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**Context**

- Child B (12) was involved in a fatal accident and tragically passed away due to the injuries sustained as a result.
- Although this specific incident could not have been predicted, 15 referrals to Children’s Social Care had been made since 2009, 8 of which had led to single assessments being undertaken.
- The review was therefore instigated to identify points of learning from the involvement of agencies over a prolonged period of time.

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**Background**

- Concerns had been raised over time in relation to anti-social behaviour and a lack of effective supervision of the children.
- Parents separated in 2018, and Mum made allegations of domestic abuse. Mum moved away from the area at this point. A further single assessment was undertaken based on the previous pattern of referrals, and concluded with a referral for early help support.
- A Section 47 investigation in March 2019 into an allegation of alleged assault also concluded that the issues could be managed within early help.
- Early help support was provided in the period 2018-19 and was ongoing at the time of the fatal accident.

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**Implementing change**

- Practitioners are encouraged to reflect on the features of this specific child’s story which have some similarities with other situations they are working with, and to review these in supervision.
- The specific issues to consider are: repeat referrals and assessments which do not always identify the patterns and signs of stress in families; engagement and disengagement; lived experience and missed opportunities to intervene.
- Practitioners should also consider the neglect Statement of Intent and the guidance and tools which it contains when encountering similar situations.

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**Safeguarding Concern**

- Referrals made between 2009-17 had focused on supervision, parental control and anti-social behaviour. Each concluded that there were no significant grounds for further involvement and did not result in other agency involvement.
- The assessment undertaken in 2018 as a result of the domestic abuse allegation was, however, instigated partly as a result of the previous history of involvement. This assessment resulted in the involvement of early help which was ongoing at the time of the accident.



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**Learning**

- **Multiple referrals** – practitioners must always consider the context to referrals and in particular the implications of a pattern of repeat referrals which may or may not have triggered further interventions. A pattern of historical case closures should be examined.
- **Engagement with services and support** - practitioners must recognise the rationale for consent being given and then repeatedly withdrawn, as this is a recognised pattern associated with long term neglect.
- **Vulnerabilities** – practitioners should reflect on the context for parents to provide effective parenting for children, including an understanding of the support networks, and the implications of breaking these networks due to relocation.

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**Findings cont...**

- Decisions to relocate a parent due to concerns such as domestic abuse, may run the risk of isolating the parent from their wider support networks. This should form part of the decision making process, especially if parents are already considered vulnerable.
- There was a sense that practitioners considered supervision of children in the local community was a more collective, community responsibility and that this resulted in a reduced expectation around the level of direct parental supervision.
- The child’s lived experience should always be at the centre of the assessment process. There is not enough evidence that the voice of the child was a significant factor in the assessments undertaken prior to 2018.

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**Findings**

- Although there was a long history of referral and assessment, there is little evidence that this resulted in a clear picture of life for the family. Agencies need to consider the chronology or involvement when undertaking assessments.
- A repeated process of initial engagement with agencies followed by a decline / withdrawal of engagement was evident. Rather than this prompting an escalation of concerns, and the development of a support plan, it resulted in the case being closed repeatedly and led to a stop / start pattern.

- **Supervision** – practitioners should continue to ensure that there is effective direct supervision of children, and not assume a level of supervision in the community to be an acceptable alternative.

- **Child’s lived experience** – professionals should always consider the voice of the child and the lived experience for the child, especially where there has been multiple assessment activity and a pattern of ongoing contact with agencies.