# Child Safeguarding Practice Review

## Practitioner Brief: Child AC

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Date: March 2022

Publication Date:
4th March 2022

Children's Safeguarding Assurance Partnership

Blackburn with Darwen - Blackpool - Lancashire

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## Background

Child AC was 14 years old and lived at home with her mother and sibling in her mother's ex-partner's rented property. The family were known to several agencies in Lancashire during the period of the review. AC attended a secondary school where she received counselling, pastoral support, and support from the Education Attendance Team. AC also received health services from the school nursing service. In June 2020, AC was admitted to hospital due to breathing difficulties, having collapsed at home. She presented as malnourished, had a significant infestation of head lice, and had multiple organ failure. A strategy meeting was convened and subsequently care proceedings were initiated and AC was placed with a foster carer.

## The effectiveness of early help

A Children and Families Wellbeing service (CFW) referral was made by the school, requesting support with identifying a new tenancy for AC's family. The subsequent assessment identified that the family was living with mother's former partner. The plan was closed within 3 months as a new tenancy was secured for mother. Work to support mother into employment was not achieved. Before the case was closed school contacted mother to support with uniform but she declined-this was not shared with CFW.
In September 2019, the school made a referral to the school nurse to support the management of AC's headlice but the school nurse did not understand the level of concern about the headlice as the referral was not a safeguarding referral. Universal support was offered. In March 2020, the Covid-19 pandemic lockdown started, Phone contact was made through mother. No professionals spoke to AC directly.

*Assessments should incorporate views of children and young people to ensure there is a record;

*When an early help assessment is completed, all identified issues should be incorporated into the plan. Any new issues should be discussed at meetings for inclusion in the plan;

*When a plan is closed, outstanding issues should be relayed to relevant professionals;

*Practitioners should contact the child to ensure their safety and wellbeing, rather than rely on parental reporting.

## Voice of the child

AC was an articulate young person who was able to verbalise her views and sought appropriate support from school staff. The school arranged for a learning mentor who mother had a positive relationship with and who she spoke to during lockdown however, AC was not spoken to. As part of the RADAR assessment by CFW, AC was spoken, but her views were not incorporated into the plan.
The school nurse provided support for headlice via AC's mother but did not directly support AC. The service had no contact with AC during lockdown as AC was only open to universal services.

*A child's views should be incorporated into the written assessment and plans, so they are available for current and future reference

*The lack of contact with AC by the school nursing service meant that they did not have a clear understanding of the impact of headlice and how it was being managed

## Multi-agency response to concerns about neglect

Practitioners did not recognise that AC was experiencing neglect as there were improved periods in her circumstances. Prior to the significant incident, there was evidence of emerging neglect. AC had persistent headlice which were not clearing. Her school attendance was poor and school did not consider this may have been a means to keep AC away from surveillance by staff. The absence of a full assessment at that point of AC's unmet needs meant that practitioners did not have a true picture and had not considered whether she was experiencing neglectful parenting. The school nurse supported the family but was not proactive in following up progress and did not recognise the neglect.

*The safeguarding system should enable practitioners to consider that children's needs may be neglected.

*The Neglect assessment tool should be used when there are concerns indicative of neglect

## Working with the challenge of limited engagement from families

Mother was quite closed and did not give a clear picture of the family's history and situation-she could also be contradictory. When AC first developed persistent headlice the school staff had several discussions with mother who seemed embarrassed but was also, on occasion, abusive towards staff. As a result of this and mother's inability to make improvements for AC school staff spoke to mother's former partner. This was not appropriate as he was no longer in a relationship with mother and did not have parental responsibility. This also meant that the focus moved from mum and was likely to have deflected from identifying that AC's needs were being neglected. It is likely that the impact of the pandemic and the school closure prevented professionals from challenging AC's mother.

*Ambiguous information provided by parent/carer should be triangulated from other sources to ensure that it is accurate and provides a shared understanding

*Practitioners should be professionally curious and practice respectful uncertainty to ensure information provided is accurate and clearly understood.

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