Rapid Review Learning Briefing

Complex Care and Support Needs & Neglect

This rapid review looked at the death of a child with complex care and support needs. The child was non-verbal and required 24-hour care to support body positioning, moving, and swallowing and had unique, intersecting health needs. The review largely focused on the 6 months leading up to their death and key points of escalation in concerns for their safety and well-being. The review investigated how the safeguarding system worked together to keep the child safe and whether there were any key areas of learning for the safeguarding partnership.

Disabled children are at greater risk of abuse and neglect. Disabled people are often discriminated against, and their quality of life viewed as lesser rather than different[1]. Furthermore, disabled people from minority ethnic communities often face 'double discrimination'[2]. Therefore, they require increased protection and culturally sensitive care.

CLICK HERE for Escalation of Risk – Safeguarding Children

CLICK HERE for E-Learning related to working with disabled children

CLICK HERE for Think Family Approach Guidance

FINDINGS: Multi-Agency Working

Examples of **good practice** included excellent multi-agency coordination and transition of care, timely and accurate information sharing. Safeguarding concerns and current needs were known to all professionals involved in the child's care.

Evidence of **excellent practice** by professionals who ensured the child had the opportunities to have a rich and fulfilling family and personal life. This included a wider network of activities and experiences which enriched their day-to-day experience.

Good practice was identified in well attended and prioritised multi-agency network and child in need meetings. There is an expectation that Health and relevant agencies will **coordinate a response when medical advice is not being followed** by those caring for a disabled child.

The review found that police held information in relation to Domestic abuse with allegation from father to mother. There was a **lack of clarity around consideration of the vulnerability of the child(ren) in their response.** Information was reviewed in isolation and not shared with social services, therefore did not inform assessment of potential harm.

FINDINGS: Parental Engagement

There was evidence of **good practice** with regular, consistent and compassionate communication despite relationship difficulties. Agencies worked hard to find the best ways of communicating with the mother and sought her views on best methods of communication, but father was not visible during the timescale of the review

The network of care did not explore the **parents' personal experiences, past trauma and adversity.** This resulted in a reactive response by professionals to avoid relationship breakdown rather than **seeking opportunities to building more meaningful informed relationships.**

Agencies recognised the presence of **racialised trauma** and **carer stress**, which may have contributed to engagement difficulties with a complex network of statutory services delivered by mostly white, British professionals. Evidence indicated limited expertise across the network in responding to specific intersectional needs of families of disabled children who are from minoritised ethnicities.

The review identified network could have benefitted from reflective space to consider parental engagement as well as advice and reflection on racialised trauma. The partnership should consider where networks can seek support and supervision to address patterns of relational behaviour which is a barrier to the child's safety and wellbeing. Use of the **Think Family Approach** would have helped to capture the family's vulnerability and needs.

FINDINGS: Assessment of Harm

The review identified some **reluctance to challenge** the mother when her perspective on the child's care needs were inconsistent with clinical advice, and to **name parental choices as neglect,** in the context of the challenges associated with caring for the child. There is a risk that some professionals' views on disability or **unconscious disablism** leads to a **greater tolerance** for parents/care givers **inability to meet the needs of the child.**

The review acknowledged the challenges of balancing decision making in line with the child's best interest (right to family life & quality care), promoting parental engagement and recognising parental carer burnout. The partnership should consider how supervision can be used for **all partners to step back from the dynamics of the immediate presenting issue and respond to patterns and histories of engagement.**

The review found that the **challenge of demonstrating harm** came from **viewing incidents in isolation** whereas the evidence indicated that a **cumulative pattern of behaviour placed the child at significant risk.**

We need to continue to **develop our approaches** in all agencies for **communicating and demonstrating the impact of harm** on children and build expertise and knowledge about the protecting disabled children. Strategies to support the workforce to **recognise disablism and racism** in their own and others' decision-making continues to be important safeguards.

As A Professional, What Can I Do?

We must maintain the good practice seen in this review as we continue to make nuanced judgements about children's rights and best interests in the parenting they receive. When articulating impact of harm, it is vital that the professionals involved step-back and consider the broader picture to identify patterns of behaviour which may put the child at risk. Professionals should use CP conferences or convene a multi-agency meeting to convey the severity of their safeguarding concerns and ensure parents/caregivers understand these concerns and remain engaged in the process.

Remind yourself of your agency's escalation policy

Use the Think Family Resource

Reflect on your own and others' views about disability & race

Proactively explore barriers to prevent relationship rupture

Use trauma informed supervision, support, and reflective practice

Courageous Conversations

What Needs to Happen Next

- Avon and Somerset Police should consider using a more systemic approach to understand the complex interrelated vulnerabilities of families in their decision making and information sharing.
- Bristol City Council Children's Services and Families Services will work with CAFCASS to consider implementation of the CAFCASS Child Impact Tool and to share best practice on how to represent impact to children.
- Bristol City Council Children's Services and Families Services will explore what resources are available to support professional networks working with children in need or children subject to child protection plans when they are experiencing repeated relationship ruptures with parents/caregivers.
- Health agencies are to disseminate learning from this review, including raising awareness and detailing practice strategies to support staff in identifying, managing and escalating concerns where parents do not appear to be following medical advice.
- Bristol SEND Partnership will review the Local Offer and highlight resources for families of disabled children from Black and minoritised communities.
- KBSP Partnership will develop a practitioner resource to support practitioners in their considerations about safeguarding children with complex needs from neglect and working with carer burnout and trauma
- KBSP Training Team will develop resources on working with racialised trauma and disablism within safeguarding children training resources and have commissioned Dialogue Ltd to deliver Courageous Conversations training from April 2023-March 2024.

1. Mackenzie, C., & Scully, J. L. (2007). Moral imagination, disability and embodiment. *Journal of applied philosophy*, *24*(4), 335-351.
2. Department of Health (2009) Valuing People Now: a new three-year strategy for people with learning disabilities. Department of Health, London.