Swindon Safeguarding Partnership

# Learning from Local Child Safeguarding Practice Reviews Alan & Tristan

***Each Safeguarding Review is a Human Story***

Please put your name and role in the chat

# Learning Objectives

This webinar is an opportunity to find out more about:

- Local Child Safeguarding Practice Review (LCSPR) and what they are.
- Learning themes identified during the review of Alan and Tristan including adolescent neglect, levels of need, Mental Capacity Act 16-17-year-olds and resolution of professional disagreements.
- Resources available for professionals to support when working with neglect

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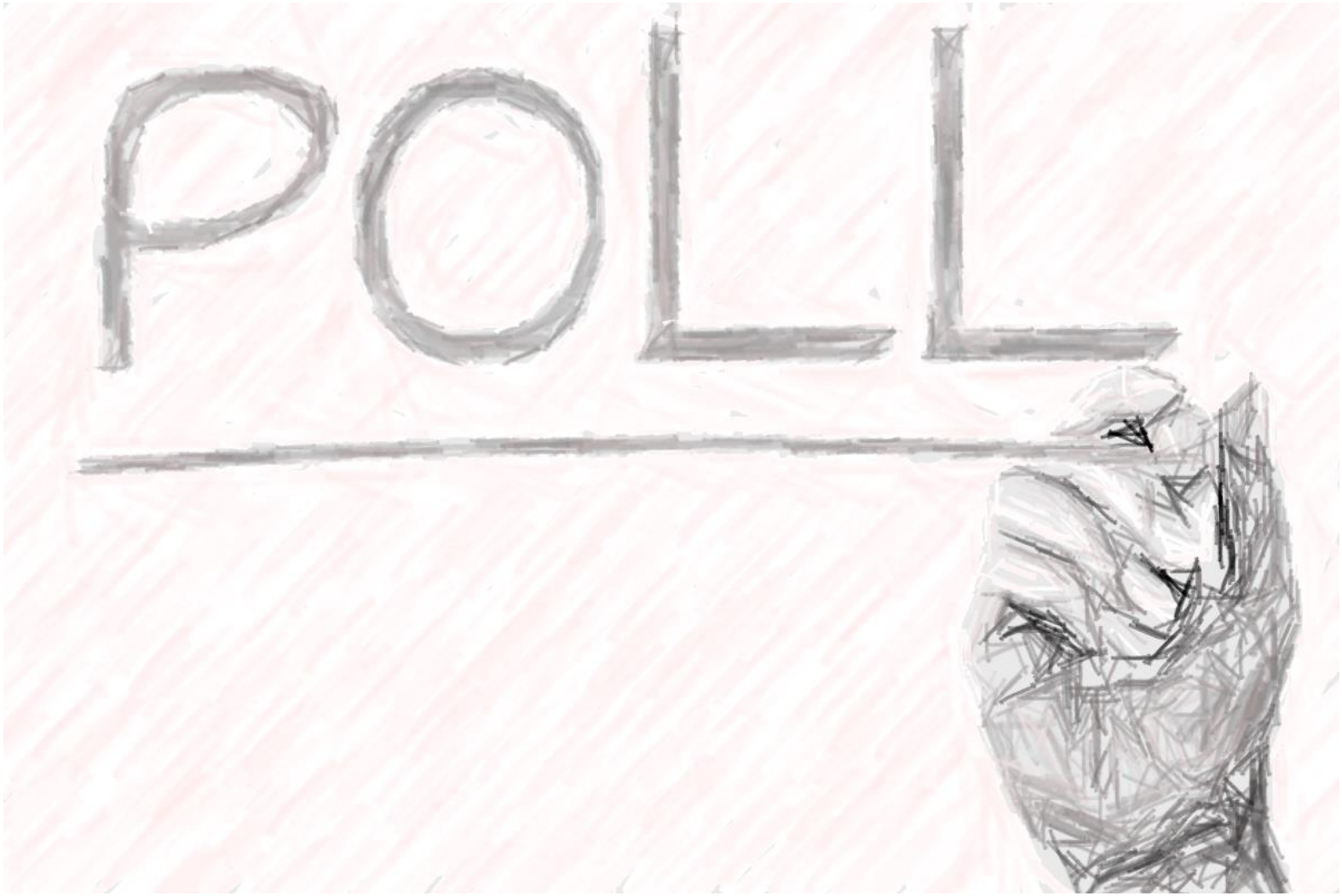

# What is a Local Child Safeguarding Practice Review?

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*Sometimes a child suffers a serious injury or death as a result of abuse or neglect. Understanding not only what happened but also why it happened can help improve our response in the future. Appreciating the impact that organisations and agencies had on the child's life, and on the lives of their family members, and whether or not different approaches or those actions could have resulted in a different outcome, is essential. It is in this way that we can make good judgements about what might need to change at a local or national level The purpose of serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children.* (Working Together 2023)

# LCSPR Alan was published in March 2023

At the time of the review Alan was 16yrs old, his school had referred him to MASH as it was considered that the early help provision that had been 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;

## LCSPR Alan (cont.)

- 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 arms as a consequence of self-harming.

LCSPR Alan_full_report

LCSPR Alan_practice_learning_brief

# LCSPR Tristan was published in June 2024

Tristan was 17 at the time of the review. Tristan's school attendance dropped from around 90% to 51% in Year 11 , then continued to drop off. He was admitted to hospital in January 2022 after a seizure, weight was to be monitored through GP and a referral to eating disorder clinic were not followed through, there was no CIN plan.

In December 2022, Tristan told a member of school staff that he was severely depressed and experiencing physical and emotional abuse at home, so the school referred Tristan to MASH, resulting in a CIN assessment being initiated and a Youth Engagement Worker (YEW) was appointed.

## LCSPR Tristan (cont.)

A further MASH referral and mental health referral made by the school in April 2023, as concerns about Tristan's weight and emotional wellbeing continued to escalate.

In May 2023, he was admitted to hospital due to concerns about his very low weight and BMI, cardiovascular concerns and risk of re-feeding syndrome, a potentially fatal condition caused by rapid reintroduction of nutrition after a period of inadequate intake. Tristan was diagnosed with Avoidant Restrictive Food Intake Disorder and an anxiety disorder.

LCSPR_Tristan_full_report
LCSPR Alan_practice_learning_brief

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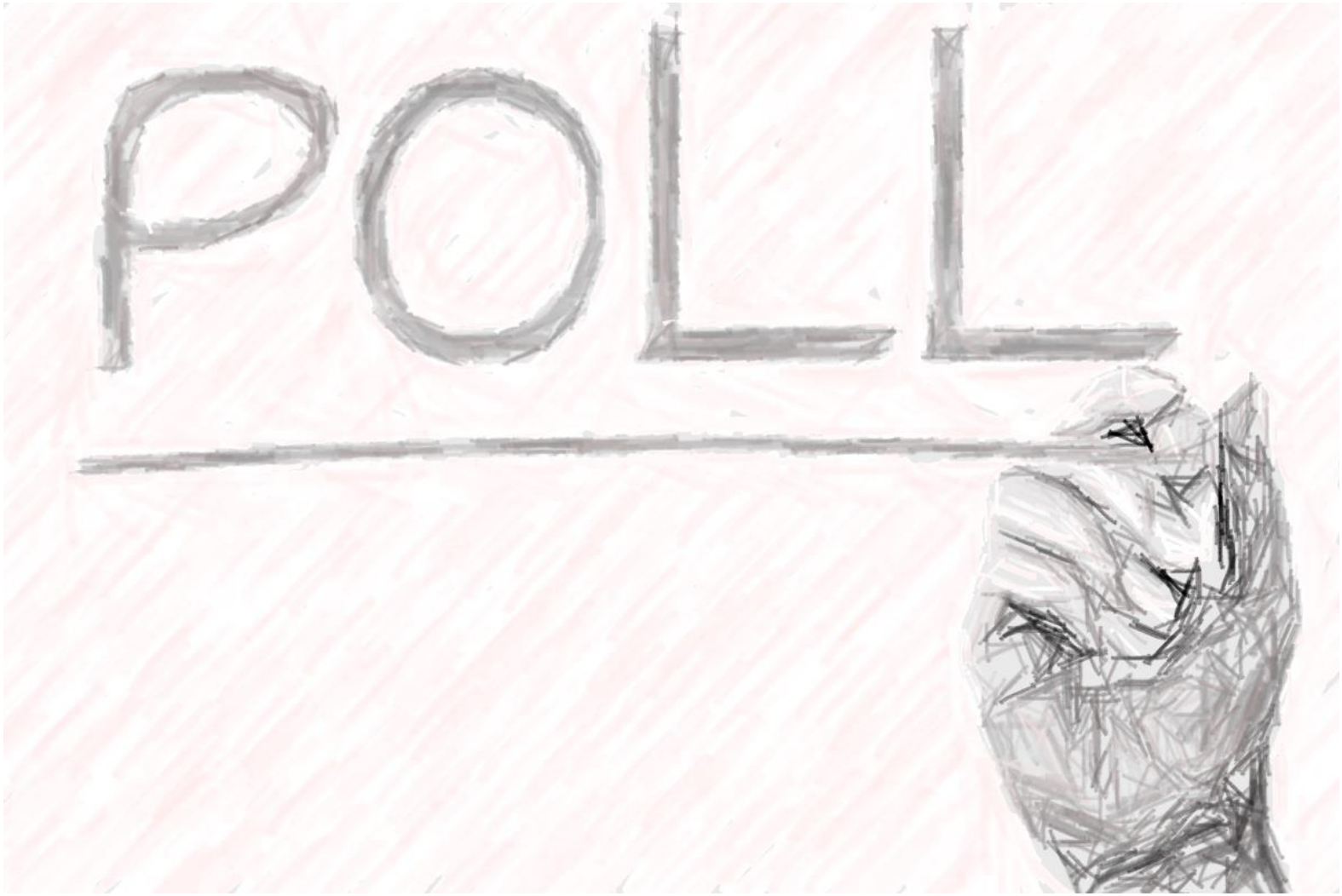

# Key factors

- Both Tristan and Alan lived with their fathers and did not have any contact with their mothers;

- Both fathers struggled with their own needs, which included mental health/substance misuse; the impact of this on their parenting was never fully assessed;

- Both Tristan and Alan struggled to return to school after Covid 19 lockdowns, their school attendance reduced, anxiety increased and they both became isolated at home;

- Both had very low weight and body mass index; early opportunities to recognise developing health needs were missed;

- The culmination of all of these factors was not considered as neglect by those working with Alan and Tristan.

# Key factors

- Both families had early help support in place. This did not seem to be effecting change despite ongoing attempts;

- Referrals were made to Children's Social Care, despite assessments being completed long term CIN planning was not in place;

- Thresholds for the assessment and support for children in need, or at risk of or experiencing; harm were not consistently understood across the partnership, in particular in respect of older children. Threshold decisions were applied too mechanistically;

- Decisions to step down to early help were not consistently challenged despite professionals not agreeing with decisions made by Children's Social Care – the escalation process was either not formally used or not used in a timely way;

- Use of the Mental Capacity Act for 16-17 year olds should have been more robust.

# Break out room questions

- **What is your experience of working with fathers?**
- **Do you work in a different way when working with fathers?**
- **What has been effective when you have worked with fathers?**

# Themes

## Thresholds/Levels of Need

*'Nothing is more important than children's welfare. Every child deserves to grow up in a safe, stable, and loving home. Children who need help and protection deserve high quality and effective support. This requires individuals, agencies, and organisations to be clear about their own and each other's roles and responsibilities, and how they work together'* (Working Together to Safeguard Children 2023).

There are lots of challenges and complexities in safeguarding. We know that children and young people are best protected when professionals talk to each other, share worries and challenge each other when they don't agree with decisions being made. Above all, we should be listening to what children and young people are telling us, recognising and respecting their rights. There has to be a shared focus on achieving the best outcomes for the child or young person.

# Themes

We know that 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. Threshold criteria **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. (LCSPR Alan)

Right Help at the Right Time Guidance

# Themes

## Safeguarding Adolescents

We need to recognise that young people who have experienced adversity or harms in earlier childhood are sometimes left with unmet needs that they might seek to address via testing boundaries in adolescence.

Working actively with young people's relationships and lived experiences is essential to keeping them safe.

Adolescent 'choice' is sometimes misinterpreted as informed choice akin to adult decision-making. Conceptualising choices as 'lifestyle choices' can lead to children and young people who have been harmed being denied appropriate support.

# Themes

Engagement is more likely when professionals focus on and work with an adolescent's strengths and have support in understanding what factors might be influencing the risks/harm.

Understanding adolescent development and the complexities of this will help. Starting with the young person's needs, goals, values and aspirations.

RIP safeguarding-during-adolescence-briefing
NSPCC learning-from-case-reviews-teenagers

# Themes

## Adolescent Neglect – What is the impact for adolescents?

The signs of neglect of young people may be more difficult to identify than signs of neglect in younger children, and young people may present with different risks. For example, older children may want to spend more time away from a neglectful home, and, given their experience of neglect, they may be more vulnerable to risks such as going missing, offending behaviour or exploitation.

When young people who have experienced neglect come to the attention of agencies, the most obvious risks of, for example, exploitation or offending behaviour may elicit an appropriate response from professionals initially. But, without understanding and addressing the underlying impact of neglect, the effectiveness of any work to support these young people will be limited.

Professionals and parents can sometimes view the presenting issues young people face as the problem: this is often an unconscious assumption. When a young people 's presenting issues become the sole problem, professionals do not always consider their behaviour in the context of the impact of neglect on the child and they can fail to take action with parents regarding any ongoing neglect.

# Themes

The impact of neglect on young people can be significant and, in some cases, life-threatening. Neglect can lead to problems in adolescence and adulthood including, but not limited to:

- Poor mental and physical health
- Difficulties with interpersonal relationships
- offending behaviour
- Substance misuse
- A high propensity for risk-taking behaviour
- Suicide

SSP_neglect_framework_and_practice_guidance
Neglect_screening_tool
Swindon Day in My Life Adolescent_Final - Swindon Safeguarding Partnership
Swindon Day in the Life Guide - Swindon Safeguarding Partnership

# Themes

## Escalation and Professional Resolution

Working with children and families with identified risk factors, is often complex and means from time to time staff from different professional backgrounds may hold a different professional opinion. It is important that this is fully understood as a different perspective has the potential to cause conflict and lead to poorer outcomes.

Often there may be no right or wrong solution and quite legitimately practitioners may exercise their professional judgement differently and have differing opinions of what the right approach should be.

The resolution process recognises that children are best safeguarded when professionals who support them and their families, work well together through timely, respectful, solution-focused, and child-centred communication and coordinated action.

# Themes

The safety of individual children is the paramount consideration in any professional difference /disagreement and any unresolved issues should be addressed with due consideration to the risks that might exist for the child.

**All workers should feel able to challenge decision-making and to see this as their professional right and responsibility in order to safeguard the child and to promote effective multi-agency safeguarding practice.**

Swindon Safeguarding Partnership Resolution Process

## Themes

### Mental Capacity Act for 16-17 year olds

The Mental Capacity Act 2005 (MCA) is designed to protect and empower individuals aged 16 and over and help to safeguard the human rights of people who lack (or may lack) mental capacity to make decisions about their care and treatment. These include decisions about whether or not to consent to care or treatment. This may be because of a lifelong learning disability or a more recent short-term impairment, for example due to drug or alcohol abuse and mental ill health or long-term impairment resulting from injury or illness.

However, just because a person has one of these conditions it does not necessarily mean they lack the capacity to make a specific decision.

## MCA for 16 and 17 year olds - Definitions

The following definitions apply in the MCA and the Code of Practice:

- "Adult" is a person aged 18 years or over.
- "Young Person" is a person aged 16 or 17 years old.
- "Child" is a person under the age of 16 years old.
- This differs from the Children Act 1989 and the law more generally where the term "child" is used to refer to people aged under 18.

# Themes

## Capacity at 16 years

- The moment that a young person wakes up on the morning of their 16th birthday, they are presumed to have the capacity to make their own decisions under the MCA.

- All those involved in supporting a young person are obliged to have regard to the MCA in all that they do in relation to that young person. If you work with young people who lack capacity and you are a professional and/or you are paid for the work you do, you have a legal duty to have regard to the MCA Code of Practice.

Detailed guidance on Mental Capacity Act for 16-17 year olds can be found here:
Mental capacity act 16 to 17 year olds learning from reviews
https://www.scie.org.uk/mca/practice/assessing-capacity/

## Themes

# Poor school attendance

Evidence shows that securing excellent attendance at school is key to ensuring positive outcomes for children and young people. Missing lessons leaves children and young people more vulnerable to falling behind, creating gaps in their learning, reducing their grades and diminishing their self-confidence. Being in school also helps to keep children and young people safe.

# Themes

Poor school attendance can impact all aspects of a child's future. Children and young people who miss school, on a regular basis, can become socially isolated; they can lack confidence and have low self-esteem. Children and young people can feel like they "don't fit in" with their peers and this can lead to loneliness. Children and young people who regularly miss school are at greater risk of anti-social behaviour, child exploitation and are more likely to become victims of crime. (*SBC Attendance Strategy 2024-27*)

Hub for Education Swindon
Video archive - Swindon Safeguarding Partnership
Education - Links to Neglect - weekly attendance drop in sessions - Swindon Safeguarding Partnership

## Break out room questions

- **How will you take away  the learning from these reviews to improve your practice?**

- **How will you take away  the learning from these reviews to improve practice in your service/ team?**

**(The evaluation form for this session asks the same questions, so keep a note of your answers to use on the form later)**

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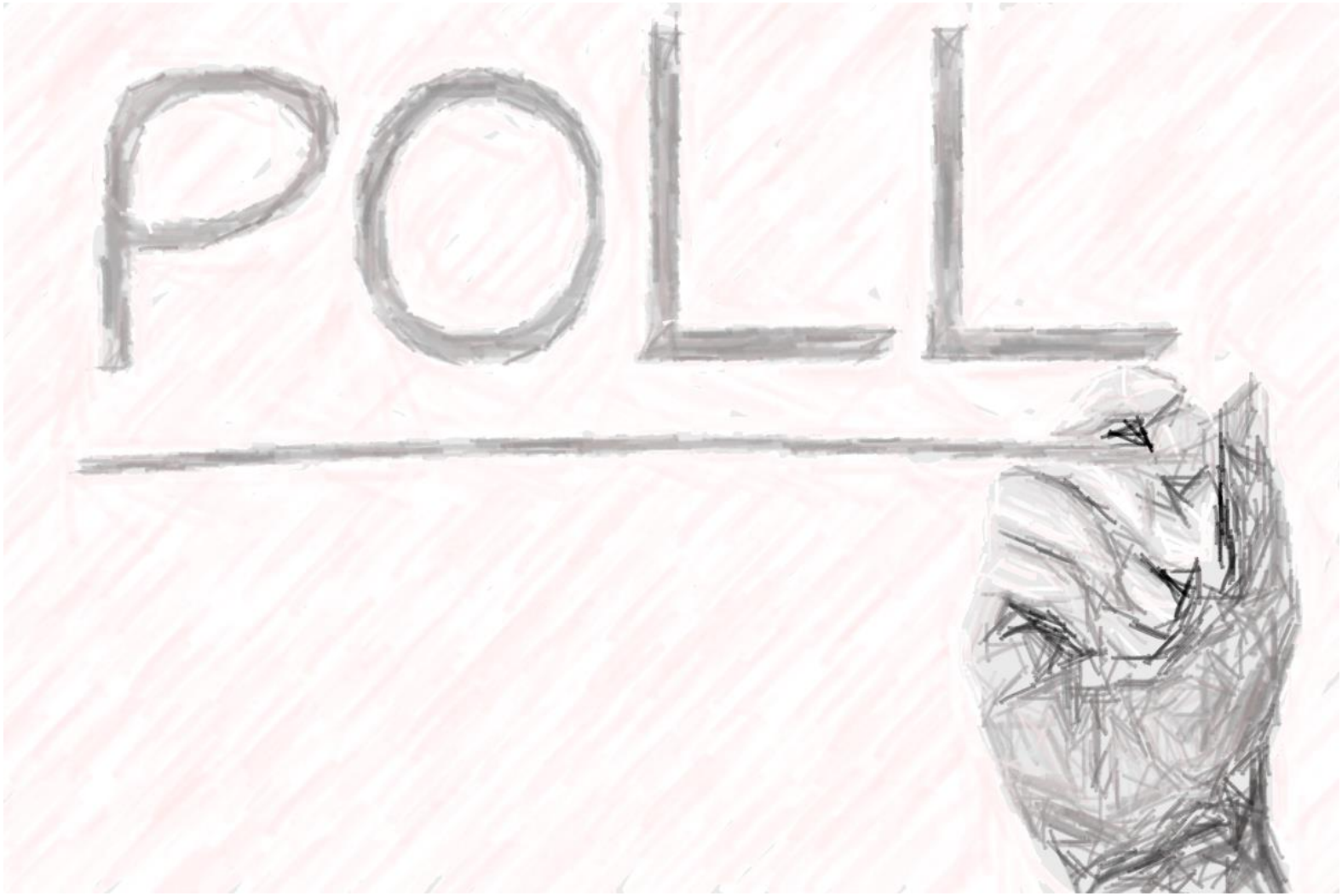

# Any questions or reflections

## Resources (1)

Working Together to Safeguard Children 2023

Keeping_children_safe_in_education_2023

https://www.legislation.gov.uk/ukpga/2005/9/contents/Mental Capacity Act

Local Child Safeguarding Practice Reviews and Case Learning leaflets - Swindon Safeguarding Partnership

Webpage: Neglect - Swindon Safeguarding Partnership

# Resources (2)

Spotlight on Neglect event 12th March 2024 Video archive - Swindon Safeguarding Partnership

SSP Safeguarding theme June 2024 - Child neglect - Swindon Safeguarding Partnership

All resources collated on here for Spotlight event - Resources - Spotlight on child neglect - Swindon Safeguarding Partnership

NSPCC Voice of the child learning from case reviews briefing - Swindon Safeguarding Partnership

SSP Safeguarding Theme Think Family August 2024 - Swindon Safeguarding Partnership

# Thank you for attending

You will be contacted in a few months time to give feedback on how you are progressing with the actions you have taken from this session.  Your responses are really important to support the Practice Review Group understand the impact of changes we have all made to support children and families in Swindon.