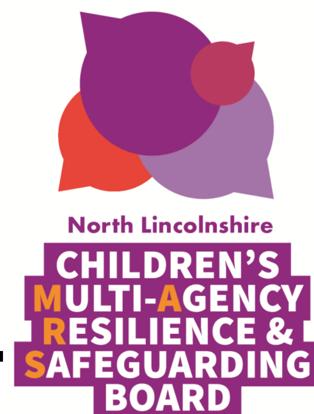
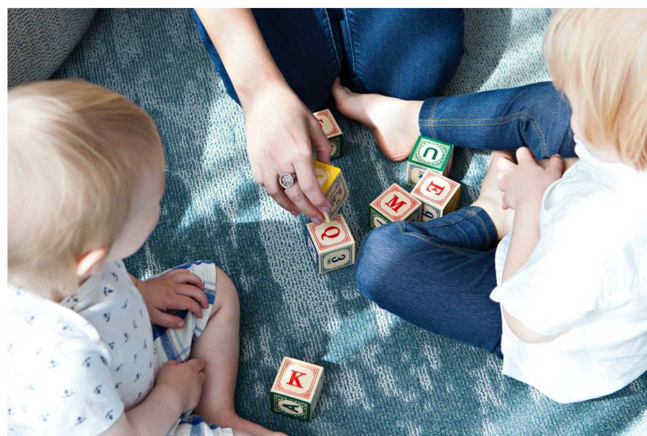
Special Edition — January 2021

Lessons Learned News Update



Welcome



Welcome to the special edition news update for the North Lincolnshire Children's Multi-Agency Resilience and Safeguarding (MARS) Local Arrangements. This News Update reflects on lessons learned from national reports, children's case reviews and from local multi agency learning processes. Reflecting on lessons learned focuses practitioners, supervisors, managers and leaders on how they can contribute to further improve our local collective response to the help and protection for children and families.

The safeguarding partners through the Children's MARS Board and its sub-groups are considering the key practice themes and messages emanating from these learning mechanisms. Where appropriate we will be embedding these themes and messages in procedures, guidance and training.

We would like to share the key messages with you so that you can contribute too through the work that you do with children, young people and families in the context of the **One Family Approach** which aims to create **a system that works for all children, young people and families** where we work together.

This is one way that as a partnership we continue to listen, learn, review and adapt to achieve our ambition for children to be **in their family, in their school and in their community**. We want children, young people and families to be supported by a workforce that is resilient, confident, competent and with authorisation to do what they think is the right thing to do without escalating children and families unnecessarily through a range of organisational systems and referral processes when the day to day contact with trusted professionals can make the difference.

We want to help and protect children and families including through promoting resilience and early help which we believe are fundamental to a successful safeguarding system.

Please share this information across your agency/organisation and use it as a means of prompting discussion, sharing learning and improving practice.

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National Reports and Children's Case Reviews

Child Safeguarding Practice Review Panel Annual Report 2018/2019

The Child Safeguarding Practice Review Panel outlined the following in Chapter 1 of their 'Annual Report 2018 - 2019 Patterns in practice, key messages, and 2020 work programme' which was published in March 2020.

We believe that this report gives a unique view of safeguarding practice in England formed by reading and evaluating 538 rapid reviews in our first 17 months of operation. Our analysis has enabled us to see patterns in practice which may have otherwise been overlooked and to draw together and share learning which can influence the work of safeguarding partners and practitioners locally and nationally. We hope the unique practice insights we have offered will support national and local efforts to improve practice.

Although this is our first annual report it covers 538 rapid reviews received between July 2018 and the end of December 2019. Across the same time period, 126 serious case reviews have been completed and submitted to us. We have taken the learning and practice themes identified from all these reviews and triangulated them with the Triennial Reviews of Serious Cases from 2011-2014 and 2014-2017.

The messages from all these reviews are striking. They represent the lives of children who have been seriously harmed or have died – the overwhelming majority at the hands of their parents or other family members.

Take a look at Chapter 3 where the report sets out key practice themes and messages: *Everyone involved in child protection policy and practice will recognise these messages and everyone has a responsibility to do something about them.*

The Annual Report is available on the government website.

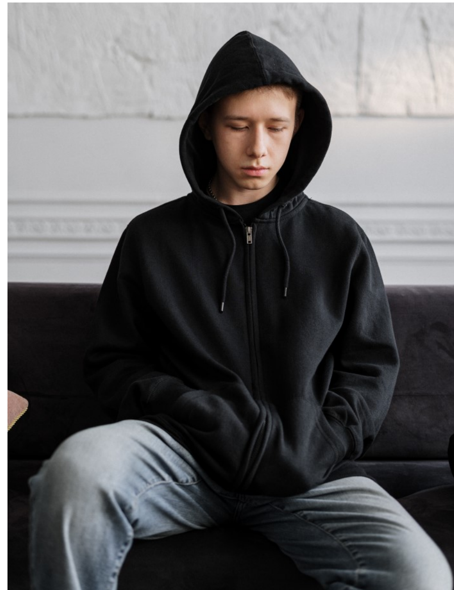
Supporting vulnerable children and families during COVID-19: Practice Briefing

The Child Safeguarding Practice Review Panel commissioned a thematic analysis of Rapid Reviews relating to serious child safeguarding incidents reported to the Panel during the initial COVID- 19 outbreak between March and September 2020.

Take a look at the Summary of Findings on page 8 of their practice briefing

It was Hard to Escape: Safeguarding Children at risk of Criminal Exploitation

The Child Safeguarding Practice Review Panel's first national review report into 21 children's cases 'It was hard to escape: safeguarding children at risk from criminal exploitation' was published in March 2020. It says:



Since we began our work in June 2018, we have seen a worrying number of cases involving children who have died or been seriously harmed where criminal exploitation was a factor.

Its focus is the response of services to the very serious risks they faced. But those children – who experienced violence, fear and exploitation as a feature of their daily lives – are at the heart of this review. We found families torn apart by what had happened and who wanted to talk to us to tell their story and influence the debate. We found local practitioners working hard to understand and respond to challenges which seem to grow and change daily as the operation of gangs and their exploitation of children become ever more sophisticated. We found some evidence about what might help children in these circumstances but also found gaps in local strategic understanding and practice.

Through this review, we have identified a series of questions and challenges in four key areas that we believe every partnership should be working on and be able to answer.

Take a look at the local learning points in Section 16 and consider what might be done differently by you in your practice, team or service to improve approaches to protecting children who find themselves threatened with violence and serious harm by criminal gangs.

The 'It was Hard to Escape' report is available on the government website.

National Reports and Children's Case Reviews

National Reports and Children's Case Reviews

Waltham Forest Local Safeguarding Children's Board Serious Case Review on Child C, a 14 year old boy

The 'Waltham Forest Local Safeguarding Children Board Serious Case Review on Child C, a 14 year old boy' was published in May 2020. It outlines the tragedy and murder by stabbing of Child C in Waltham Forest in January 2019.

Alongside a number of other systemic issues this review highlights the importance of maximising **'reachable moments'** e.g. when a child is in crisis situation in police custody or being transported back to their home local authority from another area with reflection time during the car journey. This report states that a 'reachable moment' is a concept taken from education, where it is called a 'teachable moment', and describes an unplanned opportunity that arises in a classroom where a teacher has a chance to offer insight to her or his students. In other areas of life the same opportunity can be called a 'reachable moment', and constitutes the same opportunity to break through a carefully constructed façade that is resistant to the development of personal insight.

In their report *It was hard to escape*, referred to above, the national Child Safeguarding Practice Review Panel describe a similar concept as **'critical moments'** defined below:

There is a concept in systemic theory literature described as a critical moment which changes social worlds. Systemic therapists promote the importance of acting wisely to identify when the words used at a particular critical moment can have a powerful influence on the direction taken after the conversation has ended. In a similar vein, the notion of the teachable moment is well established in education, youth offending and health sectors. They may not happen in the office or between 9 and 5!

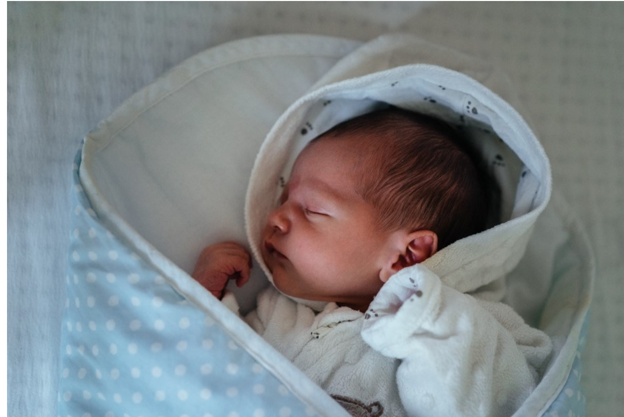
See section 8 of *It was hard to escape* for examples of critical moments such as after a child has been arrested, taken to hospital after being injured, attending the youth court for the first time, awaiting sentence, or being excluded from school.

Are there opportunities for reachable or critical moments in your practice?

The full report is available on the Waltham Forest Safeguarding Children's Board website or the NSPCC repository.

Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm

The Child Safeguarding Practice Review Panel's second national thematic review is 'Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' was published in July 2020.



It begins by explaining:

Many of the recognised risk factors of SUDI overlap with those for child abuse and neglect and this is reflected in the experience of the national Child Safeguarding Practice Review Panel. Of the 568 serious incidents notified to the Panel between June 2018 and August 2019, 40 involved infants who had died suddenly and unexpectedly, making this one of the largest groups of children notified.

Sadly, most of these deaths are preventable.

Almost all of these tragic incidents involve parents co-sleeping in unsafe sleep environments with infants, often when the parents had consumed alcohol or drugs. In addition, there were wider safeguarding concerns – often involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse.

The report outlines key learning points and key features of a practice model in Sections 7 and 8. The report is available on the government website.

The Children's MARS Joint Safe Sleeping Guidance is available on the Children's MARS website. The appendices contain guides and fact sheets for parents and professionals with links to useful sources of information.

National Reports and Children's Case Reviews

Local Multi Agency Learning Processes

Multi Agency Learning Events

A key aspect of recent learning is:

For agencies to highlight to their staff the need for 'consent' from parents and carers as part of the process of information sharing with Children's Services Single Point of Contact (SPOC) previously known as the Single Access Point or the Integrated Multi Agency Partnership (IMAP).

The IMAP Information Sharing Agreement explains the Seven Golden Rules for Information Sharing and includes information about consent:

The starting point in relation to sharing information is that practitioners will be open and honest with families from the onset about why, what, how and with whom information will or could be shared.

It may be necessary and desirable to deviate from the normal approach of seeking consent in cases where practitioners have reasonable grounds for believing that asking for consent would be unsafe or inappropriate - for example if there is an emergency or if seeking consent could create or increase a risk of harm.

The full IMAP information sharing agreement is available on the Children's MARS website.

Practice Learning Line of Sight Event—Children who are at risk of, or who are experiencing sexual and/or criminal exploitation

Practice Learning Line of Sight events remain an important part of the Children's MARS Board scrutiny and assurance activity. These events bring together strategic, senior and safeguarding leaders with practitioners and supervisors to enable a line of sight on multi-agency frontline case work practice and its impact on children's lived experiences.

All events involve agencies auditing children's cases, case discussions and reflective debrief discussions chaired by either Independent Scrutiny Officers, a safeguarding partner or Children's MARS Board representative to distil the good practice, learning and development work for the Children's MARS Board to take forward.

During June 2020 we held two events virtually on the theme of child sexual and criminal exploitation. Reflect on the good practice and learning to inform your practice by taking a look at the 7 Minute Briefing - Children at risk of and/or experiencing child exploitation and take a look at the Change the Narrative: Appropriate Language relating to Child Exploitation toolkit.

Preparation for and attendance at Child Protection Conferences

As a brief guide the top 10 expectations for agencies who are helping and protecting children and families through child protection conferences are:

- Be specific about who will be at the conference and make sure names, addresses, dates of birth, wider family members and friends are explored and contact details are agreed. Remember the family can have a supporter at the conference
- Explain your role within the child protection process to children and parents
- Be mindful of language used within your report and at the conference and uphold anti-oppressive and anti-discriminatory practice, being respectful of cultural customs, values and beliefs and show understanding of diversity issues. Arrange translation and interpreter services where English is a second language
- Encourage children's attendance and/or their contribution. This could be attendance for a short period supported by e.g. school staff, an advocate attending with them or on their behalf or the use of direct work tools to promote the child's voice. The conference chair where possible will make contact with the child
- Share your report with the family and other professionals prior to the meeting (two days before an Initial Child Protection Conference and five days before a Review Child Protection Conference). Include the child and parents voice in the report and provide an up to date chronology and genogram
- Be clear about the risks and impact upon the child(ren)
- Be on time and available for third party information. This is information such as police intelligence or ongoing police enquiries that cannot be shared with the family. This part of the conference, if required, will be held without the family present
- Remain on task and focussed in the conference. Using virtual technology can be unpredictable and requires all attendees to give their full attention and respect
- Give a clear rationale for your decision making and evidence based judgement about whether the child is judged to be suffering or likely to suffer significant harm as you will be asked to provide a professional view regarding the need for a child protection plan
- Contribute to the multi agency outcome focused plan that should be reviewed and updated at every core group meeting. Make sure the plan is Specific, Measurable, Achievable, Realistic and Time scaled (SMART) and reviewed in a timely manner

For more information see the Children's MARS Policy and Procedures for 'Assessing Need and Providing Help' which is available on the Children's MARS website.

Local Multi Agency Learning Processes

Further Information

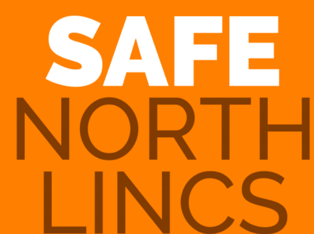
For further information visit our website www.northlincscmars.co.uk or contact us by email at mars@northlincs.gov.uk

If you wish to subscribe for Children's MARS communications emails, including updates on training, events and new resources for professionals, please complete the communications sign up form.

Follow us on Facebook at www.facebook.com/SafeNorthLincs

Follow us on Twitter at www.twitter.com/SafeNorthLincs

Safe North Lincs is a partnership between the Children's MARS Board and the Community Safety Partnership. Our vision is to promote the safeguarding and resilience for children, families and communities to enable people to feel safe and be safe in North Lincolnshire.



Children, Young People and Families are Resilient and Safeguarded