



Local Child Safeguarding Practice Review 'Alan'
March 2023



How to use this document

The purpose of this practice learning brief is to share the learning that has been identified in the Local Child Safeguarding Practice Review 'Alan' with Swindon safeguarding partners to support the development of services and practice. Please share this resource widely.

Further information about LCSPRs can be found [here](#)

There are also hyperlinks to external resources such as websites, which can be accessed by either ctrl+click on the hyperlink. Alternatively, you can use your mouse to right click and select open link from the options. If you are unable to open a hyperlink please copy the information and paste into your usual internet search engine e.g. Google



Alan

Alan and his family have been well known to many of the agencies in Swindon for over 14 years. In March 2021, when Alan was 16yrs old, his school referred him to the Swindon MASH as it was considered that the current early help provision working with the family was not effectively meeting his needs nor reducing the risks he was experiencing. As a consequence, a social work visit was made and that revealed that Alan was:

- Very thin and potentially malnourished
- He had muscle wastage and his movements were very slow
- His skin was in very poor condition – grey with acne
- His hair was unkempt
- He was spending nearly all his time in bed, rarely leaving his room or the house
- His dietary intake was unclear but believed not to be very healthy
- He was very self-deprecatory, believing he did not matter, that he was not important
- There was evidence of some (superficial) cuts to his arm as a consequence of self-harming

This visit resulted in an A&E presentation, which was then subsequently followed up with a strategy meeting, a Section 47 (under the 1989 Children Act) investigation which led to an Initial Child Protection Conference and Alan and his siblings being made subject to a child protection plan (see below for more details). In November 2021, Alan's case was subject to an internal audit and this eventually led to a rapid review being convened by Swindon Safeguarding Partnership and a decision taken (in February 2022) to complete a Local Child Safeguarding Practice Review (LCSPR) This decision was subsequently endorsed by the national Child Safeguarding Practice Review Panel.

Conclusions from the review

1. What are the multi-agency barriers and enablers to safeguarding adolescents from neglect including the application of a mental capacity assessment?

- Barriers in this case were between Early Help & statutory intervention
- Threshold decisions applied too mechanistically - thresholds are to guide professional decision making not to replace it
- Family needs are complex – covering different threshold categories at any one time and they change over time
- Decisions made did not reflect the complexities of Alan and his family nor in recognition of the fact that little change was being effected by those involved
- Application of Gillick competencies and Mental Capacity Act only apply once social work intervention tried

2. How can child protection processes be strengthened for older teenagers who are experiencing neglect, including quality assurance processes such as core groups, midpoint review and supervision?

- Neglect guidance needs to address the difficulties of working with young people who do not easily engage
- Need to explore how 'transitional safeguarding' applies in practice – adult safeguarding is founded on the notion that people can make unwise decisions...can adolescents?
- Guidance needs to address use of Mental Capacity Act

Conclusions from the review

3. What has been the impact of the Covid pandemic on the child's well-being, parenting capacity and the multi-agency response to the child?

- No evidence found that the pandemic adversely impacted service provision to Alan and his family. Some evidence that he and his father were very anxious about it, which made engagement with them difficult

Two further conclusions:

a) The Escalation Procedure

Poorly and underused

No response for dealing with 'stuck' cases

b) Working Together 2018 expects that safeguarding partnerships will:

- *“facilitate and drive action beyond usual institutional and agency constraints and boundaries*
- *Ensure the effective protection of children is founded on practitioners developing lasting and trusting relationship with children and their families”*
- Insufficient evidence of that in Alan's case

Themes

Neglect

Neglect is the persistent failure to meet a child's basic physical/psychological needs, likely to result in serious impairment of the child's health/development. Neglect may occur during pregnancy as a result of maternal substance abuse.

Once a child is born, neglect may involve a parent or carer failing to provide adequate food, clothing and shelter (including exclusion from home or abandonment). Protect a child from physical and emotional harm or danger. Ensure adequate supervision (including the use of inadequate caregivers). Ensure access to appropriate medical care or treatment It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. (*Working Together 2018*)

Neglect differs from other forms of abuse because: a) Frequently passive, b) Not always intentional, c) more likely to be chronic in nature rather than crisis led & can impact on how we respond as agencies. d) can be combined with other forms of maltreatment, e) can reflect a revolving door syndrome where families require long-term support, f) it is not always clear-cut & may lack agreement between professionals on threshold for intervention. The way we understand & define neglect can determine how we respond to it.

Briefing on the persistent failure to meet a child's basic needs resulting in serious impairment of the child's health and development can be found [here](#)

The Swindon Safeguarding Partnership Neglect Framework and Practice Guidance can be found [here](#)

Neglect resources and screening tool can be found [here](#)

Themes

Escalation

Escalation is a process of challenging a decision made by another professional or organisation. The escalation policy ensures that all professionals have a quick and straightforward means of resolving professional differences in order to safeguard the welfare of children and young people.

When working with children and their families' professional disagreement can be a positive, as challenge allows for review and can foster creative ways of working. However, disagreements can negatively impact on positive working relationships and consequently on the ability to safeguard and promote the welfare of children. Professional disagreements always require resolution.

Differences of professional opinion arise on a safeguarding case when professionals deem decisions not to be in the best interests of the child. These professional differences are most likely to occur around:

- Levels of need and intervention-differing opinions about thresholds
- Lack of understanding about roles and responsibilities
- Disagreement regarding decision making and action to be taken e.g. At a strategy meeting, at a Child Protection Conference or any other professional meeting
- Concern about the lack of action of another professional in relation to a child or family member
- The need for action and communication
- Concern there is a drift or unreasonable delay in progressing a case.
- Disagreement over the provision of services

Case Reviews have highlighted a lack of awareness and use of escalation within agencies and it seems that for various reasons professionals have tended not to refer to the policy. This has led to drift and delay in individual cases and means that practitioners have not been able to satisfactorily resolve professional disagreements.

Swindon Safeguarding Partnership Escalation Policy can be found [here](#)

Guidance & Resources for Professionals

<https://www.gov.uk/government/publications/neglect-matters-a-multi-agency-guide-for-professionals-working-together-on-behalf-of-teenagers>

<https://www.childrenssociety.org.uk/sites/default/files/2021-01/troubled-teens-executive-summary.pdf>

https://safeguardingpartnership.swindon.gov.uk/downloads/file/631/neglect_matters

https://safeguardingpartnership.swindon.gov.uk/downloads/file/788/capturing_the_voice_of_the_child_in_records

<https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

https://safeguardingpartnership.swindon.gov.uk/downloads/download/37/the_right_help_at_right_time_threshold_guidance