1 Background and Concerns

Child 12 and 13 were siblings and were aged 7 and 13. The family moved from Lincolnshire in 2014, where the children were subject to CIN on three occasions. Concerns around parental substance misuse, longstanding chronic neglect, physical harm, domestic abuse and parental mental health. Open to CIN in NEL in 2016 and 2017, children became subject to CP November 2017, category emotional harm for 6 months. Children became subject to police protection in January 2021 following significant domestic abuse incident.

2 Purpose of the Review

The purpose of a Line of Sight review is to identify learning for the multi-agency partnership which will strengthen the safeguarding system. Beyond individual cases reviews they also provide a window into wider systems (ways of working/ processes) which may need to be changed. In this case it was felt that there was an opportunity for learning and practice improvements in several areas.

3 Key Lines of Enquiry

- Was MARAC effective in reducing risk?
- Did use of the escalation policy resolve issues?
- Was there a consistent response to the assessment of neglect?
- Was the response to resistant parenting effective?
- Was there a robust assessment of the impact of domestic abuse and physical harm on the children?

4 Key Practice Episodes

Expected good practice

- Police protection taken appropriately.
- Operation encompass.

Areas for improvement

- Use of escalation policy without the desired outcome, issues with recording escalation.
- Better use of Body Worn Video and Evidence led prosecutions to be progressed.
- Agencies response to resistant aggressive behaviour.
- No assessment understanding what life was like for the children.
- Lack of joint working, communication between CSC and NAVIGO re mothers' mental health.
- Public law process could have been used more effectively and drift avoided.
- The child protection plan/ MARAC did not reduce risk domestic abuse.

5 Learning

- Clear lack of support for children with assessed behavioural difficulties related to experience of neglect and domestic abuse, findings to be shared with commissioners' mental health services.
- Lack of parental engagement, resistance and mothers' aggressive manner was a barrier to the case progressing, need to consider different ways of working.
- The MARAC process was not effective in managing reducing risk, the case was heard at MARAC 7 times over 4 years. The police plan to undertake a multi-agency audit of the impact of the MARAC.
- Inconsistent use of neglect tool, dental neglect is a reoccurring theme, review planned of the local use of the neglect tool, work has commenced to ensure dentists are aware of referral pathways.
- There were periods of drift and potential missed opportunities to intervene earlier in safeguarding the children. The impact on the children was not fully assessed or understood. Voice and influence practice guidance has been develop and training.

6 Progress/Impact

- An action plan has been developed and is being implemented.
- The escalation process will be a practice session for schools.
- The identified gaps in mental health services have been shared with the commissioners.
- The effectiveness of the MARAC will be subject to audit.
- Capturing the voice of the child by agencies has improved, work is being undertake on assessing lived experience.
- Work is being undertaken in raising awareness with dentists on the local referral pathways in respect of dental decay related to neglect.

7 Further information

- Graded Care Profile 2
- SCP Training
- Line of Sight process
- Threshold of Need
- Referral Process
- SCP Policies & Procedures