Leeds Safeguarding Children Partnership

Report to: Leeds Children and Families Scrutiny Board
Report from: Leeds Safeguarding Children Partnership Executive
Title of Report: Cross Cutting themes from Review Processes
Date: 8 March 2023

1. Purpose of report

1.1. This report sets out to update the Children and Families Scrutiny Board on key cross cutting themes identified through Leeds Safeguarding Children Partnership (LSCP) review processes including:

- Rapid Reviews
- Child Safeguarding Practice Reviews
- Local review processes
- Auditing work

2. Introduction

2.1. The LSCP is a multi-agency partnership which supports the implementation of the multi-agency safeguarding arrangements within the city. The LSCP is led by the LSCP Executive which compromises the key statutory safeguarding partners who have responsibility for safeguarding as outlined within Working Together 2018 (Local Authority through Children and Families Directorate, Health through the West Yorkshire Integrated Care Board Leeds and West Yorkshire Police Leeds District). They are responsible for the city's multi-agency safeguarding arrangements and ensuring these are robust. An Independent Chair is appointed to provide oversight and scrutiny of the arrangements.

2.2. Working Together to Safeguard Children 2018 states that "Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken".

2.3. A serious child safeguarding case as defined by Working Together to Safeguard Children 2018 is one whereby abuse or neglect of a child is known or suspected and the child has died or been seriously harmed. It goes on to clarify that serious harm includes (but is not limited to) serious and / or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health.

2.4. Serious child safeguarding cases are initially reviewed by the Rapid Review process which seeks to identify leaning in a timely way[1], whilst considering if there is further learning to be identified and explored through a Child Safeguarding Practice Review. In addition to the statutory requirement to review serious child safeguarding

[1] Statutory timescale for a Rapid review is 15 working days

cases the LSCP, as part of its commitment to learning and improvement, also reviews other cases from which learning can be identified through local review processes and auditing.

2.5. The fundamental purpose of reviewing incidents is to learn from those cases to help make improvements to the systems that protect children and to prevent other children from being harmed

2.6. Working Together 2018 states that

"the purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy-makers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings."[2]

2.7. The LSCP strongly believes learning is obtained by considering what worked well and associated good practice, as well as areas for improvement, and therefore always starts from a strength-based approach when considering learning.

2.8. The implementation of review processes and the consideration of subsequently identified learning is the responsibility of the LSCP Review Advisory Group (RAG)[3].

3. Review processes May 2021 to December 2022

3.1. Between 01 May 2021 and 31 December 2022, the LSCP have undertaken 11 Rapid Reviews. Of the cases reviewed:

- 2 were under 1 year old
- 5 were aged 1-4 years
- 3 were aged 5-11 years
- 1 was 12 years or older
- 5 were male
- 6 were female
- 3 were in relation to a child who had passed away
- 8 were in relation to a child who had suffered serious harm

3.2. Four Child Safeguarding Practice Reviews were commissioned.

3.3. In addition local learning review processes were initiated for a further three cases.

3.4. Identified good practice and learning in relation to where practice could be improved for all reviews is disseminated through the LSCP Business Unit to the partnership in a variety of ways including:

[2] Working Together to Safeguard Children 2018 P84
[3] A sub-group of the LSCP with member representatives from the three statutory safeguarding partners

- The production of learning briefs which summarise the incident which has been reviewed and the key good practice and learning – this is also provided to partner agency training leads to support them in reflecting lessons within single agency training
- Updating training to reflect learning, including a section in relation to learning from reviews within the LSCP Refresher Training
- Presentation to the Leeds Children and Young People Partnership meeting including requests for partners to disseminate and embed learning internally
- Inclusion in any learning from reviews presentations for example at the Leeds Children and Young People Partnership Bi-Annual Meetings
- Consideration of practitioner presentations based on the review and identified learning – consideration is also undertaken with regards to capacity in relation to the number of sessions required to reach the workforce within Leeds.

3.5. It is acknowledged that although the LSCP has a strong system of gathering learning there is a need for greater assurance with regards to the dissemination of learning by and within partner agencies, how learning is implemented and subsequent changes to practice, and the outcomes for children and young people. The monitoring and evidencing of this will be a focus for the LSCP Business Unit and RAG going forward.

4. Cross Cutting Themes from Reviews and Partnership Response

4.1. From the reviews undertaken in 2021/22 the following cross cutting themes, and the response of the partnership, has been identified:

Professional curiosity – Although there were some examples of excellent practice in relation to the application of professional curiosity, a lack of professional curiosity, or the recording of where a practitioner has been professionally curious has been evident within a number of reviews. This has potentially meant that practitioners haven't had a full understanding of a situation or what life is like for a child or family potentially resulting in responses that do not always fully address the concerns or issues or what might be needed to support a child / family.

Partnership discussions have been held in relation to professional curiosity to consider good practice, barriers and support required, along with a partner agency survey in relation to how professional curiosity is promoted and supported (including within supervision) by partner agencies. The findings have been fed into an ongoing piece of work with Safer Stronger Communities and the Leeds Safeguarding Adults Board to develop consistent city-wide resources around professional curiosity.

A Yorkshire and Humber Masterclass series in Spring 2023 will focus on professional curiosity with the findings of the above work influencing the choice of topics and speakers.

Disguised compliance – Reviews have demonstrated how individuals were able to divert attention from what was happening within the family through appearing co-operative, providing practitioners and agencies with the information requested, and this was not further pursued regarding assurances in relation to how the family were undertaking what was asked of them. It was acknowledged that this was closely associated with the need for professional curiosity.

This learning has been fed through to the LSCP Training and Development Officer and the work being undertaking in relation to professional curiosity due to the links between

disguised compliance and professional curiosity, as well as being referenced in the joint work outlined above.

Escalation processes – Within some reviews a lack of escalation of concerns regarding the risk to a child has been highlighted, and occasionally where professionals have attempted to escalate concern have not always been resolved as expected. This has led to ongoing work across the Partnership to understand barriers to implementing the LSCP multi-agency Concerns Resolution Process which supports the escalation and resolution of concerns. It was determined that the process was widely known across the Partnership with some good examples of how it is implemented. However issues of confidence and power differentials were identified, and these issues are being taken forward through both training and specific guidance and messages for practitioners across the Partnership. It was also identified that it is not always consistently recorded where the process is implemented in the early stages of a concern, making it difficult to identify where it has worked effectively. This is being reiterated within the guidance.

Individual partners have also identified single agency actions to ensure the Concerns Resolution Policy is widely promoted and imbedded in practice.

Death of a significant family member – A number of reviews identified families who had recently experienced the death of a significant family member which understandably had an impact. Good practice was identified in relation to how families were supported, and where appropriate signposted to bereavement support. However the reviews also identified the need to ensure a sensitive balance between supporting families in relation to the grieving process alongside the need to monitor plans and assess risk. It was acknowledged that the impact of a bereavement needs to be considered in all assessments, including the impact on accessing services or progression of a safeguarding plan.

This learning will be shared with the Partnership as part of the presentation of learning from reviews and will be a specific discussion at a Leeds Children and Young People Partnership bi-annual meeting in Spring 2023. It will also be fed into the LSCP Learning and Development subgroup

Domestic abuse – The majority of cases identified domestic abuse either historically or in the present. Reviews identified good practice in relation to consideration of domestic abuse including identifying and recording children within the family, and appropriate referrals to Children's Social Care; the use of Routine Enquiry[4] and information sharing in relation to domestic incidents, MARAC[5] and DRAMM[6] meetings and the associated outcomes including flags on individual's records.

Reviews have identified in some instances a need to improve how consideration of domestic abuse, including further enquiries is recorded by practitioners, along with outcomes of any enquires. In addition there is an identified need to improve how risks and / or impact for children is assessed, including how historical abuse is considered and assessed in relation a first-time pregnancy or the birth of a first child based on the research in relation to pregnancy being a time of heightened risk in relation to domestic abuse. This learning was shared as part of the LSCP Domestic Abuse Review and provides recommendations for the Partnership.

[4] Routine Enquiry is a proactive screening tool used within health settings to enquire about experiences of domestic abuse with a female patient
[5] MARAC – Multi-Agency Risk Assessment Conference considering high-risk domestic violence incidents
[6] DRAMM – Daily Risk Assessment Management Meetings discuss discusses police domestic abuse incidents and MARAC referrals from the previous 24 hours, or the previous 72 hours when held on a Monday

Different agencies risk assessment processes – Good practice was evident in relation to single agency and multi-agency assessment processes, information sharing and partnership engagement in processes. However it was identified through reviews that practitioners are not always fully aware of / fully understand the risk assessment processes used by different agencies or what the identified risk levels / assessment outcomes mean. This was particularly evident in relation to the assessment and management of Registered Sex Offenders.

The Partnership is considering broader discussions to develop work in this area including a workshop to consider improved multi-agency oversight and management of Registered Sex Offenders currently being developed by police colleagues.

Impact of Covid Pandemic – The impact of the Covid Pandemic on how services operated was evident in the majority of the reviews. Some excellent practice was demonstrated from staff going above and beyond to ensure services were offered and provided, through to the provision of food parcels, regular visits and contact with families and services adapting in order to continue to operate within the required guidelines.

Reviews also identified specific impacts of the Pandemic from which learning has been taken; reduced agency capacity and staffing levels which resulted in a lack of consistency of allocated workers for families; differing ways of working which reduced face to face visits and contact; isolation for children from services, schools, and peers; the cancellation of appointments both by agencies and families due to either ways of working or illness (positive Covid test) resulting in longer periods of time between an agency's contact with a family.

Complex health needs – Two reviews considered children with complex health needs, and although good practice was identified in relation to services and support provided, the reviews identified the impact for a family of the numerous services and agencies that were involved, along with the co-ordination of numerous medical appointments. In addition, the potential to normalise a child or family's presentation was acknowledged and that a child's needs should always be assessed and considered.

In addition, the need for assurance in relation to access of appropriate medical support when a child is staying out of area was identified, resulting in the LSCP Policy for Children with Complex Health Needs Travelling Abroad being updated in November 2022 to include traveling out of area.

Consistent application of safeguarding approaches – Throughout reviews the impact of the consistent application of core safeguarding approaches including the Think Family Work Family approach, Was Not Brought Approach, Early Help Approach and Safeguarding being everybody's responsibility was evident for improving outcomes for children and young people. There have been examples of excellent practice whereby these approaches have been considered and applied, however it was recognised that these approaches were not always consistently applied across the Partnership resulting in the potential for differing responses to situations.

These approaches are continually being promoted across the partnership, and where appropriate reviewed and updated to reflect specific learning.