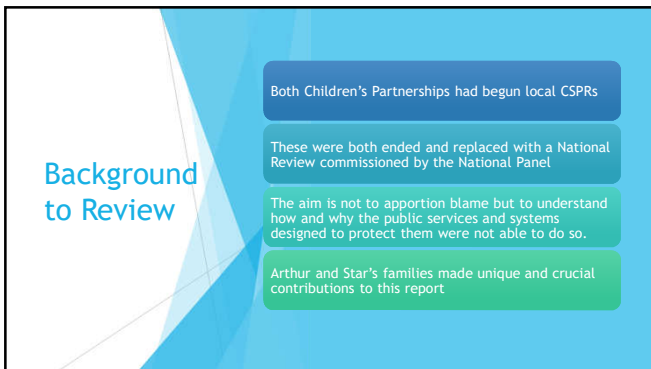


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3

Key Issues

Weaknesses in information sharing and seeking within and between agencies.

A lack of robust critical thinking and challenge within and between agencies, compounded by a failure to trigger statutory multi-agency child protection processes at a number of key moments.

A need for sharper specialist child protection skills and expertise, especially in relation to complex risk assessment and decision making; engaging reluctant parents; understanding the daily life of children; and domestic abuse.

Underpinning these issues, is the need for leaders to have a powerful enabling impact on child protection practice, creating and protecting the optimum organisational conditions for undertaking this complex work.

4

Two important factors

The review contends that multi-agency arrangements for protecting children are more fractured and fragmented than they should be

There has been insufficient attention to, and investment in, securing the specialist multi-agency expertise required for undertaking investigations and responses to significant harm from abuse and neglect.


5

Overarching recommendations

- ▶ Multi-Agency Child Protection Units - integrated and co-located multi-agency teams staffed by experienced child protection professionals - are established in every local authority area
- ▶ National Multi-Agency Practice Standards
- ▶ A new Ministerial group is created to oversee the implementation of these new arrangements

6

Reflection:
your initial
thoughts



7



Theme for Learning One
Listening to Families

8

Listening to Families

Arthur

- ▶ A total of 130 bruises were found on Arthur's body at the time of his death. Blood tests indicated very high levels of sodium, suggesting the possibility of salt poisoning

Who shared his voice

- ▶ Arthur's Paternal grandparents, Paternal Uncle and Maternal Grandmother all shared concerns regarding Arthur having bruises with Police and Childrens Social Care and their concerns that he was being abused.

Star

- ▶ Photographs as part of the police investigation show a sad child with many bruises on her legs, arms and face. These photographs are in stark contrast to earlier photos of the happy child taken by her extended family. Following her death there was evidence that Star had been physically assaulted on numerous occasions

Who shared her voice

- ▶ Star's Great Grandmother and Grandfather , shared concerns regarding her care as did her father and Uncle when she had bruises to her body and face.

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Challenging Our Own and Others Assumptions


- ▶ Contacts by family members viewed as malicious or **was it unsubstantiated** .
- ▶ Agencies not sure what to do with photographs- how to store and share, worry that images of the right child.
- ▶ Not enough weight given to what the images were showing- Children who are mobile do bruise, fall and fight. They don't need a CP medical???. What about underlying injuries and injuries seen by others.
- ▶ Paediatric view not sought or multiagency strategy held to consider causes or Think the Unthinkable. Multiagency approach strengthens information sharing and safety planning.
- ▶ Professional Optimism- Arthur had been exposed to past trauma. His father stated he had concerns regarding his behaviour. Camhs services reviewed him and acknowledge trauma, but were parent led and saw father as **protective factor in his care as he was providing stability for Arthur since he left his mothers care, who was in prison.** Arthur behaviour was linked to past trauma with no exploration of what could be happening for him at the time.

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How can we listen Better....

- ▶ A Think Family Approach- Gathering information from those who knew the children. Rather than viewing information from relatives/neighbours the community as malicious, viewing it as unsubstantiated and in need of exploration.
- ▶ Documenting names of family members, new partners ,changes in partners, who cares for the child. Do they bring support and safety or harm and risk. What is know about them. Who is in the room when you visit. Asking- who are you. What involvement do you have with the child.
- ▶ Use Family Trees Genograms across agencies with a willingness to share what you know if you are concerned.
- ▶ Be professionally curious, What is the childs behaviour trying to tell you. Think- What do you see when you look at me- The Child? How does my world around me affect me? What is my daily lived experience? Arthur and Star had both lived with extended family members at times, what was this loss like for them when ties were cut and contact stopped?
- ▶ Consider as a partnership- Past, Present and Potential Harm and the unthinkable rather than accepting immediate solutions.

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Theme for learning Two
The Day in the Life of a Child

13

'Professionals had only a limited understanding of what daily life was like for Star, beyond a superficial assessment from "one off" visits, which did not build on any historic information known by each agency. Star experienced a high level of disruption due to constant moves throughout her short life. No professionals understood this. The fact that she may have been experiencing serious and systematic physical and emotional abuse was never really considered and addressed.'

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What can we learn from Arthur and Stars Experiences?

- ▶ There was limited direct work with the families. For example, in Arthur's case, it was often the voice of his father that was heard by professionals rather than his own.
- ▶ There was a lack of reflection and further exploration into how the children and families presented themselves during visits.
- ▶ There were gaps in specialist skills around interrogating and analysing evidence; the versions of events given by parents were too readily accepted and photos provided by wider family members were not properly examined.
- ▶ In both cases, professionals were often kept at arm's length by those who were perpetrating abuse. For example, professionals were prevented from coming into contact with the child, or consent to share information was not provided.

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When do we get it right?

- ▶ When we focus on children and actively listen to what their words and behaviour tell us in a variety of environments.
- ▶ When we observe children and analyse what this tells us and use this to underpin our decision making.
- ▶ When we ensure that we consider what daily life is like for the children we work with- healthy challenge when this is not clear.
- ▶ When we seek information for a variety of sources to consider what children's day looks like not just take information from family at face value.
- ▶ When we look at what each child has experienced in their lifetime and consider what it might tell us about their needs.

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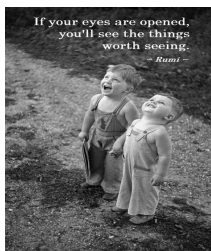
What practical action can we take



- ▶ Always spend time observing children when you visit them and spend time with them, even non mobile and non verbal children can tell us how they feel!
- ▶ Direct work about daily life can be really illuminating - use of toys, worksheets.
- ▶ Make it clear to parents/carers that you will spend time with their child and that this is a key part of you assessing their needs.
- ▶ Be curious about what the child's day looks like- if this is unclear think about why? Is this because we need more information or is the child "hidden" in parental interactions.
- ▶ Check out with other professionals what they have observed about the child- does it fit with what you have seen/heard. If there are differences, what is your hypothesis about this?
- ▶ If parents are reticent for you to spend time with their child- be curious with them about why, explore with other agencies what this means.

People look for flamingos when sparrows are all around them

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Close Encounters of the Third Kind

- ▶ Ground control: Pilots Flying over Indianapolis air space
- ▶ Pilot asks if there is any other traffic and ground control confirms there is a TWA and DC9 aircraft and also confirms that there is no other high or low altitude aircraft.
- ▶ Pilot: unknown aircraft type – no distinct outline but its brilliant / brightest thing seen. It changes from white to red. Its striking. Possibly extra bright landing lights. It's luminous and displays **non-ballistic motion**. (When a UFO is **recognised** it has to be **referred** and **responded** to but no one took **responsibility** for doing so despite the need to do so being voiced aloud)

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Watch the clip

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What is non-ballistic motion?

- ▶ EVERYTHING moves ballistically, along parabolic curves, as the kinetic energy of an object is dissipated during the course of its motion along a path. So for something to exhibit "non-ballistic motion", it would inherently need to defy the laws of physics as we currently understand them.*
- ▶ They all recognised the sighting of a UFO but didn't want to refer this as they were concerned about the **response** they would get.
- ▶ Individual elements of what they saw were "normal": e.g. Other actual identified flying objects / lights / brightness / brilliant luminosity / changing colours. Although the combination of elements seen in the close encounter along with the non-ballistic motion was not normal no one was willing to actually take responsibility and act....

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Close Encounters of the Third Kind

- ▶ **Close Encounters of different kinds:**
- ▶ The first Kind: Seeing a UFO less than 500 feet away
- ▶ The Second kind: Some physical effect such as electronic interference / physiological effect
- ▶ The Third Kind: Presence of an animated creature such as an apparent UFO pilot

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What went wrong in Close encounters?

- ▶ **Recognition** - they looked and saw but didn't acknowledge / want to see it; they tried to 'normalise' the evidence
- ▶ **Referral** - they had information but lacked persuasion when discussing the evidence
- ▶ **Response** - they listened to the concerns / evidence but didn't hear it / didn't want to hear it!!

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Close Encounters of the Protective kind The 3 'R's + 1

- ▶ The first Kind: **Recognition:** Use of your Vision: **Look and See**
- ▶ The second kind: **Referral:** Use of your Voice / Speech: **Inform and persuade**
- ▶ The third kind: **Response:** Use of your ears / Audio: **Listen and hear / Read and comprehend**
- ▶ The Fourth Kind: **Responsibility** – is 'having a **duty** to deal with something or having control over someone'. It requires action to be taken. Take it!!

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What went wrong for Arthur and Star?

When reading the National Review identify the Failures of the 3 'R's' + 1:

- ▶ Recognition
- ▶ Referral
- ▶ Responses
- ▶ Responsibility

▶ Let us all learn from these and when we have a close encounter of the protective kind take responsibility and act!

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Theme for Learning Three

- ▶ Domestic Abuse

Ensure practitioners know how to respond to incidents of domestic abuse and have a clear understanding of coercive and controlling behaviour, including female perpetrators and as well as the impact of domestic abuse on children'

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Domestic Abuse: What went wrong?

- ▶ The biological parents of both Arthur and Star were not fully aware of their new partners previous Domestic Abuse history.
- ▶ In Star's case a safeguarding referral was made to Children Social Care by a local Domestic Abuse Provider, however Savannah Brockhill was not named on that referral.
- ▶ At the time Star and Arthur who were living in households where there was Domestic Abuse would not have been classified as 'Victims'.
- ▶ Extended family expressed concerns about both Child Abuse and Domestic Abuse, yet these concerns were dismissed.

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Facts & Statistics on Domestic Abuse

Living in a home where Domestic Abuse happens can have a serious impact on a child or young person's physical and mental wellbeing as well as their behaviour, which can last into adulthood.

1 in 5 children under the age of 18 will have lived with an adult perpetrating Domestic Abuse during some point in their childhood (Refuge Stats)

Data from 2020 (WomensAid) suggests children and young people make up more than half of those who live in a refuge

Domestic Abuse was a factor in over 40% of Child Safeguarding Practice Reviews (2021)

Children who witness domestic abuse between parents may also be at greater risk of being violent in their future relationships

3800 reports of DA were made to A&S Police in S.Glos between Jan-Sept 2022. This is about a 50/50 split of Crimes and Non Crimes.

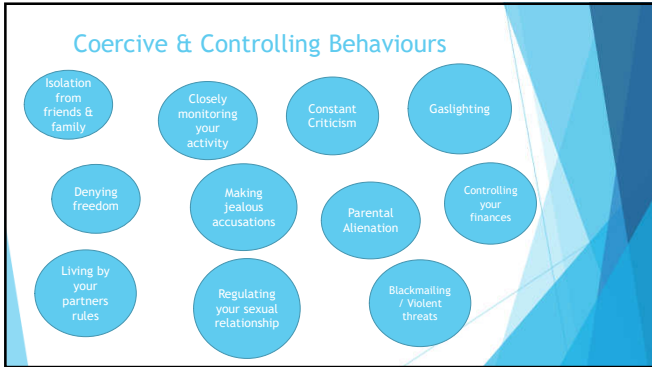
Across the Force Domestic Abuse makes up about 20% of all recorded crimes

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New Legislation: Domestic Abuse Act 2021

- ▶ The new statutory definition of domestic abuse, emphasizes that domestic abuse is not just physical violence, but can also be emotional, controlling or coercive, and economic abuse. It also extends the controlling or coercive behaviour offence to cover post-separation abuse.
- ▶ For the first time, following the passing of the Domestic Abuse Act 2021 Children who live in a home where domestic abuse takes place are now being recognised as victims in their own right rather than just witnesses. This change gives them more rights and should ensure locally commissioned services consider and address the needs of the child/ren in addition to the adult victim.
- ▶ The law will provide a new Domestic Abuse Protection Notice and Domestic Abuse Protection Order
- ▶ Places the guidance supporting the Domestic Violence Disclosure Scheme ("Clare's law") on a statutory footing.

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What can we as Practitioners do differently?

- ▶ Consider utilising the Domestic Violence Disclosure Scheme (DVDS), whether this be encouraging an individual to pursue an application, or submitting one on their behalf.
- ▶ Be 'professionally curious' & ask questions which glean further information
- ▶ Ensure full & accurate information gets included on inter-agency referral forms
- ▶ Use the online reporting tool to report a Crime or Intelligence which doesn't require an emergency response [Report | Avon and Somerset Police](#)
- ▶ MARAC Referral for High Risk Cases
- ▶ Keep up our own CPD & Training around Domestic Abuse
- ▶ Language Matters- In Avon and Somerset we want to change the language to enable a more conscious and trauma-informed approach for Victims of DA

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Theme for Learning Four

- ▶ Professional Optimism & Curiosity

Assessments were often overly optimistic and lacking 'professional curiosity' in testing out parental self-reporting. They were too parent-focused and not always considering all adults in the household

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What is Professional Curiosity?

- ▶ Professional curiosity is the capacity and communication skill to explore and understand what is happening with an individual or family.
- ▶ It requires you to not accept things at face value, to be inquisitive and not make assumptions.
- ▶ You need to 'think outside the box' and consider people's circumstances holistically.
- ▶ It is about enquiring more deeply, using proactive questioning and challenge
- ▶ Curious professionals engage with individuals and families through visits, conversations, observations and asking relevant questions to gather historical and current information.

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What skills are needed to exercise professional curiosity?



LOOK



LISTEN



ASK



CHECK OUT

35

What gets in the way of professional curiosity?




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Professional curiosity is likely to flourish when practitioners:

- Are able to 'walk in the shoes' of the person and consider the situation from their lives experience
- See the child/family in a range of settings, alone and in the context of their family
- Are not reliant on a singular view: be that of a family or member of the network around the child
- Understand the cumulative impact of multiple or combined risk factors - trigger trio and think about gathering information within the context
- Have an analytical and reflective approach to their work and the information they gather from a range of sources
- Have good management support and good quality supervision
- Have skills, confidence and knowledge to hold difficult conversations and are happy to raise concerns and challenge information appropriately
- Appreciate that respectful scepticism/robustness and challenge are healthy, questioning what you are told is ok as long as you do it in a respectful way.

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Top Tips

- Build relationships and spend time getting to know the child, family and network
- Question your own assumptions about how families function
- Don't be overly optimistic, healthy scepticism is good
- Be willing to have challenging conversations
- Expect the unexpected, think the unthinkable, believe the unbelievable
- DEAL - *"I need to point out something that you may not be aware of... Describe - I need to point out that every time I ask a question, you interrupt me Explain - this makes it difficult to progress matters - and will take me much longer to finish... Action- please do not interrupt, please allow me to finish my Question - I'll do the same for you Likely - if you keep interrupting me ...I'll have no other option than to end the meeting"*
- EARS - Elicit, amplify, reflect, start over
- Understand history to consider cumulative impact or combined risk factors - chronologies are key to helping this
- Articulate your intuition into an evidence based professional view

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Where can I find out more?

-  You can read the full report [here](#)
-  The NSPCC have produced a helpful summary - read it [here](#)

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