Kingston and Richmond
Safeguarding Children Partnership

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Child Safeguarding Practice Review concerning Child Y
Summary of Learning

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Preface:
This review concerns a child who it has not been possible to engage with in the review process. In order to support in making the learning accessible while maintaining the child and family's anonymity, this learning summary has been written to identify the key learning within the review to be shared across the partnership. Gender neutral language has been used throughout the learning summary, with the child being referred to as they/them. This is to support in maintaining anonymity.

1. Introduction

1.1 This review is in relation to Child Y, a 16-year-old of White British and White Other ethnic background. They have been known to a range of services, including private services due to concerns in relation to witnessing domestic abuse including concerns of physical abuse, poor parental mental health, neglect, their own emotional and mental health, self-harming behaviour including intentional overdoses, cutting, alcohol and substance misuse. At the age of fifteen, Child Y sustained significant, life changing injuries from an incident.

1.2 Child Y was residing with their mother and subject to a Child Protection Plan in pre-proceedings at the time of the incident.

1.3 A serious incident notification was completed and rapid review[1] was conducted. Feedback from the rapid review recommended for a Local Child Safeguarding Practice Review (LCSPR) to be commissioned. It was highlighted that key areas for focus within the LCSPR should include professional risk assessment and decision-making and exploration of the impact Child Y's culture and heritage may have had on their response to services.

2. Review process

2.1 A Rapid Review took place in September 2023 to gather the facts and identify any immediate safeguarding for Child Y and their family. The independent reviewer was appointed in February 2024 and the first panel was held in April 2024. It was

[1] Rapid reviews should identify, collate, and reflect on the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning- Child Safeguarding Practice Review Panel

identified for the review to build upon existing learning identified through local practice reviews that covered similar themes, including Young Person W and other local reviews.

2.2 The focus on the review for Child Y looks to dive deeper into the barriers experienced by practitioners in reviewing the full history of children and families known to services to support in risk assessment and decision-making. Given the strong themes of mental and emotional health, the review aims to explore how mental health was understood in the context of Child Y's age, the family's cultural background, and how this may have impacted their engagement with services.

2.3 In order to achieve this, four key lines of enquiry were identified. Consideration and exploration of the family's cultural background and heritage were maintained throughout each line of enquiry.

- What are the barriers and enablers to recognising and responding to cumulative harm?
- What is helping and hindering practitioners regarding risk assessments, decision-making and escalating concerns?
- What is helping and hindering practitioners in recognising and responding to the impact of trauma?
- What helped and hindered the network in recognising and responding to the risk at home? And in the community?

2.4 Information for this review was obtained through the completion of single agency chronologies, practitioner events, and individual meetings with key professionals. Practitioners within the meetings included those who had worked directly with the family across two local authorities and professionals who did not know the family but added value from their agency's involvement.

3. Limitation of the review

3.1 Engaging with the child and family is paramount to ensure the voice of the child and family is captured within the review process. Due consideration was given to the ability for the reviewer to engage with the child and family, which was done by the review panel in conjunction with Child and Adolescent Mental Health Services and Child Y's allocated Social Worker. Some practitioners working with the child have been able to share their views with the reviewer to help build a picture of the young person.

3.2 The lack of engagement with the child and family is considered a key limitation within this review, in particular in gathering a clear picture of their views of services and their lived experiences during this time. The review has used research to try and draw on potential learning, but it is noted that this is not first-hand information gathered from the review.

3.3 In making this decision, the reviewer and the review panel considered the impact of perpetuating some of the concerns raised by the family with professionals in relation to the family's worries around information sharing and distrust of services. A risk analysis was completed by the independent reviewer with information from CAMHS and Children's Social Care professionals. This was shared with the LSCPR panel, and it was deemed that the risk was too high to engage with the child and their family. Therefore, it has not been possible for the reviewer to engage with them for this review.

4. Summary of learning

4.1 The review focused on a 10-month period prior to the significant incident where Child Y suffered significant injuries. Other key episodes throughout Child Y's life were also included as they support in providing wider learning and provide further context in respects of the child's experiences.

4.2 The additional key practice episodes identified within the review included step-up and step down between plans, transition between local authorities and services, and the use of both private and family courts. These episodes were identified due to the long-standing pattern identified for the child and family.

4.3 The themes in this review focus strongly on the impact of neglect, looking at how risks and harm were identified and assessed for Child Y. It explores what tools and assessment tools supported in analysing the information available at the time. The findings and recommendations seek to identify barriers that may have affected agencies in identifying and responding to Child Y's needs.

Good Practice:

4.4 Child Y had a trusting relationship with staff in their school. Both schools who participated in the review were able to speak fully in relation to Child Y's experiences, concerns and outline key times where things in Child Y's life were working well or concerning them. When looking at Child Y's help seeking behaviours, it was evident that this would regularly happen in the school environment. The school health services, including the first aid staff and the school counsellor were a key point of contact for Child Y and often supported Child Y accessing further health services.

4.5 When concerns were raised in relation to peer-on-peer abuse, this was within the peer group at the same school. It is good practice the safer school's officer was able to speak with Child Y around the concerns, and support with advice and guidance in a space where they felt safe. It is evident that Child Y was well known by their school who advocated strongly for their needs through referrals to children's social care and health services. Schools were able to engage with parents through an education lens and this supported in building more trusted relationships.

4.6 There is positive practice in relation to multi-agency working in exploring methods and approaches to support Child Y in accessing therapeutic support while also navigating them accessing private services. Effective multi-agency working during this period included appropriate escalation, consideration of the child's age of consent and information sharing with trusted professionals in Child Y's network.

The Child's Voice

4.7 Child Y has been reported to be an articulate and smart young person who is able to express their wishes and feelings. Throughout the review, it was found that Child Y would often share their experiences and wishes with professionals. There is a history of Child Y making multiple disclosures of historical abuse or harm that they experienced throughout their childhood. It was found within the review that the professional responses to these disclosures were unclear, potentially leaving Child Y without assurance or understanding of what was being done with the information that they were sharing.

4.8 The Jez and Siblings Safeguarding Case Review[2] outlines key learning in relation to professionals' responses to children's disclosures of abuse from within the home. It highlights that children and young people often receive little feedback about the action taken when they raise concerns about abuse with professionals. This can leave them feeling that their concerns were not heard, valued, or responded to. It can undermine their trust and confidence and prevent further help seeking behaviour. There is often too much focus on what cannot be achieved because of procedural and evidentiary barriers, as opposed to what could be done to acknowledge harm, and action that could be taken to increase safety and address wellbeing.

4.9 This is evident within Child Y's case. Child Y made multiple disclosures throughout their life in relation to the harm and abuse they experienced at home. While it is evident in Child Y's younger years that safeguarding actions were taken, there is limited evidence to show how the reports of historical abuse and disclosures were responded to with Child Y as they progressed through their adolescence.

4.10 This was further compounded by Child Y's disclosures of low-mood and suicide ideation were often made when under the influence of substances. This had a significant effect on the mental health teams completing an assessment at admission/presentation at hospital due to them being under the influence of substances. This often resulted in Child Y being discharged with community follow-up rather than being assessed at the point of admission.

4.11 The ability of practitioners to find effective engagement techniques with Child Y and their family was a key theme throughout the review. In instances, Child Y was

[2] Local Child Safeguarding Practice Review: Jez and Siblings

regarded by professionals as articulate and ‘beyond their years,’ and a young person who is able to ‘control the narrative.’ This indicates a sense of professionals not affording Child Y the same levels of innocence and vulnerability as other children. While it is pivotal in ensuring that the child’s wishes and views are embedded as part of the plan, key support needs to be provided to ensure the overall welfare of the child can be met within their home environment. For Child Y, it was found that there was little meaningful support put into the family to respond to concerns in relation to Child Y being a young carer. Furthermore, the long-term impact of this from such a young age was not adequately assessed or considered within the planning for them. Further exploration around family networks and trusted people may have supported in developing plans to help achieve safety for Child Y within their family environment.

Finding One:
It was found that although Child Y was able to articulate the circumstances of what was happening at home, their lived experiences, feelings and the impact of these may have been overlooked by professionals. Child Y’s behaviours were often incongruent with what they were expressing verbally. Child Y’s behaviours are part of their way of communicating their feelings, yet due to them being quite articulate with professionals, these behaviours were not regarded as highly as what was being said.

4.12 This highlights the need for professionals to remain curious regarding how to engage with children and young people, and the need to be open to all forms of communication. Learning identified in other local and national safeguarding reviews has not been embedded within frontline staff to support in strengthening their recognition of the child’s voice through their behaviour. Practitioners struggled to implement the learning due to the child’s age, wishes and ability to intervene with the family based on previous missed harm.

Finding Two:
Child Y made a number of historical disclosures to professionals in relation to harm and abuse that they had experienced in their childhood. Practitioners' responses to Child Y’s disclosures of historical abuse were unclear, particularly with how this was communicated to Child Y. It was not possible to review all historical disclosures, but it was hypothesised that how these were assessed and progressed were not shared with Child Y in an age-appropriate manner, both at the time and subsequently when Child Y raised them again in their adolescence.

Heritage and Culture:

4.13 Culturally competent practice refers to social workers not being an expert but seeing themselves as learners in other people's culture[3]. Both Child Y's parents' cultural backgrounds play an important part in shaping the family norms and responses to safeguarding concerns, including the exploration of wider family networks. There is little evidence to suggest that this was included within the direct work with the family during their time known to services.

4.14 Professionals working alongside the child and family regularly reported difficulty in engaging with Child Y's mother, identifying that a mistrust of services due to potential experiences in her country of origin and her mental health may be contributory. Although there is evidence to suggest that practitioners considered the impact of this, there is little evidence that work was completed with the child and their family to understand how their cultural background impacted on their engagement with services, and if further support was required to help break down potential assumptions and barriers to engagement.

4.15 Furthermore, practitioners having an understanding from research in relation to some of the potential lived experiences of children and families growing up in mother's country of origin may have supported practitioners in understanding mother's distrust in relation to services.

4.16 There was an absence of further exploration in relation to the lived experiences, cultural values and considerations that mother's mental health may have on mother and Child Y's experiences of mother's mental health presentations and impact on her parenting.

Finding Three:
Professionals engaging with Child Y and the family struggled to find effective methods to overcome the difficulties they experienced in building a meaningful relationship with the family. There is no evidence of how professionals explored different approaches to direct work and engagement with the family based on their cultural background using informed practice from research. This is not to suggest that the family's cultural background was the only barrier to engagement but the lack of evidence of culturally competent practice indicates that this was a gap within the interventions and support provided to the family and may have acted as a barrier to services engagement with the family.

[3] Practice-based knowledge perspectives of cultural competence in social work, Osborn, P. (2022)

4.17 Practitioners from children's social care were unable to gather directly from mother her views in relation to her mental health due to the difficulties experienced engaging with mother. Reports from medical professionals and Child Y report that their mother does not consider herself to have any mental health concerns and is not taking medication prescribed. When looking at the Think Family approach, where concerns are held in relation to parental mental-health, Adults Mental Health services are identified as crucial partners. Although Child Y's mother was closed from these services, guidance or advice from Adult Mental Health services acting in a consultative capacity may have supported professionals to gain insight in alternative methods for engaging with the family and support in responding to the needs of Child Y living in their mother's care.

Cumulative Harm:

4.18 Child Y has been subject to 3 Child Protection Plans under the category of emotional abuse and 2 Child Protection Plans under the category of physical abuse. In total, Child Y has been on 9 Child in Need Plans. Across this timescale, there is little evidence of long-term sustained change for Child Y and their family.

4.19 The review found that the professional network primarily focussed on the presenting needs of Child Y at the time of the referral, which included self-harming, substance misuse, extra-familial sexual abuse, and bullying. Due to the difficulties experienced by professional network in engaging with Child Y's parents and the high level of presenting need, the professional network were focussed on responding to immediate concerns of harm and exploring appropriate safety planning. It was found that there were limitations in the use of reflective spaces, supervision and multi-agency discussion to remain curious in relation to Child Y's family history and how this may be affecting their presenting needs.

Furthermore, historical information held for Child Y and their family was not used to inform decision-making, as evidenced in decisions being made not to progress to public law outline in order to engage with the family yet without identifying what works to properly engage with the family. It is crucial for social workers presenting to court to ensure that they can evidence diverse plans to address the changing needs of the child.

Finding Four:
Historical information in relation to how the family engages with services was not considered as part of the decision-making around Children's Social Care's response to cumulative harm and the practitioners did not go far enough to unpack the long-term impact that this may have had on Child Y. Additionally, there was limited consideration in relation to how the family history and lived experiences could influence their approach to engaging Child Y and family to result in more meaningful plans to create safety.

4.20 Chronologies have been identified as a key tool to support practitioners in identifying and assessing risks in relation to cumulative harm and neglect. It was found that this was due to the high turnover of staff and competing demands for social workers, chronologies were not actively updated on a timely basis and did not form part of their direct work practice, supervision, reflective supervision or multi-agency meetings. It is identified across a number of national and local safeguarding reviews that the absence of active and informed chronologies has significant impacts on practitioners' understanding of and assessment into children and families' lived experiences. The use of chronologies as a direct work tool with children and families, as well as an assessment tool needs to be strengthened within practice and shared within a multi-agency setting.

4.21 Child Y was seen by a number of different health professionals, private therapists, and attended two different schools. It was found that the high turnover of staff across the partnership also contributed to the delay in identifying cumulative harm.

Professional Risk Assessment, Decision-Making and Escalation:

4.22 Working Together to Safeguard Children 2023 guidance states 'successful outcomes for children depend on strong partnership working between parents/carers and the practitioners working with them'[4]. Throughout the review, there were key identified moments where professional decision-making, risk assessment and escalation were considered. It is noted that there are some areas of good practice identified in multi-agency working, particularly when looking at the liaison between school, health and children social care at crucial times of crisis and admission into hospital.

4.23 Overall, it was found that the significant barriers for services in engaging with the family also had subsequent impact on the effectiveness of the multi-agency information sharing. This included practice in relation to agencies' review of historical information known to their services and using this to support in decision-making and

[4] Working Together to Safeguard Children 2023

escalation of concerns. All agencies identified concerns in relation to the lack of impact the Child in Need/Child Protection Plans were having for Child Y, yet there was limited evidence of professional challenge towards Children's Social Care in relation to their decision-making around step-up/step-down.

4.24 Once Child Y started to engage with CAMHS, they shared multiple accounts of historical self-harm from when they were younger. This demonstrates that Child Y has been experiencing difficulties in relation to their emotional and mental health for a number of years but was only identified when their self-harming behaviour became more apparent to those in contact with Child Y.

Finding Five:
Prior to CAMHS involvement, it was deemed that the absence of liaison with Child Y's private therapist led to a gap in knowledge and understanding on how Child Y was being supported in relation to their emotional and mental health. Earlier escalation could have occurred sooner given the seriousness of their self-harming behaviour. It was found that at the point of this escalation, the multi-agency working was strengthened around the support for Child Y and their family.

4.25 Further findings from the Child Safeguarding Practice Review Panel Annual Report 2023/2024 outline that 'among children with a mental health condition who experienced serious harm, child sexual abuse or exploitation was the most prevalent cause.'[5] Further outlining the most common risk factors identified for children with mental health conditions were physical abuse, neglect, child sexual abuse/exploitation, domestic abuse and addiction to or misuse of substances. All these risk factors were identified within the findings for Child Y, therefore highlighting the need for agencies to have a clear understanding of how adverse childhood experiences can present for children and adolescents. It is necessary to ensure that assessments of children presenting with mental health concerns are providing a holistic picture of the child's lived experience from a trauma-informed perspective.

[5] The Child Safeguarding Practice Review Panel- Annual Report 2023 to 2024

Finding Six:
The review found that historical information was not reviewed by professionals working with Child Y and the family during this time. Additionally, there was no escalation between services in relation to override consent regarding checks with the local GP regarding mother's mental health. It is noted that this may be due to a lack of representation of health professionals in strategy meetings, child protection reviews, and core group meetings.

4.26 The review found that there was a breakdown in communication across the two Local Authorities when Child Y transitioned between parents' care. Although information was sought from the receiving authority, this was impacted due to the requester being required to attend the office to view the files. The archaic nature of this response resulted in delay and uncertainty if information was shared accordingly across the two boroughs. Subsequently, this resulted in key information being excluded from the social worker's analysis for the s.37 report.

Finding Seven:
It was identified that the information provided to the courts for the s.37 did not capture a full analysis into Child Y's history and lived experiences of living with their mother. Practitioners identified that this was due to this sitting within the private arena which is often solely reliant on the key information provided to the court during this time.

Recognising and Responding to Trauma

4.27 Professionals supporting and working alongside Child Y and their family had to hold many considerations in mind when exploring how to best to support them. It was identified that the difficulty experienced by professionals to engage with parents significantly impacted on their ability to implement meaningful support for Child Y. Due to the lived experiences of Child Y's parents, the whole family required a trauma-informed approach, working as a team around the family.

4.28 While many Local Authorities' Children's Services are implementing a trauma-informed approach to practice, key partners in health, education and policing shared that they have less knowledge and confidence in implementing a trauma-informed approach in their direct work. Although Kingston and Richmond Safeguarding Children Partnership have rolled out one training in relation to trauma-informed practice, it was found throughout the review that the multi-agency knowledge of trauma-informed approaches varies across the partnership. This was further impacted due to Child Y attending school and health services in other local authorities, identifying a gap practice for children accessing out of borough services.

4.29 Additionally, there is a need for all teams working with children and families to understand the impact of neglect, abuse and long-standing safeguarding concerns can have on a child as they develop through childhood. Being able to include research within practice is crucial in providing an evidence base for professionals and families in relation to decision-making. This forms part of a trauma-informed approach for services in remaining curious regarding the overall impact of their lived experiences, particularly in relation to the child's feelings of safety and security.

Recognising and Responding to Harm

4.30 It was identified that there were long-standing concerns for Child Y while at home including disclosures of previous abuse, witnessing domestic violence and potentially being a young carer for their mother. In addition to this, there were concerns for Child Y in relation to extra-familial child sexual abuse, drug and alcohol misuse, missing episodes, bullying, and peer on peer abuse. In order to recognise and respond to potential harm Child Y may be experiencing; practitioners needed a clear understanding of the complexities in relation to the push and pull factors for Child Y within the home and the community.

4.31 The review highlights the importance for multi-agency teams to understand the impact that a lack of parental consent can have on the support and wellbeing for the child, in particular where professionals are experiencing difficulty in confirming alternative arrangements put in place by parents.

Finding Eight:
Concerns raised from within the family home have been recurring for Child Y since they were a young child. At all points of escalation, there was no evidence of a critical review on the ability for family to engage or the long-term impact for Child Y, often resulting in decisions to engage with the family and the child being stepped between child protection and child in need plans. At the point of step-down, there is little evidence of safety planning done with Child Y around what to do or who to speak with should things at home become difficult for them.

4.32 With the increase in awareness and practice around contextual safeguarding, there has been a separation within Local Authorities between Children & Families, and Adolescent Safeguarding services. Adolescent safeguarding teams are primarily developed with practitioners who have skills and experience at engaging directly with young people, exploring aspects of risk outside the home. Given the presenting needs for Child Y were in relation to substance misuse, bullying, and risk outside the home, they were allocated to the adolescent safeguarding team within children's social care. Practitioners from other agencies identified a gap in their knowledge and understanding of the social care adolescent safeguarding teams and how this may have impacted on their knowledge or awareness of the safeguarding concerns within

the home. It was identified that CAMHS also have a specialist adolescent team and cross-partnership knowledge of the remit of these teams requires strengthening.

Finding Nine:
Multi-agency knowledge of the role and remit of adolescent safeguarding teams impacted on professional curiosity in relation to risks, vulnerabilities and safety inside and outside the home.

4.33 Multi-agency knowledge and assumptions in relation to adolescent safeguarding teams led to lack of curiosity in relation to the parental impact on Child Y. Whilst the Adolescent Safeguarding Team prioritises responding to risks and increasing safety outside the home, practitioners need to work alongside parents to be supported in identifying techniques and skills to support in keeping their children safe.

Finding Ten:
Overall, the analysis of the harm experienced and risks for Child Y did not evidence the interrelationship between neglect, abuse, and mental health. It was evident that practitioners were trying to address the individual identified risks for Child Y, but this was not responded to in a holistic way across the partnership. This was further exacerbated due to the strained relationship between the family and services.

5. Summary of Recommendations

Recommendation One:

- Review the impact of historical recommendation within the Safeguarding Children Partnership around children's voice. The Safeguarding Children Partnership to consider how it can strengthen practitioner skills that enable the child's voice and experiences to be listened to and responded to whether there is a verbal or nonverbal disclosures and communications. This needs to include child observations and understanding of behaviours that may reflect harm and distress. This should include responding to disclosures of abuse, with particular emphasis on historical disclosures.

Recommendation Two:

- As part of the Early Help work for Family Hubs, Children's Early Help and Children's Social Care to ensure that services working with children and families are considered in line with the diversity of the population within Kingston and Richmond.

Recommendation Three:

- The Safeguarding Children Partnership to set up a task and finish group to support work around improving practice and the use of chronologies and genograms. Information in relation to practice barriers and challenges should be fed into a multi-agency task and finish group.
  For example, identifying practice leads across departments to support in strengthening practice within teams, the use of genogram and single-agency chronologies within multi-agency meetings, Independent Reviewing Officers and Child Protection Chairs to embed and monitor the use of single agency chronologies across the partnership within conferences and reviews and provide feedback to agencies regarding practice in this area.

Recommendation Four:

- Children's Social Care to review trigger levels and guidance for children who are subject to repeat Child Protection Plans. This should include processes to robustly review the child's history and use reflective multi-agency group supervision to support considerations for long-term impact of neglect for children and families.

Recommendation Five:

- The Safeguarding Children Partnership to map and raise awareness of how adult mental health expertise can be brought into the team around the child/family in a consultative capacity as required from for example GPs, Mental Health Teams, and Adult Mental Health Social Workers to support the team in exploring how to support parents to engage with services.

Recommendation Six:

- The Safeguarding Children Partnership to strengthen knowledge across agencies in relation to the local escalation pathway and to include how this is communicated when working with partners across boroughs.

Recommendation Seven:

- All agencies identify and use the Pan London Training offer in addition to their local training offer to address and respond to training gaps and knowledge within services. This should include particular focus on trauma-informed training.

Recommendation Eight:

- The Safeguarding Children Partnership to review the impact of the child sexual abuse training and identify plan for monitoring and evaluating how this is embedded into practice through the use of internal quality assurance and audit pathways.

Recommendation Nine:

- CAMHS and AfC Substance Misuse Service to review pathways and offer for children and young people presenting with mental health and substance misuse concerns with particular focus on children and young people who have repeated presentations to A&E and emergency services.