SWINDON SAFEGUARDING PARTNERSHIP LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

ALAN

March 2023

1. Introduction

1.1 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

1.2 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).

1.3 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.

2. Process

2.1 In commissioning this review, the partners wanted there to be an exploration of:

1. What are the multi-agency barriers and enablers to safeguarding adolescents from neglect including the application of a mental capacity assessment?
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?
3. What has been the impact of the Covid-19 pandemic on the child's well-being, parenting capacity and the multi-agency response to the child?

2.2 This report has been authored by Mark Gurrey, an experienced senior social work manager and consultant, who has had no previous knowledge about the case.

2.3 This review has been completed based on the rapid review and supporting paperwork; on individual interviews with Alan's current social worker, senior managers in early help and from quality assurance and via a practitioner event with staff from the education service; children's social care; the reviewing service; the Family Service (early help provision); education welfare; named safeguarding nurse; Alan's last school; the local CAMH service and the specialist community public health nurse.

2.4 I have met with Mr F and have summarised that conversation below. Alan declined the opportunity to meet with me.

3. Background History

Family Make-Up

Name	Age (at time of report)	Relationship
Alan	17yrs	Subject of this review
Mandy	5yrs	Half-sister
Taylor	10yrs	Half-brother
Richard	16yrs	Step-brother
Paula	17yrs	Step-sister
Mr F		Alan's father
Ms L		Alan's mother
Ms C		Alan's step-mother

3.1 Alan was born to Mr F and Ms L. He was made subject to a child protection plan pre-birth and in the early part of his life under grounds of neglect as a consequence of his mother having had two daughters removed, one of whom lived with her mother and the other was adopted. There were allegations of domestic abuse – both parents claim they were the victims – and both parents evidenced substance misuse problems. Mr F had a heroin addiction and then later was on a methadone programme and Ms L had a history of long-term cannabis use.

3.2 In 2008, Swindon children's services had four separate contacts from Ms L saying she had fled another area due to domestic abuse. She and Alan initially moved into a refuge then into their own accommodation. An initial assessment revealed no concerns about Alan's care. In 2009, Mr F reported Alan and Ms L as missing. He then moved to Swindon himself, originally with the view of seeking custody of Alan, but he resumed his relationship with Ms L. That relationship finally broke down in 2010. In October of that year he sought, successfully, for Alan to be in his sole care when Ms L moved with a new partner to Plymouth. In a subsequent hearing in 2011, the Court ruled that Alan remain with his father. The court also sought further information on both parents from substance misuse agencies and GPs and made a number of decisions concerning Alan's contact with his mother.

3.3 CAFCASS provided a report for these proceedings and in it they detail histories of both parents allegations of domestic abuse and of their drug usage. When seen by the CAFCASS worker, Alan was clear he wanted to remain with his

father. His then school reported no significant concerns other than to say his attendance improved when in the sole care of his father who was described as supportive of Alan's education.

3.4 Mr F met Ms C in 2012 and they started living together in 2013. They had two children, Mandy and Taylor.

3.5 By 2013, the Education Welfare Service contacted Mr F as Alan's attendance had fallen to approximately 66% and whilst he was warned that legal action might follow, there was no follow up. In 2014, four further reports were raised with social care by the then family support worker, none of which resulted in social care intervention.

3.6 In 2016, when Paula was 11 and Richard 12 years, and living with their mother, Ms C, three further referrals were made to social care from the school relating to both children. The school was concerned about their general welfare and reported that on one occasion both children had been found on the street by a teaching assistant, crying and clearly very upset.

3.7 In 2017, a further school referral was made about Richard, concerned about him 'mixing with the wrong people' and that he had been involved in a theft from a local shop. They were also concerned that he might be carrying a knife. He, Richard, said his mother and stepfather (Alan's father) argued a lot.

3.8 In 2019, Richard was assaulted on the street, resulting in injuries to his face and abdomen. He was attended by an ambulance and the crew became concerned about his mother's and stepfather's apparent lack of concern and their delay in collecting Richard. A safeguarding referral was made as a consequence.

3.9 None of these referrals resulted in a social care assessment or intervention.

4. Recent History

4.1 In January 2020, Alan's then school referred him into the MASH and did so on behalf of the involved agencies at the time so were able to give quite a rounded picture beyond Alan's non-school attendance. The concerns were that he had only attended school three times since September 2019, he was not leaving the house (and often not leaving his bedroom), that he was not managing his own hygiene and that he had texted friends expressing some suicidal thoughts. "His mental health is a real concern and he should be allocated support" The referral states that Mr F and Ms C were in support of the referral.

4.2 The response from the MASH is of relevance to the central theme in this matter. *"Family service (how early help provision is referred to in Swindon) had offered support but the worker is on sick therefore school have referred to CSC (children's social care). It is unlikely that Alan would engage in an assessment or with a social worker. It is my opinion that the best intervention continues to be family service. I do not believe that social work intervention would be appropriate in this case as Alan may withdraw even further due to the label of 'social worker".*

4.3 A further referral was received from the Targeted Adolescent Mental Health Services (TAMHS). They had visited Alan and his father and reported concerns about Alan's neglect when with his mother, about his lack of schooling and unwillingness to engage with a tutor and father's concern that he may have ASD. Alan refused to cooperate with the assessment. The outcome of the referral was for continued early help intervention and that the case would be closed by TAMHS.

4.4 A further referral to the MASH was received in October 2020 and this time it was allocated for the completion of an assessment. This was not easy to complete – Mr F was anxious about and resistant to a social work visit due to the pandemic and whilst the social worker was allowed to enter, Mr F said Alan did not want to see her. The assessment was nevertheless completed with a recommendation that Alan should be subject to a children in need plan and intervention.

4.5 At the first Child in Need meeting in November 2020, various professionals met with Mr F and Ms C. This meeting was in effect to hand over the case from the front door and the assessment process to the locality team for on-going work. The meeting was attended by the assessing social worker and the (potential) receiving manager amongst other colleagues. However, it seems that it was not immediately clear what the social work role would be so the agreement of the meeting was that the case should remain with early help. There was a subsequent exchange of correspondence between the locality manager and the assessment manager which clarified the rationale for the decision of the meeting.

4.6 The lead role therefore passed back to family service who continued to try to engage Alan with a particular emphasis on trying to get him back into school. This was unsuccessful and no significant changes were effected during this period.

4.7 In March 2021, the school made another referral expressing concern about Alan's continuing neglect, absence from school and his emotional well-being combined with the fact that the current intervention was simply not working. The referral was accepted by the MASH and resulted in a social work visit, which found considerable concerns about Alan's welfare.

4.8 Following this visit the social worker sought advice and input from the GP, from CAMHS and from other medical professionals. As a consequence, Alan was encouraged to attend A&E, which he did. He spent the night in hospital and a strategy meeting was then convened. This resulted in a Section 47 investigation, which concluded that Alan had suffered medical neglect (he was not being enabled to see CAMHS and had not received any medical intervention); nutritional neglect (Alan is 6ft 3ins and at the time weighed 54 kgs); emotional neglect as a consequence of living in such isolated conditions; educational neglect due to his 2 year absence from school and physical neglect due to the poor hygienic conditions in Alan's bedroom and his lack of basic personal self-care.

4.9 The Section 47 assessment described how although Mr F said he wanted help with Alan, he was also experienced as obstructive to professional input and that

during the pandemic in particular, he made it difficult for agencies to gain access to his house and to Alan. He was described as being pre-occupied with his own health needs.

4.10 The decision from the completed Section 47 was to convene an Initial Child Protection Conference and Alan and his siblings were made subject to child protection plans.

4.11CAMHS continued to be involved and they referred Alan to the eating disorder clinic. They found no evidence that he was deliberately trying to lose weight nor that he lacked motivation to eat. They agreed to continue to regularly monitor him.

4.12 Alan then missed a series of appointments with CAMHS – mostly they were cancelled by Mr F who said that Alan was not well enough to attend. The service continued to try to engage with him and specifically to agree to an ASD assessment but to no avail.

Current Position

4.13 Alan is 18yrs old later this year and his child protection plan will be ending. The plans for his siblings have already ended and they are now living with Ms C and there is currently no agency involvement save for universal provision for either of them. Taylor and Mandy now attend school reasonably consistently (92% and 85% respectively) and they are both more punctual and more engaged. Richard's attendance remains low at 37% and he continues to be unwilling to engage on a consistent basis – he has now turned 16yrs so I suspect any further engagement will prove unsuccessful. Their health needs are being met – all have attended any appointments as needed and it does appear that the structure of the child protection planning and then children in need planning has been helpful.

4.14 Alan remains at home and the evidence is that he has not been out of the house since April 2022. He has now been diagnosed with ASD. For a long time Alan resisted the input from clinicians needed to make this diagnosis. Since diagnosis, however, it has, as reported by his social worker, helped him understand some of his anxieties and given him some useful insight into his condition. He has medication for anxiety and depression and whilst he does not take it, the social workers view is that it gives him some comfort knowing it is there.

4.15 He has continued with the on-line CBT work although the CBT practitioner believes it has limited impact. CAMHS will be ceasing their involvement and have referred him to adult mental health for on-going work. He is also due to meet someone from the local MIND service. His physical health has improved in that he has put on weight and is eating healthier and is doing some of his own cooking.

4.17 He has not seen his mother in over 12 months and the prospect of seeing her causes him some anxiety. Mandy and Taylor still see their father once a fortnight but they have little or no relationship with Alan.

4.18 Mr F himself is now described as proactive, caring and cooperative in seeking to meet Alan's needs.

5. Interview with Mr F

5.1 Mr F met with me and his current social workers via a Teams call. I am grateful for the time he gave to the meeting. He clarified some family history details for me and he dates the onset of Alan's difficulties to the disputed contact hearing described in the preceding paragraphs. One of the consequences of the hearing was that Alan visited his mother and her then partner (by then living in Plymouth) every half term. Mr F said he never wanted to go and was never happy there. The visits were continued because that was the order of the court and they did not finish until Alan was 13yrs. Mr F said Alan's mother has never been a consistent or kindly presence and neither he nor Alan now know where she is other than Mr F believes she may have moved back to Swindon.

5.2 Mr F felt Alan's circumstances worsened when he was around 13-14yrs. He (Mr F) had always had concerns that Alan might be autistic and that it increasingly impacted on his life from around that time. He got more and more concerned about what he was eating and less and less comfortable about socialising, about going out of house or even his bedroom and his school attendance worsened as a consequence.

5.3 Mr F said in his view the educational welfare service never realised the extent of Alan's difficulties or challenges and instead saw him as 'naughty' for not going to school and Mr F as failing as a parent for not getting him there. Mr F described how sometimes he would try and literally manhandle Alan out of bed, out of the house and into school but as Alan got bigger that became increasingly impossible.

5.4 The input from the Family Service had been helpful but in his view, there was not enough focus on Alan prior to the crisis that led to the A&E admission and subsequent child protection intervention. Whilst he has seen the social work and CAMHS input as helpful, he believes they could and should have come earlier.

5.5 Alan is soon to turn 18yrs and Mr F is anxious about the support that will be available to him from adult services. He knows CAMHS has liaised with adult mental health services to take over Alan's case but he is concerned that the same level of service they have received more latterly will not be replicated in the future.

6. Conclusions

6.1 Swindon partners wanted three areas explored through an examination into Alan's case, as set out above in 2.1

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

3. What has been the impact of the Covid-19 pandemic on the child's well-being, parenting capacity and the multi-agency response to the child?

6.2 Of these, the third is probably the most straightforward to comment on. There is clear evidence that the pandemic meant that any pre-existing resistance or obstruction from Mr F to the involvement of any of the safeguarding agencies was given a stronger rationale and that he made it harder for agencies to see and engage with him and Alan throughout this period. There was instances of him only allowing staff to speak to him from outside his front gate (on the pavement therefore) and he said he had himself contracted COVID four times although there is no independent medical evidence to support that. There are also reports of Alan himself expressing anxiety about COVID and not wanting to see anyone or leave his room/house as a consequence.

6.3 I found no evidence of agency-imposed restrictions, which prevented the family receiving a service and indeed it is my view that those involved at the time did all they could to engage with Alan and his family during the pandemic.

6.4 The first two areas identified by the partnership are however more complex. My analysis of this case is that in fact the core issue, which warrants further exploration, centres on the relationship between the early help system and the social work-led system. More particularly, it centres on how fluid the boundaries are and to what extent the different skills and expertise in both parts of the system are seen as complimentary one with the other. It is my view that this issue is the fundamental one that needs addressing based on this case, rather than either the use or otherwise of the Mental Capacity Act

6.5 The Mental Capacity Act only applies to those 16yrs and older (before that judgements are made based on Gillick competence) The use of the Act or interventions designed to override the expressed wishes and feelings of a child are both rare and would require a detail and focussed assessment and a judgement that all other options have been tried and failed. Given that Alan never got into the social care system, this assessment was not conducted so therefore it could not be said that there were no other ways forward.

6.6 I have commented below in Sections 7 and 8 on the second terms of reference set out above, about how child protection processes could be strengthened based on an analysis of this case.

6.7 I think it is necessary to explore how and why Alan's case was considered not to meet the thresholds necessary for social care intervention.

7. Thresholds

7.1 The threshold based system that Swindon (like nearly all other local authorities and safeguarding partnerships) operates is essentially to offer guidance to those who identify extra needs for children and how they can be best met - the aim is to ensure the right child is in the right part of the system receiving the right service.

7.2 A threshold-based system can be used to ensure that families experience the least intrusive, least formal and least anxiety-provoking service to help them care safely for their children. I suspect that what was intended by the MASH decision maker in identifying the potential risk of Alan withdrawing yet further if a social worker became involved. That was in my view a credible, laudable but essentially untested hypothesis.

7.3 The reality is of course that family needs do not fit neatly into one or other threshold category – and nor are their needs static. At any given time, a family can have needs that require universal provision AND early help provision AND statutory social work input – and that can vary and develop over time dependent on all sorts of factors and changes in their circumstances.

7.4 As set out above, guidance on thresholds is or should be primarily about ensuring children are receiving the 'right' service commensurate with needs and risks. However, threshold guidance is also used to help manage workload and demand especially the number of children receiving social care intervention. What the application of the guidance should not result in is a rigidity of decision-making that does not reflect the complexities of family's lives. There has to be enough flexibility to ensure that the different skills and expertise in different parts of the system are used creatively and holistically to meet need. Skills and abilities within and across the entirety of the safeguarding system need to be matched, as far as is possible, to the perceived or assessed needs of families.

7.5 This is a family with a significant history of need – domestic abuse, substance misuse, low levels of school attendance, considerable health needs, child sexual abuse – and an agency history which when looked at in the round actually shows very little evidence of successful engagement or of effective change. This is not a criticism of the work of those agencies or of the staff who sought to engage with Alan and his family. It is simply a statement of reality – despite those efforts and the commitments from family service, from schools, from CAMHS, from various health professionals, there is no period when one can identify that work as successful or of achieving the changes needed.

7.6 The rapid review for Alan identifies a number of instances where a more nuanced and child-centred responses were needed than that provided – education welfare's input focussed too much on non-attendance issues at the expense of a broader understanding of Alan's needs; CAMHS intervention was on observations rather than seeking to engage and get close to Alan and Turning Point (a substance misuse service) did not seek more than Mr F's own reports on

Alan's well-being. Safeguarding was not reviewed consistently in line with their safeguarding policy throughout Mr F's engagement with them.

7.7 Some of these difficulties were compounded by Mr F's seeming reluctance to engage with the agencies especially during the pandemic. The voluntary nature of early help intervention further contributed to the lack of successful engagement with the family – it made it easier for Mr F to not engage and harder for family service to insist on involvement.

7.8 Decisions about if and when social care could or should have been involved needed to have been taken in the light of these realities, with full regard to history and context rather than, as it appears, in the moment and based on what was immediately presented.

7.9 The referral from the school to the MASH could have been concluded differently. A decision could have been taken that said in effect, the issues identified are real and substantial and the work of the agencies involved is not making the necessary differences so a professionals meeting to discuss next steps would be a helpful way forward. This might have concluded that persevering with Family Service and other colleagues was the right way forward but it would then be a decision based on a collective view about what was in Alan's best interest rather than the imposition of a threshold decision. Similarly, the decision to revert back to Family Service even after an assessment concluded a child in need plan was warranted was another opportunity to intervene differently with the family. The evidence was that insufficient progress was being made and there was not enough reason to think that might be different after this meeting. A period of joint work with a social worker and the family service, with support from CAMHS, might have resulted in a more effective engagement with the family. It might not have done of course but the opportunity was not explored.

7.10 Threshold criteria are useful and can help guide agencies in identifying and responding to family needs – but essentially they provide a context within which key questions such as 'what is it like to be a child in this family' 'what do we understand to be the needs of this family and 'how can our collective resources best respond to them' can be asked and answered. They should not be used mechanically nor should they be seen as rigid and fixed – they are there to aide professional decision-making not replace it. My conclusion is that there is insufficient evidence of that happening in this case.

7.11 There is no doubt that Alan's well-being has improved in recent times and it is likely that the structure of being on a child protection plan has helped. The social worker has described how Alan would not want to see him but the plan required regular visits so he would return and return almost regardless of Alan's wishes and eventually an engagement was made and a relationship established. Whether such positive developments were possible under a child in need plan will never be known of course but it is clear progress was not being made whilst in early help despite the best efforts of staff involved.

7.12 There are two other, connected, issues worthy of some further discussion – neglect and adolescence and transitional safeguarding.

"Making Safeguarding Personal and Transitional Safeguarding both emphasise the importance of curious, tenacious, relationship-based practice. Social workers are highly skilled in working with people in this way and have much to offer" ("Bridging the Gap: Transitional Safeguarding and the role of social work with Adults' Government June 2021). This quote provides a useful introduction into both subject areas.

8. Adolescent Neglect

8.1 It is a matter of fact that most neglect work focusses on younger children especially those under 5yrs where of course the impact of neglectful parenting can be both substantial and long lasting. I am aware that Bexley published a LSCPR earlier this year (Young Person S) which mirrored some of the issues in this review but it is the exception not the rule.

8.2 That said, as at August 2022, Swindon had 130 children subject to child protection plans under the category of neglect and of those 21% were 14yr + and 14% 15yr +. Clearly, some of these plans may have started when the children were somewhat younger and some will be older siblings in families where there are concerns for all the children but nevertheless there is a significant cohort of older children who have been judged to be experiencing neglect.

8.3 Swindon has an agreed approach to neglect, captured in 'Neglect Framework and Practice Guidance'. This is a comprehensive and accessible document that does, commendably, have a section on adolescent neglect. The guidance encourages practitioners to fully explore areas of neglect and its completion would or could have given a useful evidence base in this case. In particular, it requires practitioners to explore the extent to which parents/carers are actively and consistently working to meet their children's needs and had it been worked through in a systematic way it might have helped inform those involved about the extent to which Mr F (and Ms C whilst there) was trying all they could to meet Alan's needs. There is no real explanation about why it was not used.

8.4 The one area the guidance does not cover is where young people themselves are either appearing to place themselves at risk or seemingly apathetic about their own well-being. Alan would frequently ignore or simply not go along with advice and guidance about his own well-being and indeed there is some evidence that remains the case.

8.5 This is a complex area – saying children are choosing to place themselves at risk does not sit comfortably and it is important that the behaviour is understood in terms that include their parenting, any external pressures being placed upon them and their own sense of self-worth. It is because of these complexities that it is my view that the guidance needs to address this and offer practitioners some advice about how to engage those who appear not to want to be engaged, how the risks of intervention should be weighed against the risks of non-intervention and when and under what circumstances use of the Mental Health Capacity Act should be considered.

9. Transitional Safeguarding

9.1 This is directly connected to the issues above. Transitional safeguarding describes the need for "an approach to safeguarding adolescents and young adults (that works) fluidly across developmental stages which builds on the best available evidence, learns from both children's and adult safeguarding practice and which prepares young people for their adult lives" ('Bridging the Gap', ibid)

9.2 One of the key tenets of adult safeguarding is the right for people to make unwise decisions even if others, family members or professionals, believe those decisions to be self-damaging. For very young children this is not the approach adopted of course – professionals default to a position of intervention and, where necessary, removal. One of the elements of transitional safeguarding is how that shift in approach is experienced in work with adolescents and older young people. It is a significant challenge to the safeguarding system to respond to this shift and to successfully reach out to and engage with and, through that engagement, protect children.

9.3 Work with young people affected by criminal or criminal sexual exploitation (CE and CSE) can for example sometimes be made even harder by young people who, for whatever reason, are difficult to engage or the system is not sufficiently flexible to make that engagement successful. An approach that defaults too readily to formal or statutory intervention is not always successful and can indeed result in young people distancing themselves yet further from the services designed to safeguard them. This is not easily resolved and requires practitioners to explore creatively a range of options designed to maximise involvement and engagement and for managers to be constantly alert to when the risks of young people not responding exposes them to a level of risk that becomes unacceptable and a more formal statutory intervention is warranted.

9.4 The first review of the national Child Safeguarding practice Review Panel, 'It was hard to escape' looking at children at risk from criminal exploitation, identified this as one of their key 'Local Learning Points' and talked about the need to regularly (and this could sometimes be daily) to review risk management plans to ensure they are well-targeted and reflect changing or worsening circumstances.

9.5 Exactly the same approach is required for young people who are experiencing neglect and who seem to be neglecting their own well-being in the way Alan was (and is). The risks of intervention, whether through children in need, child protection planning or more extremely through the use of the Mental Capacity Act needs to be weighed against the risks of non-intervention and meeting the apparent and expressed wishes of children. Again this is complex in exactly the same way as it is for children experiencing CE or CSE and any refreshed guidance needs to explore the risks of intervention alongside the potential benefits.

9.6 Finally, it is worth highlighting that Working Together 2018 actively supports and expects the kind of approach implicit in what is set out in these preceding

paragraphs. Chapter 3 sets out the need to establish Multi-Agency Safeguarding Arrangements and paragraph 9 contains the following expectations on safeguarding partners:

- "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"

9.7 Whilst these expectations are primarily strategic imperatives for safeguarding partnerships, they can and should be understood operationally and in relation to individual service provision to individual children and their families. It is my view that the response overall to Alan and his family did not reflect that creativity or flexibility required by Working Together and nor did it focus on the development and maintenance of an effective relationship based intervention into his life.

9.8 These are key but often overlooked requirements placed on safeguarding partnerships and give the authority for those partnerships to ensure that their collective provision is as well targeted to meet the needs of children and families in their areas as is possible.

10. Escalation and Case Resolution

10.1 At various points, the use of the escalation procedure might have alerted senior managers to the issues highlighted in this report and may have generated a different response to Alan and his family. There was in my view too much of a readiness to accept the decisions of either MASH or the social work teams without challenge. In discussion, there was some sense that early help felt the junior or 'Cinderella' partner and that their voice was not always heard or not heard as clearly as the social care voice.

10.2 It is the role of supervision in all safeguarding agencies to recognise when children's circumstances are either deteriorating or not changing quickly or substantially enough. It is for the supervisor to work with the practitioner and, if necessary, other agencies to identify a way forward. Cases can become 'stuck' and despite the best effort of all involved, changes are not being effected or not being effected quickly enough.

10.3 In those instances, there needs to be an acknowledged procedure within the safeguarding system that enables practitioners to come together and problem solve, often with the help of a senior and/or uninvolved agency member to help review the nature of the 'stuck' elements of the case and to amend existing plans and interventions as necessary.

10.4 There was in my view insufficient evidence that the management and supervision of those involved with Alan led to the necessary escalation or engendered a different approach to resolving a case that was very clearly stuck.

11. Recommendations

11.1 I am aware that last year Swindon commissioned an independent report into their early help provision which looked at the relationship with social care and covered issues around step-up and step downs, escalations and dispute resolution and the need to better evidence management decision-making. I have not seen the full report but have had sight of some of the relevant recommendations and had the opportunity to talk it through with the relevant Head of Service.

11.2 I am also aware that in May 2022, Swindon formally implemented the Family Safeguarding model introduced and developed by Hertfordshire.

11.3 Both of these have had and will continue to have an impact on the working relationship between early help and social care and I am assured that some of the issues raised in this review have or are being addressed.

11.4 In addition, Swindon Safeguarding Partnership have reviewed and relaunched their threshold guidance and there is in the new version a greater emphasis on conversations rather than rigid decision-making. The guidance does not spell out the 'step-up, step-down' processes nor how they can operate seamlessly with proper handovers and with the early help assessment given its proper weight. The document still relies on a four stage identification of need – universal, early help additional support, early help intensive support and statutory social care, specialist support – and there remains the danger that decisions are made based on the criteria under each heading rather than a discussion about the needs of the child and their family.

11.5 **Recommendation 1**

I recommend therefore that the partnership conducts some checks to actively seek **reassurance and evidence** that the issues raised by this review are in fact being or have been addressed consistently and persistently on the ground, at an operational level and practitioner level. Specifically, they should explore the following:

a) That agencies providing intervention at the early help level of need do not, in reality, feel like the 'Cinderella' service (as was quoted to me by one person) and that their voice is heard with authority and respect across the system

b) That decisions about step-up and downs are not being taken solely on the grounds of threshold definition but are clearly and explicitly based on the needs of the child and family

c) That decisions re step-up and downs are informed by multi-agency perspectives of those professionals involved with the child, such as education and health

d) That those decisions are flexible and that there is a willingness to use the skills and expertise in both early help and social care together– that cases can be identified where families are receiving both early help and social care services contemporaneously when needed

e) That the circumstances of Alan's case are worked through the new threshold guidance to provide a sense-check on whether they would now help lead to a different outcome for Alan.

11.6 **Recommendation 2**

In addition, I recommend that the existing practice guidance on neglect is reviewed with a view to:

a) Adding some helpful guidance to practitioners designed to help them think about working with adolescents who are difficult to engage with and to help explore the boundaries between their right to some level of self-determination on the one hand and the need to more formally intervene in their lives on the other.
b) The guidance should extend to the use of the Mental Health Capacity Act and assessments around Gillick competency.
c) I suggest the engagement of the adolescent at risk services in this work – working in the field of criminal exploitation or those on the edge of care will almost certainly generate some transferable learning and guidance.

11.7 **Recommendation 3**

The escalation process and its implementation should be reviewed to:

a) Ensure it encourages both the airing of concerns about children and an expectation that those concerns will be received positively and responded to proactively, accepting that raising concerns about children by one agency to another is a critical part of keeping children safe.
b) The procedures should focus more on expected behaviours and responses, on promoting the importance of escalating concerns within the system and wanting those concerns to be proactively aired rather than an expectation that escalations simply means going up the management line until a resolution is reached.
c) Such a review should include an examination of the escalation procedures set out by Wiltshire Safeguarding Vulnerable Partnership, which includes an approach to managing 'stuck' cases. A number of agencies cover both Swindon and Wiltshire and there is clearly some benefit in there being a similarity of approach by both partnerships.

11.8 **Recommendation 4**

Finally, I recommend that the partnership reviews its work more generally and explores the Working Together requirements set out in 9.6 above are evident in the work of the partnership at both a strategic and an operational level and that there is a flexibility and creativity in both the broader development of the partnership and in services to individual children and their families.