Briefing Note

Safeguarding Practice Review briefing Note– Harry

July 2020

Background

The case was referred to the SPR panel by the hospital. Harry (aged 11) was found alone in the community and presented with a head injury with inconsistent accounts of how it happened.

Harry has been known to professional agencies since birth due to neglect and physical abuse concerns. He has spent time in care including when he was first born. His mother has also spent time in care in her youth and has displayed aggressive tendencies to professionals and the community. Harry has a history of physical injures which his mother has minimised and he has been reluctant to explain. He has been found to be left home alone on four separate occasions. He has been subject to CP and CiN plans whilst his mother's care.

An independent author was commissioned to lead the SPR.

Key Lines of enquiry

1. Was Harry's voice heard and acted upon?

There were missed opportunities to hear Harry's voice. Even when given the opportunity, he was reluctant to express himself due to his fear of, and loyalty to his mother.

2. Were there any missed opportunities to provide appropriate intervention?

There were a number of incidents suggesting potential chronic neglect including the four occasions when Harry was left home alone, suggesting a number of missed opportunities

3. Were partners working together and sharing information appropriately?

Information was not always shared appropriately with concerns about record keeping, professional curiosity and awareness of historical concerns. Minutes of meetings were not always shared in a timely way.

4. Were concerns regarding progress and processes followed up appropriately?

Policies and Procedures regarding escalation and dispute resolution procedures were not followed

Key Lines of enquiry Continued

5. Was there an element of professional accommodation?

This was not borne out but a lack of a holistic approach to evidence gathering prevented professionals from seeing the overall pattern of neglect.

Findings

Recognition of signs and symptoms of neglect, enhanced risk and enhanced professional curiosity

There were persistent concerns raised regarding neglect including delayed presentation for medical needs; injuries that were not acceptably explained; 4 home alone incidents and school absence. These were noted but not followed up appropriately; the enhanced risk due to the history of the case was not considered and professional curiosity was not evident.

Recommendation

The Slough neglect strategy and tool should have been used as well as the application of greater professional curiosity

The need for practitioners to remain child focussed to capture the voice of the child and to apply the threshold guidance

Harry's voice was often missed, especially when tensions arose between professionals and when his mother behaved in a volatile way. The whole picture of Harry's life was not considered which hindered the use of appropriate thresholds for interventions.

Recommendations

Voice of the child is essential to inform risk assessment

Partners should be aware that any partner can call a professionals meeting to ensure communication and challenge of safeguarding thresholds

The Slough Multi agency Threshold guidance should be refreshed and communicated.

Supervision, recordkeeping, communication and sharing information

Safeguarding meetings were not always completed and shared with relevant agencies in a timely way

Findings Continued

Recommendations

Relevant practitioners must be invited to meetings; minutes must be shared and actions completed. Support should be provided for management oversight to ensure all actions are completed.

Review of TVP function within MASH

TVP at this time had an expectation that matters would be escalated by CP chairs. They now consider that this creates an unacceptable risk

Recommendations

TVP have made a recommendation to reassess their process for handling of case conference notes and police action within the MASH to ensure all crucial intelligence is gathered and shared.

Professionals working together, compliance with policies/procedures/use of the escalation policy

Professional disagreement was not dealt with appropriately

Recommendations

Every agency and practitioner should be treated with respect and contributions given equal weight. Disagreements should be resolved using the Pan Berkshire policy – Resolving Professional Disagreement and escalation

Understanding of disguised/varied compliance

Mother displayed varied and superficial compliance and was confrontational when dealing with the school. She did not abide by safeguarding advice surrounding the home alone incidents.

Recommendations

Training in dealing with confrontational parents and disguised or varied compliance should be provided.

CP medical refusal

Mother refused permission for a CP medical twice

Recommendations

Practitioners should be made aware of the range of options when a parent refuses a CP medical. This should be added to the Pan Berkshire Policies and Procedures .

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SPECIFIC LEARNING POINTS

Improve Effectiveness of all agencies working together in multi-agency safeguarding meetings

Safeguarding meetings including Core Groups and Strategy meetings did not always have all the right people in attendance; were not always completed on time; actions not followed up and an appropriate step down process was not followed.

Relevant partners including schools and voluntary sector should be invited to meetings including Strategy meetings and Core Groups. Agencies must prioritise attendance at these meetings when invited and all agencies should challenge if a relevant partner is missing

All agencies should be aware that they can call a professionals meeting to ensure effective communication and challenge

Minutes should be completed swiftly and shared with all agencies in a timely manner

Partners should challenge when actions have not been completed

*When stepping down, clear plans should be agreed and a lead professional **must** be identified. All agencies have a responsibility to identify the appropriate Lead Professional and are jointly responsible for monitoring the plan to a point where cases can return to universal services.*

All Agencies should ensure that sufficient time is provided for good quality management oversight to ensure agency actions are completed.

Improve awareness of chronic neglect and importance of reviewing full history of child

There were persistent concerns regarding neglect which were not considered in totality including 4 weeks absence from school despite the schools determined attempts to resolve this.

Harry presented with unexplained injuries on a number of occasions but these were not always linked and professionals disagreed regarding the thresholds for neglect

*All agencies should ensure they consider the **full history** of the child and consider the **cumulative** effect of chronic neglect*

*Agencies should ensure that **all concerns** are shared including all types of potential abuse*

Agencies should use the Slough Neglect tool

The Slough multi agency threshold guidance needs to be refreshed and all agencies reminded of the thresholds and the ability to challenge professionally and appropriately.

A culture of professional curiosity should be developed and encouraged in all agencies

Develop a "Home Alone" strategy

There were four occasions when Harry was found to have been left home alone.

Slough agencies should develop a Home alone strategy and communicate it to all partner agencies.

Ensure Voice of the child is prioritised

Harry's voice was often missed amongst the adults' interactions especially when professionals disagreed.

All agencies should ensure that the child's voice has a focus in assessments, practice and records

Improve recognition and resolution of disguised compliance

Harry's parent displayed challenging behaviour to some professionals whilst appearing to be complicit with other agencies. A CP medical was refused twice,

Agencies need to ensure training is provided to professionals regarding disguised/varied compliance and dealing with confrontational parents

Agencies should ensure understanding of the range of options when a parent refuses a CP medical. Pan Berkshire Policies should include the options

Improve awareness of escalation processes for professional disagreement

Professional disagreement was not dealt with appropriately.

All agencies have an important part to play in safeguarding children; every agency should be treated with respect and all contributions given equal weight. The Escalation process should be highlighted to all agencies and this should be followed for any professional disagreements