Ava, Lucas, Harper and Chloe Child Safeguarding Practice Review (CSPR) Practitioner Briefing

Children's Safeguarding Assurance Partnership
Blackburn with Darwen - Blackpool - Lancashire

This CSPR reviewed multi-agency interventions with a family of four children, aged between 18 months and 16 years, who were neglected over a considerable period of time. At the time of the incident that triggered the review, a child protection plan had been in place for over a year and involved professionals had expressed their concerns about the lack of progress. Lucas's reported feeling "scared and confused" much of the time. The children's neglect was underpinned by domestic abuse, poor parental mental health, substance and alcohol use, and offending behaviour.

The complex and cumulative nature of neglect that the children experienced was a constant challenge for professionals, while their parents' chaotic lifestyles served to draw attention away from the day to day experiences of the children. Consequently, the children were not always the key focus when decisions were made. The review considers multi-agency responses to neglect, the effectiveness of child protection and public law outline processes, how successfully services working with adults safeguard children, and professional de-sensitisation. The following areas of learning are relevant for all practitioners working with children.

Understanding the lived experience of children

The review sought to understand the lived experience of all four children and paid particular attention to how this was recorded and understood by professionals working with the family. Professionals undoubtedly did record what the children said to them and how the younger children presented, however this highlighted the question as to what difference this made—so what?.

The review therefore concludes that, "even when we listen to children and observe their lived experience it is what professionals do individually and as a collective with the concerns that have been spoken about or observed that matters. If opportunities are not taken to act on what is seen or heard, taking note of what is happening in the lives of children will be just that. Extensive records, as in this case, will become larger but proactive responses and positive outcomes must be the aim."

Good Practice

The review identified a number of areas of good practice:

⇒ The engagement of services working with the adults in the family in child protection processes was good.

⇒ The probation officer undertook a number of home visits, and observed and recorded information about the children which was shared with other agencies.

⇒ A substance misuse worker likewise identified on a home visit that Ava was acting as a carer for her younger siblings.

Read the full Ava, Lucas, Harper and Chloe CSPR report here.

Responding to drift and delay in child protection plans

A child protection plan had been in place for all four children for a little over a year at the time of the significant incident, with agreement having been made to progress to Public Law Outline process over six months earlier (this process should be concluded in 16 weeks). There was evidence that the plan was hindered by core groups not being quorate, while changes in practitioner, particularly the social worker, disrupted the delivery of the plan.

Practitioners working with families in similar circumstances are reminded of both the Resolving Professional Disagreement process, which should be followed until a satisfactory solution is reached, and the role of the child protection conference chair. Any professional can raise concerns about a child protection plan directly with the chair at any time, who should act to ensure that the plan is delivered and the children are safeguarded.

Understanding family circumstances

The children's family structure and circumstances were complex, with the four children having three dads and a number of step– and half-siblings. The review has highlighted the need for agencies to collect and refresh details about family members and to understand how they connect to each other. This is most easily achieved through the construction of a genogram, which should be shared between agencies to ensure that it is accurate.

Too often in this review, the children were placed in an emergency with a family member, who had their own problems and who Ava did not want to live with. By properly understanding family structure and simply asking parents who would care for their children in an emergency options can be identified and assessed for their suitability.