BROMLEY SAFEGUARDING CHILDREN PARTNERSHIP

LEARNING SUMMARY 2021-23

April 2023

Bromley Safeguarding Children Partnership

SUMMARY OF LEARNING

Bromley Safeguarding Children Partnership (BSCP) conducts reviews and multi-agency audits each year.

As well as our own reviews, we also contribute to other local partnership reviews (such as Domestic Homicide Reviews, if the victim was a young adult or had children who suffered harm) and we can also have a role in other areas' reviews. This short paper summarises some key learning from our work over the last two years. Some of the learning is similar to what we have identified before and where this is the case, we have given a reference to the case.

This document is for the purposes of learning for the children's workforce in Bromley, who continuously strive to do the best we can for our children, young people and families.

MULTI AGENCY AUDIT

In December 2022, the BSCP carried out a multi-agency audit on the theme of extra-familial harm / serious youth violence and how Bromley partners are able to best prevent and respond to the factors behind the risks this poses to young people in the Borough. The audit focused on the young people who were stabbed during Summer 2022.

The BSCP held a multi-agency workshop in Jan 2023 to explore the learning from the audits. Partners came together from CSC, Schools, Police, Youth Service, Community Healthcare, Probation, Drug and Alcohol Service and Housing.
The key learning was about:

- Importance of information sharing (particularly with schools and GPs)
- collecting and analysing information
- resource differentials across the partnership
- effective methods of engaging with young people at risk of extra-familial harm ('teachable moments', being creative to encourage engagement)
- importance of early help (particularly speech and language therapy, and interventions to avoid school exclusion).

Detailed learning will be shared with all practitioners soon. In the meantime, watch our BSCP lunchtime learning session (44 mins), recorded in April, explaining how childhood trauma and ACEs affect children and young people's behaviour through changes to executive brain function.

Summaries of our reviews can be found on our website www.bromleysafeguarding.org

Each Review has an Action Plan agreed to address the recommendations made in the report. These are monitored quarterly in the BSCP Performance, Challenge and Impact Subgroup.

NSPCC REPOSITORY

The NSPCC holds a copy of every statutory review published. It can be searched by topic as well as area and date. This is a rich resource and free to use.

Search NSPCC Repository.

FGM PATHWAY AUDITS 2022

We completed Learning Review 'Natalie' and published a summary in April 2020. The recommendations were undertaken but one audit remained a challenge. This was audited twice in 2022 and we are now assured that we identify baby girls born to mothers who have suffered FGM, adding warning flags to the health visitor records of children as with other safeguarding risks. We need to further improve how GPs can easily see FGM alerts for infant girls.

The number of women who have suffered FGM is very low in Bromley but practitioners need to be aware of our local FGM Protocol and flowchart

Key learning from the original review and subsequent case audits which remain relevant:

- Be aware of the father's views about FGM, and those of his family, as well as assessment of the history and views of the mother
- Ensure staff are trained on FGM and how to conduct a proportionate risk assessment
- Continue to ensure FGM of mother is noted clearly on all maternity discharge summaries so GPs and Health Visitors are aware and add appropriate alert to own recording system.

TABLETOP REVIEWS

Where a case does not meet the criteria for a Child Safeguarding Practice Review, we may still choose to investigate further if we feel there is further learning to be had.

In 2021 we held a tabletop review on a vulnerable young adult who died by suicide and a young perpetrator who committed homicide in another London borough. Both had difficult family relationships, experienced negative external influences, were exluded from school, suffered with mental ill-health and participated to varying degrees in drug use.

Some of the learning was similar to that in our Learning Review 'Leo' (summary on BSCP website) such as:

- The importance of involving Housing in operational safeguarding discussions
- The need to use Strategy Meetings for complex cases
- Assessing and engaging fathers
- Professional curiosity and deeper analysis during SWA, including lived experience of other siblings, and what life is like outside school for them
- Quality of recordkeeping, use of genograms/ecomaps by CSC
- Importance of applying Was Not Brought policies when children do not attend appointments
- Importance of quality supervision to enable reflective practice and challenge/ oversight/ management direction
- More expertise in acknowledging increased risks to black boys in contextual safeguarding and reflecting this in assessments and work undertaken
- More expertise amongst workforce of contextual safeguarding risks, CCE, gangs and serious youth violence and the preventative services available
- Multiple referrals from different agencies is a red flag

Specific learning from the Tabletop Review included:

- Use the 2016 Home Office APVA guidance on children who represent a risk to parent/carers
- Ensure there is clarity about diagnoses (or what is being considered in a differential diagnosis) when sharing information about a child/YP. Each agency to record accurately in own organisation's records who gave the diagnosis and when. Contradictory findings to be discussed in TAF/TAC/Core Group to ensure clarity.
- Explore how we provide better support to YP and their families when we do so on the basis of their voluntary engagement.

JOINT TABLETOP REVIEW WITH BROMLEY SAFEGUARDING ADULTS BOARD

In 2022, the BSCP and BSAB carried out a tabletop review regarding a young adult whose newborn baby died at birth due to complications associated with uncontrolled diabetes. Although the death of the baby did not meet the threshold for CSPR, it was agreed that there was learning with regard to the mother's transition between children and adult's services.

We used learning from this particular case as part of a discussion more broadly about transitional safeguarding.
An Action Plan is being drawn up in Spring 2023.

Early learning includes:

- Need for advocacy and support outside statutory services
- Consideration of a 'vulnerable panel' from children's to adult's services for those without SEND
- Raising awareness of the significance of housing issues
- Impact of uncontrolled diabetes and its link with safeguarding
- Professional awareness of impact of trauma/abuse on executive function (watch our video for learning summary)
- Understanding of mental capacity and what this means for safeguarding professionals

REFLECTIVE LEARNING 'CHILD O'

It is important to reflect on our practice when we receive negative feedback. In December 2021, partners spent half a day looking in depth at the case of 'Child O' following a Court decision to send her home to her family with no Court Orders and therefore no statutory role for Children's Social Care.

Learning which may impact on other cases:

Complex mental health with varying diagnoses over time can make it difficult for non-health professionals to understand how parents are managing a young person's mental health difficulties. The focus of concern initially began with atypical eating disorder, with queries around ASD, OCD and unusual experiences. She was later diagnosed with ASD. It is common for parents to become involved in the routines and rituals of young people with OCD.

It can be helpful for professionals to better understand different types of mental health conditions and how they can co-exist.

Child O was diagnosed with Autistic Spectrum Disorder (ASD) aged 16 as part of the Court Ordered Assessment. Some professionals questioned whether they would have worked differently with O if her neurodiversity was known at a younger age.

When parents use private therapies and alternative healthcare, it is difficult for professionals to know what is being provided. This information is not recorded on NHS files. The parent holds this information and chooses what to share. O's first Child Protection Plan recorded that the parents preferred to use private therapies but there is no evidence in statutory service records that this took place. The difficulties of having oversight of non-NHS health interventions was also a finding in Learning Review Matthew.

RAPID REVIEWS

We have held two Rapid Review Meetings in the last 12 months. One for the newborn baby mentioned in the article above and the other regarding a sibling child sexual abuse case. The latter will be a Local Child Safeguarding Practice Review in 2023. We are currently agreeing the terms of reference for the CSPR and seeking to appoint an independent reviewer.

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THEMATIC REVIEW: ‘Patrick’ – A journey through custody

In 2022, we started a thematic review to analyse in more depth the journey of a child through custody. We used a specific case study of ‘Patrick’ due to the young man’s pattern of being moved around to different youth offending services and institutions (seventeen in two years), with lack of consistent support, frequent confrontations and attempts to self-harm.

The Independent Reviewer made 14 recommendations.

Learning themes include: the impact of permanent school exclusion on a child, adultification of children in the criminal justice system, importance of having a high level of professional curiosity for children placed in the secure estate and to understand the child’s lived experience, assessment of behaviour of children looked after in secure settings, ensuring young people have sufficient support to rehabilitate into the community and are able to cope with semi-independent living, ensure children in secure estate gain access to the education they need, address the barriers for children in care or in secure estate to access mental health support, ensure access to advocacy.

Learning will be shared in more detail in the coming months. Look out for our video.

LEWISHAM REVIEWS

Bromley services have been involved in Lewisham’s CSPR for Child FA, and DHR ‘Kate’ in the last two years.

CSPR FA focused on the impact of domestic abuse on children. Learning related mainly to practice in Lewisham, for instance, where one sibling was placed on a CPP without consideration of other siblings. The learning for Bromley focused on cultural assumptions and disproportionality. If there had been more professional curiosity about the father and his cultural beliefs and how that influenced his parenting and his beliefs around the motivations and intentions of professional agencies, that may have improved the quality of transfer to Lewisham.

There were also issues around the perception of the mother’s view because of her mental health. This perception affected the depth of exploration into the lived experience of the child in that house. The father was perceived as the protective factor and was believed more than the mother.

Learning from DHR Kate included:

- Decisions should not be passed solely on the information provided by referring agencies. Decisions should also consider historical information known to the agency. (There was no evidence that all five DA incidents were assessed as a series of events).
- The importance of taking a whole family perspective in order to adequately assess the potential risks.

BROMLEY Domestic Homicide Reviews

DHR ‘Najara’ is with the Home Office for agreement. The BSCP co-chaired this review given the significant impact on the children. Learning events will follow post publication. Following the DHR panel meetings, a review of the Bromley MARAC took place and a significant additional number of domestic abuse training sessions were commissioned by BSCP and Bromley Adults Safeguarding Board jointly.