



Children's Safeguarding Board Practitioner Briefing

Voice of the Practitioner

Embedding the Lessons learned from the Serious Case Review of Child K

Child K died aged 2 years and 5 months old, from an overwhelming infection and was found to be chronically malnourished. Whilst the infection was not preventable, the boy's underlying malnutrition and dehydration may have contributed to his death. His mother accepted a caution for cruelty. He was a severely disabled child with complex needs and was placed on a child protection plan in the weeks leading up to his death. His mother, a teenager had experienced a troubled childhood and was homeless when she met his father. There were recorded incidents of domestic violence, disguised compliance and failing to attend appointments.

Agencies did not collectively appreciate the full extent of the mother's difficulty in caring for him and therefore the risks that he faced; the focus of their involvement was his disability and at times there was insufficient recognition of her parenting ability and issues of neglect. Professionals struggled to understand the roles and responsibilities of the agencies working with the family, were unclear about the role of the lead professional and failed to share information, record events and escalate concerns when risks for child K increased.

These learning points were taken from the child K SCR **practitioner event** held in July 2015 to be shared with professionals for improved safeguarding practice.

- **Information Sharing**

'If it's not written down then it didn't happen' (Ofsted) – Professionals need to clearly record on their systems information about the family and the work being undertaken with them.

Check out the exact spelling of names according to the family / avoid using jargon and acronyms.

Be clear about what the purpose of meetings about the family are and what they entail.

Be clear about why you are copying in an agency into a letter about a family and know what to do with a letter in which you have been copied into.

- **Information and escalation**

In terms of safeguarding the child, information can / should be shared by agencies. All professionals should insist on receiving information and escalate if necessary.

Don't back down – if you feel that the child is at risk – **escalate your concerns**

- **Referral routes**

If there are child protection concerns refer to the contact centre– do not just leave your concerns with the active social worker.

- **Challenge**

Professionals must find out about each other's roles and responsibilities. Practitioners can professionally challenge agencies, if they feel that their assessment, method of working, knowledge of the family is lacking or leaving a child at risk.

- **Understanding Risk**

Understand what the 'risks' to the child are, from other agencies perspectives and specialist knowledge.

Identify risk / analyse the situation – What is mum saying? / What is dad saying? What are the agencies saying? / What am I observing? (What is the attachment between parents and the child?).

What is the lived in experience of the child? Is this normal child development?

Think about what appointments a child should be attending and with what agency– which are the most important? and which appointments should not be missed?

- **Communication and Working Together**

Liaise with other agencies working with the family. Don't think 'I've sent an email' that's my job done – follow it up.

- **Professional Curiosity**

Ask more questions be '**professionally curious**' with the family and with agencies who are working with them.

Be aware of the 'context' and 'lived history of family members' – what does the information that is recorded actually mean and what does it mean for them?

- **Focus on the child**

Professionals need to be careful not to focus too much on the parents needs at the risk of the child's needs and safety.

Remember that research tells us that children with disabilities are vulnerable and at a greater risk of abuse. The disability of child K became the focus of professionals work and the assessment of mother's parenting ability and capacity (Neglect of the child) became secondary.

- **Family Engagement**

Practitioners to involve parents where possible, try to see fathers outside normal working hours (if they work) and try to take them to one side when they are with other significant others who do not need to know/have the right to know about his child(ren).

How can we define good parenting? Don't let the coping with the disability of a child over ride inadequate parenting.

Think about how to deal with **disguised compliant** parents and the setting of achievable goals to safeguard their children.

- **Conflict of Interests**

Think about when working with families who are related, there should be supportive management oversight, a plan for working with any complexities and where possible, separate case workers.

- **Child Protection Conferences**

Minutes and the child protection plan should reflect what was covered within the meeting and be sent to professionals who attended the conference in a timely fashion.

Core groups should work on the action points from the plan and firm up the family and agency involvement to safeguard the child.

- **Lead Professional**

There should be a clear indication on family / child files, which is easy to see, as to who the lead professional working with the family is.

Best practice would inform that the lead professional should be one who is working more closely with the family and they should be supported by supervision and line management and to know when to escalate cases to other professionals in terms of increased risk.

- **Supervision**

Complex cases, which involve fluctuations in risks should be raised within supervision sessions for overview and challenge and to; support practice, explore risk and ensure the safeguarding of the child(ren).

Taken from the Practitioners event July 2015 and presented with kind permission from those attendees.