1 Background and Concerns

A line-of-sight meeting was held in relation to a young person who was subject to Child Protection Plan due to risk of physical harm. Additional concerns linked to missing episodes, reports of arguments and increasing tensions within the family.

Four strategy discussions were held in short period of time and there was an allegation of physical harm perpetrated by the father, which resulted in the young person being accommodated by the Local Authority under Section 20 of the Children Act 1989.

There was a delay in the young person being seen following a strategy meeting and key decision makers and professionals were not always involved in planning and decisions. An example of this included decision making "out of hours." There was uncertainty to decisions around a single or joint agency SC. 47 enquiry and on occasions there was a lack of coordination between agencies to consider all eventualities and safety planning. An example of this was the planning around the arrest of parents following a medical examination.

This impacted on the young person's mental health which escalated to self-harm episodes and taking an overdose of medication. Increased tensions within the home environment and impacted on relationships with extended family members and younger sibling.

Concerns were noted in relation to the young person seemingly having a lack of understanding of their family dynamic which could potentially impact on their self-identity.

2 Purpose of the Review?

To explore the multi-agency response and whether this was timely, proportionate, and responsive to the young person's needs. This includes considering the effectiveness of safety planning, multi-agency sharing of information and the co-ordination of responses and parental consent.

3 Key lines of Enquiry

Were strategy discussions held in a timely manner and all relevant professionals included?
How was consent obtained for the child protection medical?
Was there multi agency planning and a coordinated response by all agencies?
Was support identified for the family appropriate and referred in a timely manner?
Was intervention planned and proportionate?
Was out of hours services used appropriately? Where partners signposted to this?

4 Key Learning

Family dynamics and self-identity - The complexity of the family dynamics was evident throughout the review. Completion of a genogram should be considered to ensure that all children in the family are considered as part of risk assessments and safety planning. It is important for children to understand their family context to understand their own self-identity. It is crucial that there is a clear plan in place for children to have planned family time, which includes siblings and wider family.

Professional curiosity – The review revealed that professional curiosity needs to be exercised around parents' reluctance to engage in parenting work. There is a need to understand the underlying issues which impacts on participation as this can result in progress being made.

Contextual risks- The review revealed that there was a need for continuous professional curiosity around contextual safeguarding (risk outside the family home) needs such as missing episodes, UTI infections and alcohol usage.

Drift and delay- There is a need to ensure that referrals are timely to avoid drift and delay, it was recognised in the review that an edge of care referral should have been made sooner. The review revealed a lack of safety planning and direct intervention. Intervention was crisis led as opposed to purposeful work that focused on resolving family conflict. This posed the question as to whether the family were caught between services and missing appropriate support.
It was reflected in the review that there were several changes in social worker which may have impacted on the progression of the child's plan.

Strategy discussions- The reviewed highlighted the importance of ensuring that all relevant professionals are included within strategy meetings, this can support with information sharing and decision making. There was some uncertainty as to the decision for a single or joint agency Section 47 enquiry. The decision regarding single or joint agency investigations should be authorised and recorded by the designated line managers in both the Police and Children's Social Care. Should there be professional differences, the HSCP escalation and resolution procedure should be utilised.

Safety planning and out of hours support - Despite several strategy meetings taking place, there was a lack of planning around the outcomes and subsequent actions were not coordinated to ensure that the actions taken aligned with best interests of the children which resulted in sibling separation and without appropriate checks. Information sharing from out of hours services to partners were not robust and left agencies unaware of decision making. Some partner agencies were unclear as to processes when out of hours support is required for children. It is crucial that partners understand the function of the Hull Emergency Duty Team (EDT), particularly when support is required out of hours. This will ensure that emergency plans for children are subject to all relevant check and risk assessments. It is also important that relevant information is recorded on the system by Children's Social Care so that EDT have access to up to date information so appropriate plans can be made in an emergency.

5 Good Practice

- Good practice was evidenced throughout the medical report provided, including the recording of how consent was obtained.
- There was some evidence of good working relationships between the police and CSC.
- Good communication noted between the school nurse and CAMHS around actions that were agreed following a strategy discussion.

6 Next Steps

- This 7-minute guide will be shared across the partnership to compliment discussions, training, and learning. Contextual Safeguarding Conference to be held in March 2023.
- Training to support practitioners with key learning points is available through the HSCP Learning Programme 2023/ 2024 and attached links (detailed above).
- Auditing activity will take place through the HSCP to consider how key learning has been established into practice.

7 Further information – links

- Hull Social Work Academy and YVIC have undertaken work on the change of social worker- Corporate Parenting Strategy Document (hull.gov.uk)
- Out of Hours- EDT (Emergency Duty Team) contact information 01482 304304
- Good practice service delivery standards for the management of children referred for child protection medical assessments Child-Protection-service-delivery-standards-2020.pdf (hubble-live-assets.s3.amazonaws.com)
- HSCP policy and procedure Child Protection Enquiries - Section 47 Children Act 1989 (proceduresonline.com)
- HSCP Learning Programme 2023 – 2024 HSCP Learning Programme 2023 - 2024.pdf
- One minute guide to private fostering PrivateFosteringHSCP-oneminuteguide.pdf
- HSCP escalation and resolution policy available on TriX