maker or service provider in a non-confrontational way and encourages service providers to put the service user at the centre of the decision making process. Using the Watching Brief model, advocates have to ensure that a number of issues are clear.

Witness-Observer Approach

The advocate, in observing the way in which a client lives their life may see or hear things that are unacceptable or which pose a threat to the person's well-being. They may also pick up on the service user's preferences and pleasures, which can in turn be used to enhance positive relationships. This approach does not require the advocate to make judgements or assumptions, merely to report on the facts of his or her observations and bring them to the attention of service providers and decision makers.

The Reviewers recommend that organisations use a trauma informed approach when considering an appropriate advocate.

Improving Systems and Practice

Cross Border Working

- Where families move between different local authority areas, clear communication and information sharing is vital, ensuring that representatives from each area are included in all multi-agency Child Protection meetings e.g. Strategy Meetings/Discussions, Child Protection Conferences, Core Groups etc. It is also imperative that there is a clear determination of overall responsibility and if agreement cannot be reached then this is escalated through the Resolution of Professional Differences Protocol.

Neglect of Neglect

- Paediatric Review should be considered and requested earlier in neglect cases and become standard practice for all Child Protection neglect cases which do not show significant progress when they reach second review Conference stage.

- All practitioners who are involved in Child Protection processes should have access to training on disguised compliance. This will enable a robust assessment of parental engagement, with clear identification of positive progress and improved outcomes for children.

Extra Familial Harm

- The Reviewers recommend that Local Authorities consider each child's circumstances fully when allocating workers to ensure the risks of extra familial harm are not absorbed within the wider family dynamic.

Voice of the Child & Advocacy

- The Reviewers recommend that each organisation considers advocacy through a broader lens such as non-instructed advocacy which may have been of benefit had the services been approved.

<u>Reminders for practice</u>

Professional Duties and Responsibilities

- The Resolution of Professional Differences Protocol should be utilised where there is inter-agency disagreement with regards to safeguarding

- Development of multi-agency neglect tool to remove subjectivity and ensure all professionals understand and apply the same the assessment. It is recognised that the Local Authority 2 have worked with Birmingham

University to develop a neglect toolkit. Other assessment tools recommended in other similar reviews include:

- the Graded Care Profile (GCP) which provides a structure for assessing the type and level of neglect so it can be addressed in a timely and appropriate way

- Safe Care which is a well-tested home-based intervention that helps parents improve their awareness of the physical and emotional needs of children aged years.

- Retain professional curiosity and respectful uncertainty. Practitioners should demonstrate professional curiosity and respectful uncertainty. Unclear or confusing information provided by a parent or carer should be cross-checked with other sources to ensure that it is accurate and properly understood

- Respond to missed appointments. Professionals in all agencies should understand the significance of children missing appointments. To this end, systems should support practice that:

  - Ensures referrals are not automatically closed if appointments are missed.

  - Ensures missed appointments are subsequently monitored and followed up.

  - Informs and instructs professionals on what action should be taken when concerns are present.

- Best practice recommends children are seen on their own by practitioners, away from parents and carers, in an environment where they feel safe, so that the child can speak about the impact that the circumstances which have prompted safeguarding concerns.

- Systems need to support and maximise the sharing of information between agencies to ensure that child's needs are met where there is any indication that there may be issues with the child's development or missed appointments.

- Providing time and space to listen directly to children supports a system which is child-centred and promotes good safeguarding practice. In the case of the children within this Review, this could have resulted in disclosures from them relating to their ongoing neglect, and may have provided evidence for further action at an earlier opportunity.

Child Protection Processes

Review Child Protection Conferences can be brought forward if :

- Significant change of circumstances has taken place which may place the child at risk of harm, for example the outcome of a section 47 has highlighted new risks of significant harm to a child on a care and support protection plan;
- there have been further incidents or allegations of significant harm
- the plan is not protecting the child from harm;
- practitioners are experiencing significant problems implementing the plan;
- the plan has been more successful than anticipated in protecting the child from harm and the core group request a review conference is brought forward to consider de-registration.

As a result of a review in process and learning from other Child Practice Reviews a new criteria is being considered by SWP to identify High Harm Threshold cases requiring police attendance at Review Conferences. This will always be on a case by case basis, but where the following are applicable, police attendance is recommended;-

- In any circumstance where there is an ongoing criminal investigation involving the child/children.
- Where the child/children are on the register under the category of sexual abuse/physical abuse.
- Where the child/children are on the register under the category of neglect and there is an ongoing criminal investigation.
- Where the child/children are on the register under the category of neglect and no progress has been made by the 3rd Review.

- All agencies should ensure that all practitioners who work with children and/or adults who have caring responsibilities understand their role in relation to safeguarding.

- All agencies should ensure relevant representation at multi-agency meetings includes professionals with the relevant expertise and knowledge, to inform decision making processes. This will ensure plans reflect the impact of concerns and can demonstrate effective progress clearly and prevent drift.

- The Local Authority needs to ensure all qualified practitioners include Public Law Outline discussions and decisions are included and considered in multiagency forums, such as core groups, to inform decision making processes. Additionally Local Authority need to ensure professionals judgements of long term impact in neglect cases are considered earlier in respect of Public Law Outline processes.

- Assessments should include consideration of parental capability and capacity for change and the impact this has on children. Professionals should support the social worker to compile and maintain a multi-agency chronology of key events. The full history of the family should be considered when new concerns arise, including patterns of previous episodes of neglect. Emotional neglect is particularly difficult to evidence, so individual observations should be systematically collated.

Supervision and Record Keeping

- All agencies should ensure that practitioners working with families where there are safeguarding concerns have access to supervision from a suitably qualified and experience practitioner. All agencies should review and be satisfied that their systems for supervision and management oversight are fit for purpose, able to identify potential drift and provide opportunities for reflection. This can include the use of Peer Review. In such complex cases practitioners not directly working with the families, using their expertise and past experiences, may provide additional direction to case workers.

- All agencies should have a robust Record Keeping Policy and ensure there is clear guidance for documenting Safeguarding concerns. Documentation needs to include the recording of any challenges or escalation, and the subsequent outcomes.

- Improved use of Health Liaison roles within Children's services would ensure that all relevant health information is available to social workers, as well providing opportunities for Health professionals to work together to meet the health needs of children, particularly in cases of neglect.

- Professionals need to ensure that there is consideration of the child's "lived experience" within assessments and that documentation demonstrates that practical steps have been taken to speak with the child/children alone to seek their views and wishes, to inform decision making.

- Professional desensitisation and normalisation – It is recognised that professionals who are routinely working with high levels of need can become desensitised to the potential risks posed to children. This means that families don't always receive the support they need and cases can drift. Similarly, where there is over optimism and an overly sympathetic or empathetic position taken with regards to the circumstances, this can cloud judgement and hinder progression.

Post Pandemic Learning

- The impact of COVID 19 and response taken by statutory bodies and partners enabled parents who were hard to engage with to avoid professional contact. Professional rigor and persistence are required so that children's needs continue to be met despite the challenges of working during a pandemic. It was recognised that all partners worked tirelessly to ensure the younger children were supported and arrangements in place to ensure attendance at school during the pandemic.

- Continued use of Microsoft Teams for professional's meetings in cross boundary cases will promote attendance and allow for greater

opportunities to support families who are moving between areas. Following feedback obtained within the learning event, consideration should be given to face to face attendance, or the use of a hybrid approach, for meetings such as Core Groups, Child Protection Conferences and Care and Support meetings, as this is felt to be more beneficial and inclusive for the families.

STATEMENT BY REVIEWER(S)			
REVIEWER 1	Jonathan Northey	**REVIEWER 2**	Tricia Thomas
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*	JJNorthey	**Reviewer 2** *(Signature)*	
Name *(Print)*	Jonathan Northey	**Name** *(Print)*	Tricia Thomas
Date	9th May 2023	**Date**	9th May 2023

Chair of Review Panel (Signature)	D.Rees
Name *(Print)*	Damian Rees

Date	9th May 2023