Repeat Child Protection Plan (CP) - Analysis Briefing Paper

Summary

An analysis of 16 families, 38 children, who presented to conference for a second or subsequent time was undertaken to gain an understanding of the reasons why children where subject to further child protection planning. In Southampton our repeat Child Protection Conferences data is higher than our neighbouring authorities so the analysis undertaken was completed to establish if we can learn from findings and adapt our practice.

In Southampton we undertake two types of conferences, risk inside the home and Risk Outside the Home (ROTH). The data submitted does not differentiate between the two types of conferences we hold within Southampton; this can produce a negative return as currently it is not a legal requirement to submit data to the DFE regarding how many children are subject to a ROTH conference. Part of the analysis was to understand if this was having an impact on our data as our neighbouring authorities within the LSPB do not hold ROTH conferences at this time.

It was also important to evaluate the reasons for repeat Child Protection (CP) planning to gain an understanding of what lessons can be learned to improve future practices. This will ensure sustainable change for the families we work with and reduce the risks children are exposed to. During Q4 172 conferences were held, 16 of these families had previously been subject to Child protection plans. It was established throughout the analysis all cases reviewed were risks within the home environment. 8 families had returned to CP planning within 2 years, all other cases presented following 2 years plus.

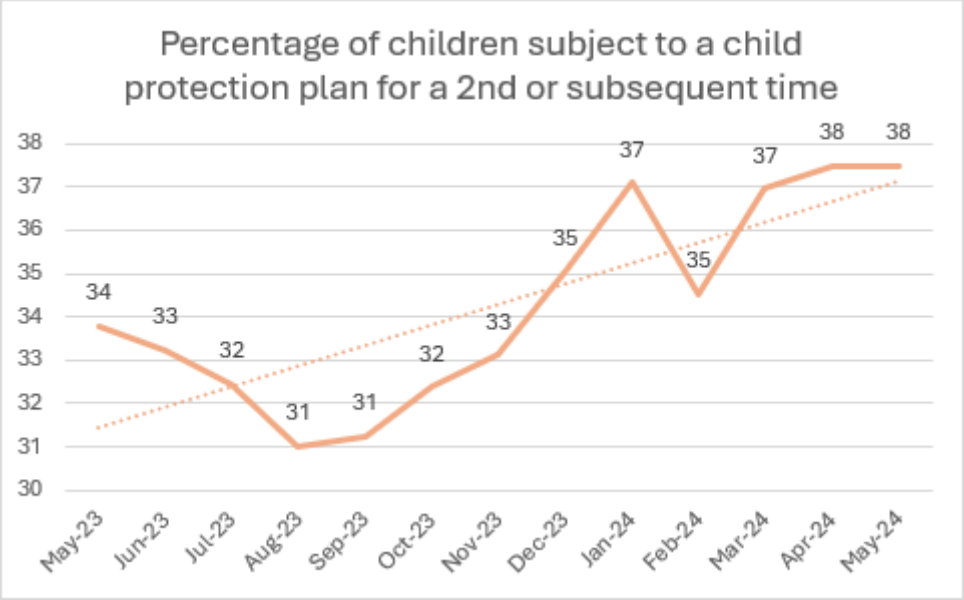
The analysis will provide a useful benchmark to measure the success of the Family Safeguarding Model within Southampton. It will also address any learned lessons making recommendations which can be embedded in future practice going forward to reduce the frequency of repeat child protection plans.

Background

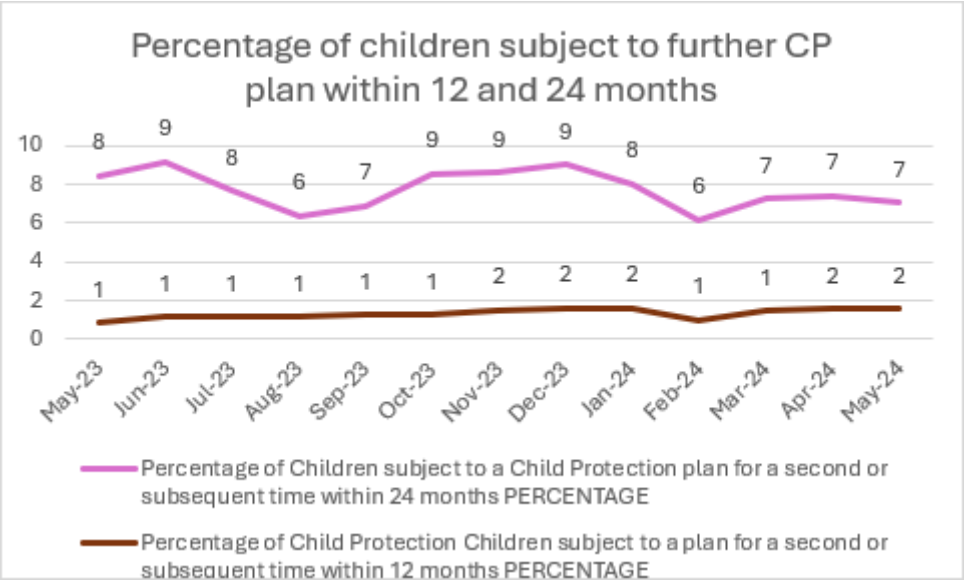
Analysis of Q4 data for the South East, spanning January to March 2024, shows that, of the total children subject to a CP plan in Southampton, 33% had previously been on a CP Plan at any time previously in their lives. Only 3% of the total number of children on a CP plan had been on a CP plan in the preceding two years.

Within the Southeast region, 26% of children had previously been on a CP Plan and 12% had been on a CP plan within the previous 2 years. This highlights that whilst there are a higher proportion of children in Southampton who have previously been on CP planning than in other Authorities in the area, significantly fewer have needed to go back on CP planning within 2 years. Our closest statistical neighbours within the region, Portsmouth, have figures of 41% at any time and 26% in the preceding 2 years.

Data shows an increase in the percentage of children subject to CP planning for a second or subsequent time, and a projected increase in the trajectory.



There appears to be a more stable picture for the percentage of children who were made subject to repeat CP planning for the second (or subsequent) time over a 12- or 24-month period.



The Local Authority has been embedding systemic social work into practice throughout the workforce. This would not have been available to practitioners or have been employed in practice during the preceding period of CP planning. Therefore, any impact that this has in relation to sustainability of change intervention will not be reflected in this analysis. The Systemic Practice Model was introduced between 28/04/2022 and 21/11/2022 to form part of the Destination 22 transformational programme. An evaluation of the model was completed in July 2023 which refers to Systemic Practice as “starting to embed”. The three cases that had a repeat CP plan within 1 year supports this.

The Local Authority has also introduced the Safe and Together model of intervention with families in which domestic abuse is a risk, alongside employing designated practitioners to work with male perpetrators to provide meaningful intervention and a

shift in thinking and acceptance which will then enable them to access evidence-based intervention programmes to reduce risk and impact of domestic abuse by holding perpetrators accountable for their behaviour and choices and supporting them to develop alternative strategies to manage at times of stress, pressure, anger and conflict. This intervention was not available previously and, instead, focussed on adopting an approach whereby the victim was required to take responsibility for her own and her children's safety within a challenging environment where in so doing she may actually increase risk. In all cases reviewed the female was the victim of domestic abuse. Whilst there continue to be examples of male perpetrators disengaging from the planning process, the focus of the work with victims is now on partnering with them to look at how they create safety and ways they can build on this. The impact of this approach in reducing risk of future harm and repeating patterns of behaviour / experience will not be able to be assessed during this analysis, as it was not available to the families in the timeframes of the preceding planning for these families.

The Local Authority has now partnered with Hertfordshire to look to embed the Family Safeguarding Model. Training is currently underway with a view to this being launched imminently and the Local Authority is working with partner agencies with a view to accessing additional expert resources required to roll out this model. All practitioners are required to attend a 2-day training course in Motivational Interviewing. It is anticipated that the use of this methodology will support sustainable change alongside social workers using the neglect toolkit when dealing with neglect.

Methodology

An audit tool was devised which the Independent Child Protection Chairs have used on a sample of 38 children from 16 families subject to repeat CP planning. These were then collated and analysed overall against themes that appeared to be emerging. This enabled there to be quantitative information gathering alongside the qualitative information.

Findings

The results found from the 16 families analysed, 3 families had repeat CP planning within 1 year, 5 families within 1 – 2 years, 6 families within 2-5 years and 2 families within 5 years + from the previous episode.

Out of the 16 families analysed, 12 families were presented to conference due to the children being exposed to domestic abuse. In 11 a significant contributory factor was parental mental health issues, impacting on their ability to function. 8 featured parental substance misuse and in 4 families there were concerns about parental alcohol misuse. In only 2 families was there no evidence or concerns relating to the toxic trio (mental health, domestic abuse and drug or alcohol misuse). In both of these families there were concerns about the male having committed previous sexual offences towards related or unrelated children. In 10 families there was evidence of at least two aspects of the toxic trio.

At the time of the initial or review conferences, there was no evidence of there being a full chronology having been completed, therefore not all historical information was considered within the conference process or within the Social Workers report submitted to conference. In these cases, whilst there may have been reference to past history of involvement, there was little, if any, analysis of the impact or meaning of this for the children. Similarly, there was little evidence of a cultural genogram having been completed from which patterns of functioning and trigger points could be taken into consideration. 3 of the families had parents who were care experienced and in 4 families there was evidence that parental trauma / adverse childhood experiences (ACEs) had been taken into consideration.

In 4 families there was evidence of previous physical assaults or abuse towards related or unrelated children. In each of these families, there was domestic abuse. In four families there was also evidence that previous children were no longer residing with their parent, and in 2 of these 4 families the parent was not having any contact with their older children. These families were brought to conference because of concerns about the impact of domestic abuse. It was noteworthy that in only one family where domestic abuse was a feature were checks completed with police and social care of adults regularly within the home. It was unclear if the perpetrator was known to MAPPA and probation had not been consulted or invited to conference.

A key factor found within these families was that they had a number of changes of social worker during the preceding period of child protection planning (10 families). Six out of ten families also experienced a change of manager during the period of child protection and 4 of these 6 also had a change in the Independent CP Chair during the period. This is likely to mean that there was no consistent social work oversight of these families, and a likelihood of information not being fully transferred and decision-making not being able to be made holistically.

Of these 14 families, the decision to de-plan from the preceding period of Child Protection planning was taken where there was evidence of incomplete interventions relating to the risk that brought these families to Conference. In 10 families, the decision to de-plan was made without there having been evidence of sustainable change over the course of at least 3 months. In 8 of the families the decision to de-plan was made with incomplete interventions on the plan relating to risk, and without 3 months' evidence of sustainable change. Of these 8 families, in 6 there was evidence that disguised compliance was not identified. 5 of these families had experienced a change of social worker during the period of CP planning and 2 had also had a change of manager and CP Chair. In all but one of the 4 families where an issue was dropped from the CP plan, or not carried over to the Child in Need (CIN) plan which later re-emerged, there had been a change of social worker and there was evidence of disguised compliance. In each of the 6 families where there was evidence of parental non-engagement with the planning (intervention) process, the decision to end the CP plan was taken without evidence of at least 3 months' sustained change.

In each of the 3 families that closed to Children in Need planning at parental request prior to the intervention being completed, the decision to end the plan was taken without at least 3 months' evidence of sustained change. Each family had

experienced changes of social worker during the period of CP planning. Two families had not completed the intervention that was agreed relating to risk reduction at the point of closure to Children's Services, and in two families there had been failure to involve wider family / friendship network in the planning process to support sustainability and change. Of these, a lead professional was only identified in one family.

In only one of the 16 families identified, was the original risk that brought the family to conference not the subject of their return to conference. In this family there was a significant gap in Children's Services' involvement of 9 years, and the most recent period of CP planning was related to a completely different scenario whereby the mother had ended her relationship with the father of the older children, remained separated from him, and the concerns that brought the family back to conference was after a subsequent relationship in which she entered into much later and had a child with multiple disabilities within broke down and she was struggling to meet the complex needs of her children without the support of the child's father living in the home.

Conclusion

There were no concerns relating to the application of threshold regarding all cases being presented to an Initial conference. There was good evidence in each case that the children had been placed at risk of harm or suffering from harm which demonstrates threshold was applied correctly. The reports submitted to conference considered the children's needs, risks and family situation however there was very little information or analysis regarding the historical concerns. This would have impacted on the development of a successful Child protection plan leading to sustained change within the family.

There was only one instance where the risks of significant harm in the subsequent period of planning was completely unrelated to the initial risks that led to the first period of CP planning, this indicates that the original plan was not successful in the vast majority of cases in securing change for the families and addressing the underlying risk.

It does not appear that chronologies and cultural genograms are being routinely used in order to fully inform family history and functioning. It appears that these tools are considered to be required for transfer and closure tasks, and there is little reference to analysis of them within assessments, supervision, or CP conferences to guide risk assessment, sustainability of change or clear SMART child protection plans increasing the repeat plan data.

It does not appear that parents' own social histories and experiences of being parented are taken into consideration as this was not demonstrated within the Social Workers assessment or within the information provided by our partner agencies. There was little evidence of a trauma informed approach within the child protection plans regarding what the parents or children have been exposed to. This is now being considered within Child Protection Conferences.

It appears that further work would be beneficial to secure engagement from key agencies, such as Community Mental Health Services, Drug and Alcohol services and the Hampton Trust. There was little evidence of them attending conferences and providing their professional insight into understanding of risk from their individual areas of professional expertise or to advise and assist the Core Group with their planning to support risk reduction and relapse prevention.

There are a number of cases where parental mental health was being managed by GPs, and little evidence of their contributions to conference, which would help to assess compliance with recommended treatments for the purpose of managing impact and stabilisation – e.g. medication being taken in accordance with prescription / being regularly re-ordered. Where contributions were made, these bore little relevance to the risks being discussed and appeared to be focussed more on such things as how many times the child had been seen by the GP during the period, whether they had accessed emergency health care and whether their childhood immunisations were up to date. If parents are receiving regular treatment and medication, it would be helpful to understand the impact this has on their parent ability going forward.

Most families within the sample experienced multiple changes of social worker during the course of their intervention. In some, this was compounded by changes of manager and changes of Independent Chair which may have led to a dilution of information on the understanding of the family dynamics and history. There was a focus in some instances on what was assessed to be a primary risk. When new social workers were allocated the case, it appears the original concern was dismissed and replaced with other risk factors. This was often compounded by a change of social worker and manager and Independent Chair. With the new team structure and retention of staff now strong in Southampton Children Services department it is hopeful this won't be an issue going forward. Child Protection Chairs are allocated at point of referral and remain throughout the duration of child protection planning wherever possible giving the family and professionals consistency.

Indicators of disguised compliance do not appear to have been picked up; disengagement within planning appeared to have been noted but not necessarily explored and analysed for their implications in reducing risk or impact on sustainability of change within supervision, assessments, reports to conference and conference discussions, this was seen in 6 cases that were analysed.

There appears to be a lack of confidence in maintaining CP planning for children where the risk of significant harm continues to exist but there had not been a specific incident, or concerns raised between conferences despite the tasks within the plan not being fully achieved. Child Protection Chairs are now ensuring they highlight the threshold clearly to core group members when concluding the conference.

In 6 cases there was clear evidence that the support of family and friendship networks was not considered. When there was evidence of family being supported, this did not appear to take into consideration fully the relationship dynamics, instability in relationships or highlight family and friends' own understanding of the

risks and worries or an agreed family contingency plan if they were concerned. Agreements appeared loose and it was not clear that families understood their role. There was little reference to where they could go to for support if they had any worries or challenges. It is hopeful the new Family Safeguarding Model will enhance this going forward.

It was clear in 5 families the cases were closed prematurely. 4 families were closed without a lead professional, this did not allow the social worker to gather evidence that that the families were able to consistently embed their learning or devise a support plan for universal services for support going forward if required.

Recommendations:

- Social workers to ensure they embed historical information into Child Protection Reports – Safeguarding Practice Managers and Service Managers will need to embed this within their teams.

- Social workers to submit and updated chronology and cultural Genogram to the CP chair for all ICPC's – Safeguarding Practice Managers and Service Managers will need to embed this within their teams.

- Work to promote continuity of case holding responsibility, management, and Conference Chairs. Where transfers are needed, the importance of reviewing chronologies and genogram should be a priority for incoming social workers, managers, and Conference Chairs – Safeguarding Practice Managers and Service Managers will need to embed this within their teams.

- Social workers to ensure they contact probation within the S47 investigation and establish if any perpetrator is open to MAPPA. This will need to be highlighted and considered within the Case Conference report. – Safeguarding Practice Managers and Service Managers will need to embed this within their teams.

- Social workers are to ensure they invite KEY agencies to conferences such as Hampton Trust, Drug and Alcohol Services, Adult Mental Health Services – Safeguarding Practice Managers and Service Managers will need to embed this within their teams.

- Child Protection Chairs to complete a repeat plan analysis on every case where children have previously been on a CP plan within 2 years following each ICPC – Child Protection Chairs and Service Manager.

- A further briefing paper to be submitted in 6 months' time to establish if the Family Safeguarding approach has made a difference on repeat Child Protection Plans.

- CP chairs to use the new Threshold Document within Conferences to support core group members applying it correctly when deciding what type of plan is required.

- Child protection Chairs and Team Managers consider strengthening the Safety Statements with the professional network and family in order to agree what evidence of change would look like and the length of time sustainability of these changes would be required to satisfy safe de-planning.

- Training to enhance understanding of working with disguised compliance and the rule of optimism and to promote changes in practice.

- A lead professional to be identified at point of closure and families being linked to family hubs.