

South Gloucestershire Children's Partnership
Learning from Rapid Review
April 2021
Family D

Who are Family D?

Family D are a mum and two children. It has been widely reported in the media that mum and the youngest child were murdered in Scotland, and the older child survived. This learning brief does not relate to the investigation into what happened in any way, but looks simply at learning for professionals and organisations

Theme One: Professional Curiosity

What did we learn?

- Information taken at face value
- Process driven work without looking at wider picture
- Not enough consideration given about ways to contact a parent when details are not on the system
- Lack of curiosity shown when exploring the vulnerability of an adult

What should we do differently?

- Ask further questions, be nosy, explore what is happening. Be careful not to simply accept what is happening without thinking about why it is happening
- Make sure you hear the voice of the child and all key people in the child's life, don't rely on one person's view
- Explore what a day in the life of the person you are working with is like



Be a curious practitioner

The Children's Partnership held a multi agency rapid review to look for learning on 26th April 2021.



Professionals from 15 different agencies took part in the review

If my work comes to an end - who else needs to know what I know?

When English is not the first language, always consider use of interpreters

Seek evidence of Parental Responsibility

Theme Two: Working Together

What did we learn?

- Not all professionals knew who else was involved and didn't know about the Child in Need plan
- The professionals who saw the family most, had the least contact with other organisations
- Information was not shared as well as it could have been

What should we do differently?

- If you undertake an assessment think about who else should be told of the outcome, and who needs this noted in records
- At a transition point – for example changing school, closing a support package, change of team or service. Make sure other professionals know what is happening and share safeguarding records so that information is not lost
- Speak to families about who else they are working with

Theme Three: Parental Responsibility

What did we Learn?

- Evidence was not always sought to check who does and does not have Parental Responsibility (PR) for a child

What should we do differently?

- Make sure this is routine practice, and that confirmation of PR is always seen

Evidence of Good Practice

- Speedy assessment by Social Care, and quick practical support
- Swift move to locality social work team.
- Appropriate DVA coding on GP records for the family
- Good communication and relationships with education settings
- Additional resources, including a laptop, provided for home learning during covid
- Support for immigration status
- Regular contact from multiple agencies
- Good communication between agencies when unable to make contact
- Good multi agency response to missing episode

Theme Four: Children and Domestic Abuse

What did we learn?

- Two children left the home with their mother and were provided with emergency accommodation following a disclosure of domestic abuse, but there were other children in the home who remained.
- The remaining children were not considered by police or subsequently by children's social care despite living in the same house and witnessing the same incident.
- Lack of voice for mum in family court process

What should we do differently?

- Consider the impact of domestic abuse on all children within the family.
- Remain curious even when another agency has already made an assessment of risk
- Ensure all appropriate information is available to court, especially relevant while case are being heard in a virtual space and ensure parents are aware when the case is happening

What is happening Now?

There is a single agency and a multi agency action plan to ensure the learning identified throughout this process is acted on in a timely manner. This is being monitored by the Child Safeguarding Practice Review Sub group on behalf of the Executive of the Children's Partnership.