Stephen Child Safeguarding Practice Review 6 Step Briefing

The Background

Stephen is an 8-year-old boy who lives in Southampton with his mother, stepfather, and older sibling, and he also has another older sibling who lives elsewhere. 4 months after Stephen was born, he was also made subject to child protection planning, and these plans ended in 2016. During this time the Public Law Outline process was started, with regards to Stephen's older sibling, however, did not progress.

In February 2021, housing received complaints around the accumulation of rubbish both inside and outside the property which continued to escalate until April 2021 when a housing officer visited the property.

Stephen was not in school, and attempts were being made by the Elective Home Education Team to engage the family by phone, letter, and attempted home visits. Whilst mother engaged with some phone conversations advising that Stephen had autism, no member of the team was able to see Stephen, and in December 2021, the local authority applied for and obtained a School Attendance Order.

The Incident

On 13 December 2021, the police executed a warrant with regards to Stephen's stepfather and attended the home address. The police raised concerns around poor home conditions as well as Stephen's presentation. Stephen's mother reported that Stephen was autistic, did not like wearing clothes, and was being electively home educated.

A referral was made to the Multi-Agency Safeguarding Hub and a strategy discussion was held with the outcome of a s47 child protection investigation. The police and a Social Worker visited the property on 15 December 2021, and Stephen's mother was advised to make improvements to the living conditions. Following another visit on 16 December 2021, it was felt that little progress had been made, and Stephen was removed by the police using their Police Powers of Protection. The local authority subsequently applied for and obtained an Emergency Protection Order, with care proceedings being initiated. A child protection medical was also undertaken where it was felt that Stephen had suffered chronic neglect. Stephen has since returned to the care of his parents in 2022.

The Review

The Southampton Safeguarding Children Partnership concluded that the circumstances surrounding Stephen's removal met the criteria for completion of a Local Child Safeguarding Practice Review (LCSPR) which was agreed by the National Panel in May 2022. An independent reviewer was commissioned to complete the LCSPR, which encompassed a period from 01 January 2020 to 31 December 2021.

Stephen's mother and stepfather were informed of the review and decided that they wished to become involved in April 2023, at which time a meeting with the independent reviewer was arranged.

It was originally agreed that the independent reviewer would base the review on information gathered throughout the rapid review process from involved agencies, however after meeting with Stephen's mother, the independent reviewer requested additional information from agencies, and a learning event for practitioners who have worked with Stephen was also arranged.

Key Lines of Enquiry

The key lines of enquiry considered by the review are as follows:

- The Impact of the COVID Pandemic and the response of services to the family
- The Impact of 'was not brought' to health appointments
- Information sharing and professional challenge
- Professional curiosity
- The importance of following statutory guidance

Findings

- Agencies attempted to engage with Stephen's mother and stepfather, however the Covid-19 pandemic gave the family a reason as to why practitioners could not come into the family home. The restrictions imposed throughout the pandemic exacerbated the problems for agencies in gaining access to Stephen, alongside difficulties in gaining engagement with services.
- The review noted that following the concerns raised in April 2021 about the home conditions and stepfather's return to the family home, a strategy discussion should have been convened at this time for information sharing to be undertaken.
- Stephen was not brought to health appointments, and this mainly related to the MMR vaccination. It is acknowledged that although recommended, this is not a mandatory immunization. Stephen was rarely seen after the age of 12 months, although the review notes that there was no evidence that Stephen's mother was invited for Stephen's 2-year check. The review also noted that Stephen had not yet been assessed for autism.
- The review felt that Stephen's mother and stepfather needed to have had greater challenge about their not wishing to work with services as well as with regards to the care afforded to Stephen. The information provided to review, suggests that the care afforded to Stephen was not good enough.
- Practitioners at the learning event agreed that professionals need to have a greater understanding of traumatic impact and psychological damage being placed in to care can have on children.
- There needed to be a greater level of professional curiosity with regards to the explanations provided by Stephen's mother and stepfather. The review felt that there were missed opportunities to intervene with regards to Stephen.

Recommendations

- The SSCP to raise awareness amongst partner agencies of Working with Resistant Parents Guidance, to reinforce its importance as a tool for working with children who are vulnerable.
- Partner agencies to remind practitioners of the importance of considering a child's lived experience of their home environment and to question whether the care offered to a child is 'good enough' to guarantee their safety, health and wellbeing.
- When a child suffers significant trauma as a result of being removed from their parents' care, consideration needs to be given to ensuring the provision of bespoke, professional therapeutic intervention is in place on their return to the family and/or if they remain a Looked After Child.
- Practitioners to be reminded to verify accounts provided by parents/carers and to ensure that information is shared within and between agencies to enable a holistic approach to safeguarding children.
- Consideration to be given to sharing information between Solent NHS Trust and SCC Early years to identify children who have not been brought for their health review at age 2 (HR2) and children who have not taken up the offer of two-year funding.
- When commissioning a Local Child Safeguarding Practice Review, the SSCP needs to ensure that statutory procedures, as set down in Working Together to Safeguard Children, 2018, Chapter 4, are followed if delay is to be avoided.

Useful Links for Best Practice

1. Working together to safeguard children - GOV.UK (www.gov.uk)
2. Neglect Toolkit – Southampton Safeguarding Children Partnership (southamptonscp.org.uk)
3. Working with Resistant Families – Southampton Safeguarding Children Partnership (southamptonscp.org.uk)