Local Children's Safeguarding Practice Review:
Children O, P and Q
Learning Brief

Background:

The subjects of this review are three children who all witnessed a significant domestic abuse incident perpetrated by their father against their mother. At the time of the attack, the three children were subject to child protection plans under the category of neglect and since the birth of their first child had been known to safeguarding services in another local authority area. The attack lasted for over 11 hours, during which time their mother was repeatedly assaulted leaving her hospitalised, in a coma and with life threatening injuries. While the children had been prevented from calling for help one child was to able to raise the alarm when their father fell asleep. He was subsequently prosecuted and sentenced to a period of imprisonment. .

Key Lines of Enquiry:

- ◊ At times the leadership within the multi-agency decision making processes (including CP Conferences) was not sufficiently robust and why partners did not challenge examples of deficient decision making.
- ◊ Joint working and information sharing between police and CSC was not sufficiently robust to:
  - ensure relevant information was known to agencies
  - avoid delays in strategy meetings taking place
  - assess the impact of illicit drugs (including cocaine) in the context of Adult P's experience of domestic abuse
  - understand fully the impact on the children's day to day experiences, relationships and the environment to which they were exposed.
- ◊ Strategies put in place during the pandemic did not sufficiently address the potential for hidden harm.
- ◊ The risk of domestic abuse escalated and whether the period of the pandemic hampered the efforts of professionals to assess this risk.

Key learning:

- ♦ All agencies should promote the importance of staff listening to children, hearing their voices, and responding to their statements
- ♦ Supervision address gender bias and objectively consider the needs and risks of both parents.
- ♦ Current risks should be assessed in the context of past analysis, chronologies and historical information available, particularly where continued safe-guarding cannot rely on the prosecution of an offender.
- ♦ Overt non-compliance and disguised compliance should be carefully assessed in relation to the experiences of individual family members. Assessments should consider the underlying issues associated with reluctant or sporadic engagement and result in greater scrutiny rather than less.

Recommendation 1: Agencies are recommended to review their guidance on professional curiosity and assess its effectiveness with frontline practitioners through a process of open feedback and/or focus groups. This feedback should factor in the development of future guidance to practitioners.

Recommendation 3: Children's Social Care Practitioners in the Family Safeguarding Model need to have specific awareness training on adult safeguarding and the use of Section 42 of the Care Act 2014 and the multi-agency risk assessment framework.

Recommendation 5: The Bracknell Forest Safeguarding Board should assure themselves that all relevant frontline practitioners have (as a minimum) awareness training specifically on coercive control.

Key learning ctd:

- Appointments resulting in the *attendance* of parents should not be mistaken for evidence of their *engagement* with services. Claims regarding compliance with arrangements should be verified, with professionals triangulating sources of information within their evaluation of the impact interventions may have had.
- Significantly low attendance of children at school should prompt an Early Help Assessment to ascertain the reasons for such absences, what support children/families required and should consider whether children have any caring responsibilities.
- Practitioners should consider the appropriateness of Family Group Conferences as a vehicle for engaging wider family members and agreeing information sharing arrangements .
- Multi-agency plans should address the actions required where (contrary to agreed arrangements) adults resume relationships and/or contact that could significantly heightens the risks to the others. Such safety planning should ensure to all professionals involved, including those working out of hours.
- The experiences of survivors of domestic abuse should underpin training and development that helps inform professionals' understanding of the dynamics of domestic abuse.
- Case closure by Children's Social Care should clarify the ongoing support being offered to the family and identify factors that should result in case being escalated and re-assessed. Where necessary the escalation of cases must be actioned and followed up by those individual raising the concern.
- To support robust information sharing, case files should include the correct details for the each GP registered for individual family members.

Recommendation 2: The Safeguarding Board should consider a learning audit of how many referrals for Section 42 and/or requests for multi-agency risk framework meetings for adults at risk originate from the Family Safeguarding Teams.

Recommendation 4: Drug and Alcohol Services should consider the implementation of 'women sensitive' services that address gender specific treatment issues and that consider women's wider social contexts, particularly their experiences of domestic abuse and coercive control.

Recommendation 6: The Safeguarding Board should seek assurance that the commissioned advocacy services in Bracknell Forest are well understood by frontline practitioners