**Introduction:**

**What is a Local Child Safeguarding Practice Review?**

A **Local Child Safeguarding Practice Review (LCSPR)** is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in seriousharm or death, and/orthere is cause for concern as to the way in which agencies have worked together to safeguard the child.

The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children; identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children.

**Thematic LCSPR**

Learning Briefing

The East Sussex Safeguarding Children Partnership (ESSCP) undertook a Local Child Safeguarding Practice Reviews (LCSPR) in 2021 in response to two serious safeguarding incidents regarding two families: Family A and Family B.

In Family A, a young adult stabbed his mother’s partner following a domestic abuse incident between the couple. The family were known to partner agencies due to concerns about long-term domestic abuse, parental mental health issues, violence and substance misuse. In Family B, the mother’s partner violently attacked the children’s mother. A 13-year-old child, one of two living at home, sustained an injury during the assault. The family were known to partner agencies due to long term domestic abuse, parental mental health issues and neglect.

In both families the adults had significant vulnerabilities, including a history of abuse and neglect in their own childhoods, previous relationships where domestic abuse featured, mental health issues and substance misuse. All children were the subject of child protection plans. The serious nature of the incidents also resonated with decision makers. It was agreed that both of these cases should be considered in a single review due to a number of similarities.

**Key learning:**

The following learning points were identified in the Partnership Review process.

1. **Knowing and considering a parent’s history and vulnerabilities**

Parents/carers who have had adverse childhood experiences, and suffer with vulnerabilities due to their mental health, domestically abusive relationships, and substance or alcohol abuse, are more likely to have children who require a safeguarding response.

Both cases were complex with multiple adult vulnerabilities that presented risks to the children over a considerable period. All adults had significant histories that were knowable to professionals.

The review found that not all professionals were aware of all of the relevant background information. Not fully understanding and considering the adult risks can mean that plans made for children are based on what parents report rather than what is knowable to professionals, if they robustly check their own agency records and ask other professionals to do the same and share what is found.

1. **Working with hard to engage families who refuse to cooperate with child protection planning**

The nature of child in need or child protection planning requires that parents engage in assessments and plans in order to reduce risks to the children. In both cases, the parents largely did not acknowledge professional concerns or contribute to the plans made to improve things. This made it difficult for professionals to work with them and can lead to drift and delay and a feeling of helplessness about how to work with the family beyond monitoring what is happening.

Professionals need support and guidance about how to respond when they are unable to work with families due to avoidance and/or threatening behaviour, as well as considering the impact on the children. The review concluded it would be helpful for managers to be physically present when professionals are setting clear boundaries with families about what is and is not acceptable behaviour, to secure both the children’s and professionals children’s safety and welfare. Procedures refer to this as a 'Contract of Expectation' or a 'Written Undertaking'.

Professionals told the review that they are aware of the need to report any violent incidents or threats, and have a process available on their phones to do so. However, there is a recognised fatigue in regard to this and an acceptance that sometimes the job involves having to work with extremely difficult individuals. There are two relevant Pan-Sussex procedures that cover this issue. Firstly, Working with Families who are [Uncooperative and or Not Engaging with Professionals](https://sussexchildprotection.procedures.org.uk/tkyqyq/children-in-specific-circumstances/working-with-families-who-are-uncooperative-and-or-not-engaging-with-professionals/) and secondly [Violence Towards Staff](https://sussexchildprotection.procedures.org.uk/tkyqys/children-in-specific-circumstances/violence-towards-staff). The procedures include the suggestion that a strategy meeting is held in these circumstances to reflect the concerns for the children living in these households and to support the staff who are concerned about them.

1. **Recognising if there is no further police investigation of an issue does not mean that a child is not at risk**

The police and the CPS require a level of evidence that will allow them to prove guilt beyond reasonable doubt. There can still be indicators that a person is a risk and the lack of a prosecution does not mean that there is no risk and that the matter will not meet the threshold for a S47 and/or legal response by the Local Authority. The review established that when this is the case, professionals need to discuss the decisions made with the police and not make assumptions about a decision not to pursue a criminal case against an alleged perpetrator. This could most effectively be undertaken at a review strategy meeting.

1. **The impact on children of reoccurring domestic abuse and parental mental health issues**

It is essential that professionals consider the evidence of domestic abuse in the relationship in the past, at the time and also the likelihood of domestic abuse reoccurring. Particularly where there has been limited insight from the adults involved into the issue and little or no work undertaken to confront and address the problem.

An analysis of Serious Case Reviews identified that a change is required in how we understand and respond to domestic abuse, ‘there is a need to move away from incident-based models of intervention to a deeper understanding of the ongoing nature and impact of domestic abuse.’ This is relevant to these cases, as there is evidence that professionals were reassured, and decisions were made in light of the lack of domestic abuse police reports.

1. **The cumulative risk of harm when risk factors are present in combination or over time**

The [National Safeguarding Practice Review Panel’s second Annual Report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984767/The_Child_Safeguarding_Annual_Report_2020.pdf) published in May 2021 states that ‘the recognition of cumulative neglect and its impact continues to be a key challenge for practitioners’ nationally. There is a danger when working with cases of long-term neglect and/or emotional harm that agencies wait for a serious one-off incident to happen to provide evidence to each other, or to the courts, that the children are suffering significant harm on a given day. With neglect and emotional harm, a number of smaller issues or concerns when collated may show significant harm over time. There is a cumulative impact on children of care that dips just above and then below ‘good enough’ on a regular basis. Both of these cases are good examples of this. Assumptions can be made about the resilience of children in cases where the concerns are chronic and long term.

It is essential that patterns over time are considered when any professional is considering the threshold for a referral or an escalation of a professional disagreement when there are concerns that children are not being safeguarded. This, along with a clear understanding of the child’s lived experience and the family culture and the likelihood that concerns will reoccur over time without significant interventions and evidence of sustained change, is the answer to this question. When there is a clear case of reoccurring risks, the likelihood of ongoing harm to the children needs to be the focus of action taken, rather than professionals feeling helpless due to what they see as the burden of needing to prove that harm is present at a given point on a given day.

1. **Vulnerable children approaching adulthood**

When a child/young person has an EHCP this can be in place until the age of 25 providing that they are engaged in appropriate education or training that provides a forward pathway.  The EHCP is important in providing an oversight of needs and provision required, and has the potential to provide access and funding to support the engagement of the young person.

In this instance a EHCP was ceased owing to a lack of engagement from the family, meaning the child became an adult without a plan for his transition, despite his known vulnerabilities. The review was told that a plan is being devised to focus on this issue, and this case should be used an example of what is required to ensure that the hardest to reach young people are helped.

1. **The impact of COVID-19**

Covid-19 was a challenging time for the families and for the professionals working with them. Research shows that social workers were often the only professionals going into family homes during the initial lockdown and this often took a lot of negotiation for families to allow this. For some families COVID-19 nurtured a culture of non-engagement, especially for families reluctant to engage with professionals.

**Recommendations:**

The LCSPR identified six recommendations to strengthen safeguarding practice:

**Recommendation 1:** The ESSCP requests assurance from the relevant agencies regarding the identified need for improvements in processes and practice to support the transition of vulnerable school leavers, including those with an EHCP.

**Recommendation 2:** That the partnership asks ESCC Children’s Social Care and Legal Services to consider how they can ensure that: a) a multi-agency view of the need for a Meeting Before Action is sought and considered at the Care Planning Forum; b) Historic information across agencies, including patterns and cumulative concerns are available and considered at the Care Planning Forum; and c) Social workers and core groups are supported and encouraged to challenge Care Planning Forum decisions if they don’t agree with them.

**Recommendation 3:** The Partnership to seek assurance that professionals are supported when working with threatening and abusive behaviour from family members. The partnership must also ensure that professionals consider the impact on the children of such behaviour, including promoting the use of the existing procedures that suggest a strategy meeting is held following a serious threat to a professional or if a professional is assaulted.

**Recommendation 4:** The Partnership to seek assurance that the learning from this review is considered by all agencies and that the following areas of learning are routinely reflected in practice: a) The serious impact of the cumulative and reoccurring nature of neglect and emotional harm; and b) The need to ensure that information is sought and shared regarding parental/adult and family history that is likely to pose a risk to children**.**

**Recommendation 5:** That SPFT share the findings of their serious incident review of the application of the Mental Health Act during Stepfather B’s admission just prior to the serious incident, including any improvement actions that are being taken.

**Recommendation 6:** The Partnership to challenge the relevant partner agencies about how professionals who work with adults/parents can be better involved in working with families where there are concerns about the children.

**Action taken since the review:**

Since work on the LCSPR as started, the following has been completed:

* A working group

**Learning for practice:**

The ESSCP invite you to discuss the issues raised in this LCSPR in your team meetings or during group supervision. We encourage your responses to be included in your team minutes and forwarded to the safeguarding lead within your organisation.

**Points for discussion:**

* How do you consider a parents’ vulnerabilities and the risks these pose to children? How do you verify information provided by parents?
* How do you approach working with parents who are resistant or aggressive towards professionals? Are you aware of Sussex procedures for working with Families who are [Uncooperative and or Not Engaging with Professionals](https://sussexchildprotection.procedures.org.uk/tkyqyq/children-in-specific-circumstances/working-with-families-who-are-uncooperative-and-or-not-engaging-with-professionals/) and secondly [Violence Towards Staff](https://sussexchildprotection.procedures.org.uk/tkyqys/children-in-specific-circumstances/violence-towards-staff)?
* Think of a case where you worked with a ‘hard to engage’ family? What difference do you think it would make to have your manager support you in person when agreeing a ‘contract of expectation’ with a family?
* How could multi-agency strategy meetings have been used in these cases?
* When did you last undertake training on neglect?
* How do you consider the evidence of domestic abuse in the past, present, and likelihood of abuse reoccurring?
* When was the last time you used the Pan Sussex Child Protection and Procedures Manual?

**Useful Links:**

**Pan Sussex Procedures**

When was the last time you used the **Pan Sussex Safeguarding and Child Protection Procedures?** Did you know you can [**sign up to alerts**](https://sussexchildprotection.procedures.org.uk/page/contact) for when the manual is updated.

**ESSCP Multi-agency Training**

Currently all ESSCP training courses are running virtually, and we will update you on the [**East Sussex Learning Portal**](https://eastsussexlearning.org.uk/The-East-Sussex-Safeguarding-Children-Partnership-(ESSCP)-/446) when these courses become available.

**Contacting the Single Point of Advice (SPoA)**

Details on contacting SPoA can be found here: [**Contacting the Single Point of Advice (SPoA) | East Sussex County Council**](https://new.eastsussex.gov.uk/children-families/professional-resources/spoa)

**ESSCP Contact**

Details about the Partnership and its work can be found at [**www.esscp.org.uk**](http://www.esscp.org.uk). Follow the ESSCP on twitter for the latest safeguarding news in East Sussex **@EastSussexLCSB**

The ESSCP can be contacted on [**ESSCP.Contact@eastsussex.gov.uk**](mailto:ESSCP.Contact@eastsussex.gov.uk) or **01273 481544**