Children's Learning Lessons: Child J1 - Practitioner Learning Brief

Background

in 2020, Child J1 (7 years old) collapsed in school having ingested a bag of white powder, one of nine that he had brought into school in a kinder egg. Child J1 was transported to hospital where he was found to have cocaine in his system although testing of the remaining white powder did not prove positive for a class A drug. Child J1 and sibling were removed from mothers care. A police investigation commenced in relation to neglect and possession of controlled drugs. The investigation was finalised with a decision of No Further Action due to insufficient evidence.

Good Practice:

Direct supervision was sought by the school nurse from the safeguarding team. The safeguarding children team and midwifery safeguarding team evidenced shared concern and professional challenge. This resulted in a meeting between the social care and a follow up with multiagency safeguarding supervision.

A school based family worker was allocated to provide parenting advice and support to mum after the local authority family worker withdrew due to non-engagement.

GMP officers tried to engage with Child J1. The officers have tried their best to find interesting ways to engage with him and to gauge whether there are any concerns.

Themes

Impact of ACES on Parenting Capacity

Historical information to better inform practitioners was not sought as part of the assessment. As a result there was little consideration of mothers childhood trauma and mental health diagnoses on her parenting abilities. Childs J1's lived experience was not considered or fully understood. Multi agency concerns for Child J1 were not addressed in a timely manner . It is also not clear how frequently Child J1 was seen or whether he was seen alone separately from his mother.

Over reliance on self-report by mother:

Due to Covid19 , a number of professionals were unable to visit the family on a face to face basis. Child J1's behaviours became the focus for many practitioners, rather than exhibiting professional curiosity as to the underlying reasons for these behaviours. Mothers suggestion that these behaviours stemmed from the trauma Child J1 had already suffered and a possible diagnosis of ADHD were too willingly accepted.

Mother reported she was struggling to manage Child J1's behaviours and queried ADHD on many occasions..

Ineffective use of processes and tools:

Processes and tools designed to assist practitioners to keep children safe were not used effectively. During the review period two Child and Family Assessments were completed however there is no evidence that the children's lived experience was understood.

In addition there was no evidence that the individuals who raised initial concerns were spoken to as part of these assessments despite them holding key information.

There was inconsistent use of policies and procedures in relation to physical injuries with only one CP medical taking place during the period under review.

Issues in relation to practice:

-There was a lack of professional curiosity

-Child and Family assessments lacked breadth and depth. Fathers and the wider family were not included, information was not triangulated & practice standards were not adhered to, leading to gaps in the risk assessment.

-Managerial oversight was not sufficiently robust to identify and challenge frontline practice

-CIN/CP plans were not robust with actions not reviewed

-The voice of mother overshadowed the voice of J1

-Opportunities to gain a greater understanding of Child J1 and siblings lived experience were missed.

What did we learn?

-Covid-19 had an impact on services at the time of this incident. Direct work was reduced and practitioners became over reliant on mothers self-reporting of the family situation.

- A reduction in face to face contact made it difficult for practitioners to establish whether there were genuine reasons for non-attendance or whether there was avoidance of services or any disguised compliance.

-Whilst information relating to alleged maternal drug use was shared by partner agencies, this information was then not consistently shared across the whole partnership leaving some practitioners unaware of the police involvement within the household. It was also not known the extent to Mother's historic drug use which was important in assessing the risk to J1.

-Significant information was known to a number of agencies regarding the family dynamic. Assessments present opportunities for practitioners to increase their knowledge regarding children, parents and the wider family and the level of risk individuals pose. The assessments completed in this case were incomplete. Key individuals were not spoken to and are not included in terms of assessing the risk or benefits they might bring. This suggests practitioners were not sufficiently curious about the level of involvement of the wider family in mother and the children's lives.

What needs to happen?

- Whilst escalation processes and multi-agency supervision were sought in this case, ultimately the final decisions were made by a single agency. The purpose of managerial oversight is to both support and challenge frontline practice and encourage wider thinking. Managers need to acknowledge the work undertaken but also identify/make plans to address any gaps or shortfalls within assessments and plans. Partnership working and decision making needs to be strengthened and the multi-agency supervision processes formalised
- Explore the effectiveness of Child Protection/ Child in Need assessments and forums in managing risk and assessing, recognising and responding to neglect.

Click here for the Neglect Screening Tool

Click here for the RBSCP Escalation Policy

Click here to book on the Neglect Training Rochdale Safeguarding Events