



Derby and Derbyshire Safeguarding Children Partnership

Working with complex features in families Learning from Serious Case Reviews

Introduction

The Derby Safeguarding Children Board carried out serious case reviews to understand the lived experiences of children living in different unconnected families in Derby and consider in detail multi-agency practice over a number of years.

The characteristics of the families and their circumstances mean that the children are easily identifiable. This report summarises the findings from the reviews that can be shared publicly whilst at the same time safeguarding the identity of the children in the families.

Why a Serious Case Review was carried out

The complexity and range of concerns that were known during the period of time and that have become more clearly evident during the process of the reviews are unusual. The abuse and neglect experienced by many of the children in the families is significant and has been investigated

The Chair of the Derby Safeguarding Children Board commissioned the serious case reviews in accordance with 'Working Together' 2015 and 'Local Safeguarding Children Board Regulations' 2006. Two independent authors were appointed to complete the separate overview reports for each of the reviews.

Publishing Learning from the Serious Case Review

On the basis of the assessment and legal advice about the identifiability of the children in the families, the independent chair of the Derby Safeguarding Children Board decided that the overview reports would not be published. The full reports and action plans have been signed off by the Derby Safeguarding Children Board partner agencies who will make sure that all actions are completed. The full reports, assessments of risk factors for publication and action plans have been shared with the National Child Safeguarding Practice Review Panel, Department for Education and Ofsted.

Improving our practice – what we understand about work with families in these cases

Knowledge of the individuals in a family in terms of their identity, race, gender, age, disability, sexuality and culture is sometimes addressed superficially and

features that would not be considered usual for family life, some known to be positively harmful, were accepted for many years.

Professional assessment of the family culture was at times a stereotypical one where chaos and marginally neglectful care was overcompensated for. Assumptions were made about the warmth and support of a large family.

Professionals should ask themselves:

- Am I considering the behaviours of family members and their apparent reluctance to engage as stereotypical of complex large families?
- Am unpicking the individual circumstances and the experiences of children in this family?
- Am I seeing one parent as doing their best to cope within this complex family while another parent is “invisible”?
- Is this leading me to overlook considering whether the first parent has a role colluding or participating in abuse of the children?

Professionals were not always sufficiently respectfully curious about what was going on or respectfully challenging of what was happening. One reason for this may be an unwillingness to appear judgmental or patronising of what could have been seen merely as a different lifestyle rather than one that posed risks. This unwillingness could be heightened by a feeling of class divide between professionals and the family.

Promoting professional practice based on an objective assessment framework such as the Graded Care Profile can help to overcome lack confidence in discussing diversity and difference with families.

Sometimes professionals felt intimidated and threatened by family members and did not discuss this and how it might affect their interaction with family members with their managers or professionals involved in the case.

Narratives focussing on children in a family solely as problematic, engaging in anti-social behaviour, and beyond parental control may miss the vulnerability of children whose needs are not being met and who are being physically, sexually and emotionally abused.

Failure to follow procedures was common to many cases where children were not protected from serious harm. It remains unclear as to why this occurs despite continual procedural revision and tightening. All organisations must understand that having a professional approach to using procedures in day to day practice is essential. Lack of appropriate supervision being available and being asked for were key features in these cases.

The extent and effectiveness of agencies sharing information and working together to protect children was variable. Poor recording of professional interactions was a significant feature at times as was a failure to make linkages with past referrals/contacts and with information about all the children within the family.

Working with complex features in families

Key learning for professionals

- ❖ Always take children and young people seriously if they tell us about sexual abuse or any other kind of abuse;
- ❖ Make sure that telephone referrals made to Children's Social Care are followed up within 48 hours; If you do not receive feedback on a referral in 3 days informing you what action is being taken make sure you follow this up;
- ❖ Use chronologies and genograms (family trees). This is particularly important to help understand complex and/or large families;
- ❖ When working with a child at all times consider '*What is life like for this child, in this family?*' Be respectfully curious about their lived experience and make sure you consider risks to children from their siblings as well as any adults in the family. This is particularly important in cases of child sexual abuse;
- ❖ Make sure any plans to talk to a child or young person about possible abuse in their life have **explicitly considered the possibility** that:
 - ❖ other children in the family may be also be abused,
 - ❖ boys in the family may be at risk, even where concerns were initially raised about girls,
 - ❖ self – harm, substance misuse and criminal behaviour may be indicators of abuse;
 - ❖ parents may be threatening them to keep quiet and not tell you what is going on
- ❖ Be respectfully curious when considering the circumstances of women during pregnancy. During routine enquiry use the opportunity to identify vulnerabilities:
- ❖ Has the identity of the father been shared? If not, is this an indication of coercion or abuse? If there has been a delayed or concealed pregnancy, is there sufficient understanding for why this has occurred? Has this occurred on more than one occasion? Is this an indication of coercion or abuse?
- ❖ Are the circumstances of a teenage mother understood and are there causes for concern? Are they isolated? Are sources of support from family members judged to be protective and acting in the interests of the mother and unborn baby?
- ❖ Make sure that you maintain accurate and timely records of your involvement with a child and their family and include explicit analysis (or formulation) where it is needed;

- ❖ Make sure that your assessments and plans are explicit about how children will be kept safe from harm, especially where there are concerns about child sexual abuse and it has not been possible to obtain criminal convictions;
- ❖ Use assessment tools to help you understand the lived experience of children. Key assessment tools include:
 - [Brook Traffic Light Tool](#) to help you to understand children and young people's sexual behaviours and decide whether the behaviour is concerning;
 - Neglect Graded Care Profile;
 - Domestic Violence Risk Identification Matrix and other relevant assessment tools in your work with families;
 - Pre Birth Assessment
- ❖ If you are unclear about the progress being made or are worried about the children make sure you seek advice and consider whether multi-agency meetings are used to help plan what everyone is doing;
- ❖ When there are differences of opinion about the safety of a child use the [Escalation policy and process](#) and seek advice if you need it;
- ❖ Seek support and supervision from your manager to reflect on the work you are doing with children and families, especially where there are concerns about neglect, drift in a case or complex/multiple types of abuse and offending behaviour within the family;
- ❖ Make sure that you discuss with your manager or agency keeping up to date with your safeguarding training especially training about child sexual abuse.
- ❖ Make sure you link up with the schools where the children go as it is extremely likely that they will have an excellent understanding of what life has been like for the children and siblings in their school over a number of years;
- ❖ Use the Safeguarding Children Procedures to help you raise safeguarding concerns, including the complex abuse section if it is relevant to the vulnerabilities in a large/complex family.
- ❖ Use the [Derby and Derbyshire Safeguarding Children Procedures](#) as part of your practice if you are not sure of something or want to discuss a concern about a child with your line manager; Save a shortcut link to the safeguarding children procedures on your computer to help you find them;
- ❖ Sign up online so that you receive [automatic notification](#) when the Procedures are updated.