Reports from the Child Safeguarding Practice Review Panel

May 2023

North Lincolnshire
CHILDREN'S MULTI-AGENCY RESILIENCE & SAFEGUARDING BOARD

Child Safeguarding Practice Review Panel publications

Type	Title document	Date
Guidance	Child Safeguarding Practice Review Panel: Practice Guidance	April 2019
Annual report papers	Annual report 2018 to 2019: Patterns in practice, key messages and 2020 work programme	March 2020
National Review	It was Hard to Escape: Safeguarding children at risk from criminal exploitation	March 2020
National Review	Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm	July 2020
Practice briefing	Supporting vulnerable children and families during COVID-19	December 2020
Annual report papers	Annual report 2020: Patterns in practice, key messages and 2021 work programme (Plus separate exec summary document)	May 2021
Annual report papers	Analysis of safeguarding partners' yearly reports 2019-20: Overview report	May 2021
Annual report papers	Annual review of LCSPRs and rapid reviews	May 2021
National Review	Myth of Invisible Men: Safeguarding children under 1 from non-accidental injury caused by male carers	September 2021

Type	Title document	Date
National Review	Child Protection in England: National review into the murders of Arthur Labinjo-Hughes and Star Hobson (Plus separate practitioners briefing)	May 2022
Panel briefing	Bruising in non-mobile infants	September 2022
Panel briefing	Multi-agency safeguarding and domestic abuse	September 2022
Guidance	Guidance for safeguarding partners	September 2022
National Review	Safeguarding children with disabilities and complex health needs in residential settings: Phase 1	October 2022
Annual report papers	Annual report 2021: Patterns in practice, key messages and 2022 work programme	December 2022
Annual report papers	Rapid Review examples	December 2022
Annual report papers	Annual review of LCSPRs	December 2022
Annual report papers	Safeguarding partners' annual reports analysis 2020-21	December 2022
National Review	Safeguarding children with disabilities and complex health needs in residential settings: Phase 2 (Plus separate practitioners briefing)	April 2023

It was Hard to Escape

Challenges that we identified in response to this report were:

- Responding to reachable/critical moments in children's lives
- Families being engaged in the joint protection of their children
- Adult's and Children's services working together where needed
- Analysis of the pattern and trend in school exclusion. The nature of alternative provision available
- Having a sufficient focus on the disruption of criminal activity as well as support for victims

For information and consideration

- Have we embedded these?
- Is there more that we can do? And if so, what ideas do you have?

Link to document

Safeguarding children at risk from criminal exploitation - GOV.UK (www.gov.uk)

Out of routine

Challenges that we identified in response to this report were:

- How well do we understand the views of parents about safer sleep information: format, accessibility, timing, key messages and 'conversations' with practitioners? How is this integrated with messages around normal infant care and safety?
- How far do practitioners in our workforces have the knowledge and understanding appropriate to their role to promote safer sleeping?
- How is the recognition of unsafe sleep arrangements and risk of SUDI incorporated into multi-agency safeguarding procedures and practice tools for responding to neglect, domestic violence and abuse, children of alcohol and substance-misusing parents, and children at risk where a parent has a mental health problem?
- How is the partnership assured about the effectiveness of its work to promote safer sleeping and reduce the risk of SUDI?

For information and consideration

- Have we sufficiently tackled these?
- Is there more that we can do? And if so, what ideas do you have?

Link to document

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 Myth of Invisible Men

Challenges that we identified in response to this report were:

- How well are the different needs of men from black and ethnic minority backgrounds, from different cultures and faiths in local communities understood and addressed?
- How are adult mental health, substance misuse, domestic abuse service providers in your area identifying and responding to their service users as parents?
- How well is Clare's Law understood and promoted in your area?
- Are the histories and backgrounds of both parents included in pre-birth assessments?
- What is the rate of attendance of men at child protection conferences?

For information and consideration

- Have we sufficiently tackled these?
- Is there more that we can do? And if so, what ideas do you have?

Link to document

Myth of Invisible Men: Safeguarding children under 1 from non-accidental injury caused by male carers

Child Protection in England

Challenges that we identified in response to this report were:

- How well do practitioners listen to the views of the wider family, friends and those who know the child well?
- Do practitioners have specialist skills and expertise in working with families whose engagement is reluctant or sporadic?
- Are practitioners skilled and knowledgeable about working with diverse communities including in relation to culture, ethnicity, gender and sexuality?
- How well is the impact of domestic abuse on children explored in depth?

For information and consideration

- Have we sufficiently tackled these?
- Is there more that we can do? And if so, what ideas do you have?

Link to document

National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk)

Safeguarding children with disabilities and complex health needs in residential settings

A supplementary recommendation from this report was:

- To ensure that practitioners understand the requirements for legally compliant practice in relation to Deprivation of Liberty Safeguards. Local authorities, health services and residential settings should review their current systems, procedures and practice to determine their readiness for meeting the requirements under this framework

For information and consideration

- Is there more that we can do? And if so, what ideas do you have?

Link to document

Safeguarding children with disabilities in residential settings - GOV.UK (www.gov.uk)

Bruising in non-mobile infants

The Children's MARS guidance on bruising/injuries to non-mobile infants and children has been updated and the key changes are:

- The name of the document and the references throughout have been changed to reflect the guidance from the Panel and the medical guidance used by Paediatricians i.e. 'non-mobile infants' is the term being used instead of 'non-mobile babies'. Our guidance is now called **guidance on bruising/injuries to non-mobile infants and children**
- The Panel recommends that in **all** cases of bruising in children **who are not independently mobile** there is a multi-agency discussion to consider any other information on the child and family and to jointly decide whether any further assessment, investigation or action is needed. The Panel also says that they do not support blanket policies that require section 47 enquiries. In response to this, the local guidance has been amended to clarify that a multi-agency meeting or a strategy discussion should be convened dependent on the circumstances and that it may or may not progress to a section 47 enquiry

For information and discussion

- Do you have any questions in relation to any aspects of this guidance

Link to document

The management of bruising in non-mobile infants paper - GOV.UK (www.gov.uk)

Link to the refreshed Children's MARS guidance

Children's MARS guidance on bruising/ injuries to non-mobile infants and children

Multi-agency safeguarding and domestic abuse

Areas for consideration from this briefing were:

- In 2020, domestic abuse featured in **over 40% of cases notified to the Panel**
- **Children as victims of domestic abuse -** The Domestic Abuse Act 2021 sets out that children are victims of domestic abuse in their own right, when it is perpetrated against their parent or carer. The review analysis found that concerns for children were often categorised as emotional harm or neglect rather than direct abuse. Actions related to the mother changing her parenting or protecting the children from the behaviour of the perpetrator, rather than identifying that the children were being directly harmed by the abuser and targeting actions on this.
- **Impact of abusers' behaviours on children and young people** - reviews demonstrated different types of harm to children depending on their age and stage of development.
- **The needs of children, young people and families from diverse backgrounds -** There was a significant lack of recording and therefore meaningful analysis of demographic information about children and their families in the case reviews. For example, ethnicity, gender, disability, immigration status
- The analysis has identified **four core practice principles** that should underpin practice approaches when working with children and young people, their parents, wider families and networks in relation to domestic abuse:
  - Domestic abuse informed
  - Trauma informed
  - Intersectional
  - Whole family
- The review identified several promising **child and family domestic abuse projects and interventions** that have some evidence of improving outcomes for children and families experiencing domestic abuse including Barnardo's Opening Closed Doors, For Baby's Sake, The Drive Project, and Harbour – Salford. Tools and guidance include the Safe and Together model and the Women's Aid good practice guide.

For information and consideration

- consider any implications or developments that could be taken forward in relation to children and families

Link to document

Multi-agency safeguarding and domestic abuse paper - GOV.UK (www.gov.uk)

Associated briefing

Microsoft Word Document

National Panel annual reports

Key practice themes from the last report were:

- **Critical thinking and professional challenge through effective leadership and culture -** Organisational culture and leadership that supports critical thinking and professional challenge is critical to securing good outcomes for children. This was a key message in the 2020 annual report and the Panel's work during 2021 confirmed the importance of effective leadership in safeguarding practice, particularly in supporting sound risk assessment and decision making
- **The importance of a whole family approach to risk assessment and support** - Rapid reviews identified a 'whole family' approach as one of the crucial aspects of risk assessment - that is conducting assessments involving all family members and carers and exploring how recorded vulnerabilities affect the dynamics in the household
- **Central consideration of racial, ethnic and cultural identity and impact on children and families' experiences -** The need for a whole family approach should be taken hand in hand with the need to recognise the unique characteristics of each family and understand their histories, racial, ethnic, and cultural context
- **The vulnerability of babies** - Babies under 1 have consistently been the largest category of serious incidents notified to the Panel. The Myth of Invisible Men review focused on the role of male carers and identified a number of challenges for safeguarding partners. This included the need to explore the vulnerability of babies under one, in depth, with both parents (regardless of whether they live together or are in a relationship with each other) as well as with other new partners
- **Domestic abuse and harm to children – working across services** - Domestic abuse featured in over 40% of cases notified to the Panel in 2020. However, the analysis of partnership annual reports for 2021 found that domestic abuse was not one of the most common priorities identified by partnerships.
- **Keeping a focus on risks outside the family** – The Panel's 2021 thematic analysis confirmed that there are continuing challenges in protecting children outside their family, including the overlaps between intra-familial harm and extra-familial vulnerability, the role of safeguarding services alongside wider community services in addressing extra-familial harm, and the balance between protective measures for individual children and disruptive measures aimed at perpetrators.

For information and consideration

- Have we embedded these?
- Is there more that we can do? And if so, what ideas do you have?

Link to documents

Child Safeguarding Practice Review Panel: annual report 2018 to 2019 - GOV.UK (www.gov.uk)

Child Safeguarding Practice Review Panel: annual report 2020 - GOV.UK (www.gov.uk)

Child Safeguarding Practice Review Panel: annual report 2021 - GOV.UK (www.gov.uk)

Learning from LCSPRs and rapid reviews

Messages for practice from this report were:

- All safeguarding agencies need to promote cultures that give their staff the confidence to ask questions. Staff need to be able to both give and receive challenge and work together to resolve professional differences
- Practitioners need and deserve proper support and resources for their work with some very demanding cases
- The term 'reluctant and sporadic engagement' rather sanitises and disguises the realities of working with some extremely hostile and intimidating families and young people, some highly demanding families, and some that are deliberately deceptive
- The detail and realities of day-to-day frontline practice are not usually visible in the reports. Although it is important to avoid long chronologies, demonstrating the realities of practice is necessary to understand the strengths and shortcomings of practice, and what support practitioners need
- Racial, ethnic, and cultural identities are often central factors in the daily lives of minoritised people, and should be given proper weight when exploring such children's lives, in practice and in reviews
- Working effectively with Black children may require regular training for professionals, highlighting the implications for practice of the children being *invisibilised*, *responsibilised* and *adultified*. Black children must be seen and treated as *children*
- Cumulative social hazards, including poverty, intra-familial difficulties, learning needs and negative peer relationships, amongst others, are harmful to children. For some children, the impact of racism magnifies these adversities. All practitioners need to be aware of these interactions and apply the understanding in their work with children and families
- Poor parental engagement by minoritised parents has been linked with fear, including fear of the power professionals wield. Professionals need to recognise, explore and seek to allay such fear while working with the parents

For information and consideration

- Have we considered these?
- Is there more that we can do? And if so, what ideas do you have?

Link to documents

Annual review of LCSPRs and rapid reviews 2021

Annual review of local child safeguarding practice reviews 2022

Getting messages to the frontline

The Children's MARS Board use a variety of existing mechanisms to get messages to the frontline including:

- Reports from the Panel are circulated via the email comms list. Practitioner briefings from the Panel or other organisations such as the NSPCC are also circulated
- Lead officers disseminate key messages from Children's MARS subgroups
- Reports/briefings from the Panel are included in the quarterly News Updates
- Relevent thematic reports are included in Children's MARS toolkits and Spotlights
- Key messages from the Panel are taken into account when commissioning training and keynote speakers for the Children's MARS Conference
- Staff briefings have been held previously to disseminate key messages from reports such as Child Protection in England and Stable Homes Built on Love and what it means for us locally
- Work is ongoing to develop the Children's MARS Learning from Practice webpage to include key messages from the Panel including links to previous reports, briefing and resources

For information and consideration

- How do you routinely share information across your organisation?
- Do you have any other ideas around how we get key messages from the National Panel to frontline practitioners?
- Do you have any ideas about how to share local good practice across the partnership?