Child N: Learning brief

This briefing sheet has been prepared by a local safeguarding board to share the learning from the Child N Local Child Safeguarding Practice Review (LCSPR). Such reviews reflect our *commitment to safeguarding children at risk and* are intended to support the development of professional practice and systems.

This brief combines key messages and lessons learnt during the review to enable you/your teams to reflect on your practice with a view to implementing positive change and promoting better outcomes for children at risk. Full details of the report and all the recommendations can be found in the report. This LCSPR focused on the circumstances leading up to Child N's fall from a second-floor window.

Background:

N is of mixed heritage and had been diagnosed with autistic spectrum disorder at the age of 3 years. N and his family had been offered services from a range of agencies and was subsequently the subject of a Child In Need Plan and Child Protection Plan. These plans reflected the serious concerns professionals shared about the neglect N suffered; the lack of take-up of services to support N's development; lack of supervision and risks to physical safety; poor school attendance and difficulties in gaining consistent engagement from his parent / main care giver. As a result, the Local Authority initiated family court proceedings and applied for care and placement orders. However, the court concluded that the test for separation of mother and child was not met, and no orders were made.

Despite this, concerns for N's safety remained. This resulted in further child protection plans being made before family court proceedings being instigated. It was during this period that N fell from a second floor window sustaining serious and life threatening injuries. N was subsequently taken into care and placed with foster parents. N remains in their care and has made a good physical recovery and is developing well.

Good practice:

There was considerable evidence of good practice identified by this LCSPR which included:

* Practitioners knowing N well and maintaining a focus on N's needs. Staff worked hard individually and collaborated to attempt to manage the risks and keep N safe.
* Practitioners demonstrated an understanding of the impact of long-term neglect on a young child with a disability and this informed their assessments of risk and escalation of concerns.
* The Social Worker showed commitment and understanding in trying to establish a working relationship with N's mother with the Judge complimenting her work.

Key learning for consideration by individuals and teams:

1. Cultural awareness and sensitivity: Work with families should demonstrate an understanding of the impact that race, culture and religion can have on parents' behaviour and how best to offer support and encourage engagement with a view to promoting the child's welfare.

Question: Does my practice with families demonstrate cultural understanding and sensitivity? Do I seek specialist advice as necessary?

2. Engagement with Father/parent not living in the household: Agencies should obtain names and contact details of a parent not living in the household (most importantly with those holding parental responsibility). Unless there is a reason not to do so, practitioners should engage them in important decisions and discussions, e.g., formulation of Education, Health and Care Plan (EHCP). Practitioners should be aware of the potential support and protection that can be offered to the child by the parent not living in the household and their wider family.

Questions: When a child's parent is not living in the household, are we mindful of the importance of involving them in significant decisions and plans when it is safe to do so? Do I consider sufficiently the role that the wider family may be able to play in safeguarding a child?

3. Working with resistant families: Practitioners require the knowledge and skills to promote engagement with families who are resistant and hostile to co-operating with services offered, whilst ensuring they focus on the inherent risks to the wellbeing and safety of children.

Question: Does my team have the knowledge and skills required when working with resistant families? If not, how can these be developed?

4. Neglect & Accidents: Accidents are sudden, unexpected, events without forewarning, but for children experiencing neglect there can be a range of factors which mean that incidents, although not directly predictable, have some element of forewarning.

Question: When considering the risk of neglect, is sufficient attention paid to safety in the home?

5. Child Protection Planning: The category of harm should reflect the risks to the child, which should be articulated in the Child Protection Plan (CPP). CPPs are dynamic documents and should be updated after every Review Child Protection Conference to reflect the current position and identified risks. All agencies represented at the CPC and Core Group have a responsibility to ensure that the CPP is an effective tool.

Question: As practitioners attending child protection conferences, do I/we help to ensure that risks are fully identified and addressed in the category of harm and the CPP?

6i. Statements for Family Court proceedings should articulate all the risks to a child and consideration should be given to how parties can provide the best evidence to the court, including key professionals who have had significant involvement with a child and family over a period of time, e.g., health, education practitioners.

6ii. Where care orders are not granted attention should be paid to the continued application of statutory safeguarding duties e.g., use of child protection plans and core group functioning

Question: When preparing a court statement, are practitioners provided with sufficient time and reflective supervision?

When children are at risk of significant harm but no order is made, do I/we objectively reconsider the statutory guidance? e.g., Working Together 2018