Learning from the Partnership Learning Review: Understanding a Child's Lived Experience

Summary of the case reviewed:

This learning summary highlights the findings and key themes of a partnership review into significant harm experienced over time by an adolescent whilst in the care of their mother. During the Review period the child attended thirteen medical appointments due to physical injuries with inconsistent explanations. Hospital tests showed a combination of 9 prescription-only and non-prescription drugs (including benzodiazepines and opiates) in the child's system.

The Review considers Mother's mental health and multi-agency assessments and responses before and during the Review period along with Mother's parenting of two older children, as this was of significance to learning.

There had been a long involvement with the family from Children's Social Care, Education, Health, Adult Services and the Police, and interventions included support, protection and Court procedures.

The Review concluded that the child was significantly harmed whilst in their Mother's care and this was not seen, assessed and stopped in a timely manner. The Child remained invisible to professionals for far too long.

Key findings:

- **The child's voice was missed**
  Professionals did not understand what day to day life was like for the child. The Child felt largely "invisible" and their views, wishes and feeling were not heard or known. Focus on the mother or siblings, meant that the child was "missed" in the family. The Child's own reflections offer important considerations for all agencies in working with young people as they enter their adolescent years.

- **Working together**
  The review found a number of examples where significant information regarding the family history was not known or shared, and communication between agencies was not as robust as it could have been to ensure a full assessment of risk and harm, as follows:
  - Communication between Children's and Adult Mental Health services was not sufficient. Mother's history and mental health should have been explored and analysed in much more depth than it was during the Review period
  - Health systems were not as effective as they needed to be in collating and corroborating information about the Child's injuries and consultations
  - Reports to Police were not referred onto Children's Social Care for further assessment and enquiries

- **Professional curiosity**: **Not seeing the full picture over time to inform decision making**
  There was evidence of "start again syndrome", meaning that practitioners desire to "start again" with a family, or view the situation with 'fresh eyes' leads to poor analysis of history and parenting capacity.

  Despite regular supervision and discussion around the child, there was a lack of pace and effective management oversight in Children's Social Care at times and supervision was task focused in nature. Practitioners and managers formed a view of what was happening and did not test or explore this hypothesis with the child when they said all was fine. There was also a tendency by Children's Social Care to not give due weight to other professional concerns raised and as such the Child's situation was opened and closed too often without further professional curiosity.

  Whilst agencies collated individual records of significant events, there was no multi-agency chronology to understand patterns and events over time.

- **Hidden men/adults**
  Agencies did not share and evaluate significant information about Mother's partner.

- **Missing education**
  The Child's regular non-school attendance and frequent change of school was impacted on effective relationship building and known levels of risk.

Strengths in practice:

- There were examples of professional curiosity and good working together from GP, Education and School Nurse
- There was a good level of challenge from school regarding non-attendance and the reasons for this

Themes in common with other Oxfordshire case reviews:

- Understanding the impact of parental mental health on parenting
- Think family and how adult and children's social care work together
- Understanding the child's world and hearing their views, wishes and feelings
- Effective multi-agency working to see the full picture
- Professional curiosity and having difference of opinion
- Assessing and evaluating the men in children's lives

Learning points for practitioners:

- **Understanding the child's world** is always strengthened by spending time with the child in a variety of settings, including the home and with and without their parents whenever possible. Try different ways to engage young people, so that they feel heard and listened to. Consider other information known and observations made, check out and reflect on all information received.

- **'Think family',** work together with Adult Social Care to understand parental mental health, capacity to change and ability to keep the child safe.

- **Professional judgement** -- be confident in your practice based upon evidence and professional analysis so that you keep sharing your worries and concerns in the multi-agency group. If you disagree with the decision making, discuss this with your line manager or Designated Safeguarding Lead and refer to the OSCB Resolving Multi-Agency Disagreements and Escalation Policy.

Learning point for managers:

- Multi-Agency Chronologies should be used routinely as a practice tool in understanding a family story over time and what is and what is not changing

- **Work with Fathers & Men** to ensure this is a key part of all multi-agency assessments and that risk and resilience factors are known and understood. OSCB's top tips for working with fathers and male carers, offers guidance on good practice for engaging dads to improve outcomes for children

- **Management Oversight** is critical in reviewing progress in children's lives and should prevent drift and delay. Prioritise time that is not task-focused to support and enable practitioners to be curious in their thinking about what else might be going on in this family? OSCB Safeguarding Conversations poster has been developed to help focus safeguarding conversations on better understanding a child's lived experience

Learning points for the safeguarding system:

- For the Board to continue to promote the OSCB Resolving Multi-Agency Disagreements and Escalation Policy so that it is widely known across organisations and publicised as part of a culture of healthy debate and challenge when safeguarding and protecting children and young people

Take the time to…….

Read all the historical information about a child you are working with, it will support your practice and thinking about what has changed, the strengths and worries.

Did you know? The following links offer useful further information and guidance:

- ✓ Research in Practice: Hearing Children's Voices
- ✓ Use the tools and resources on the OSCB multi-agency toolkit and neglect webpages , Oxfordshire County Council's practitioner toolkit and the social workers toolbox (range of free tools and resources) to help you understand the child's world
- ✓ Watch 'Was not Heard' a short film by young people about youth voice and the importance of listening and creating safe environments of communication

If you do one thing…..

Spend time getting to know children, their family history and what life is like for them now. Be professionally curious to consider all possibilities and remember the importance of thinking the unthinkable in your practice, to safeguard children.