Joint Child Safeguarding Practice / Safeguarding Adults Review

Independent Reviewer: Nicola Brownjohn

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1.Rationale for review

1.1 A rapid review was conducted by the Safeguarding Children Partnership (SCP) on 23 February 2023. There was a decision made to commission a Child Safeguarding Practice Review in respect of Child H. There was also a referral made to the Safeguarding Adults Board (SAB) in respect of Adult H, and it was subsequently agreed that a joint Safeguarding Adults Review and Child Safeguarding Practice Review would be undertaken regarding the mother and child.

1.2 The SCP and SAB agreed that they would commission a reviewer to look across both the child and adult systems and to produce a learning report as the final, publishable, joint review.

1.3 There were delays in completing the review due to the complexities of the investigation across child and adult services. This required a recommissioning of the review in July 2024. At this point, it was evident that agencies had already taken forward urgent actions resulting from the early learning from what had happened to Child H and Adult H.

2. Scope and Methodology

2.1 The period under review has been from March 2022 when it became known that the work undertaken previously within the Child Safeguarding system (child protection and Child in Need) had not created sustainable improvements for the family, until February 2023, when both Adult H and Child H died.

2.2 The review has been undertaken using a systems focus and appreciative inquiry. Appreciative inquiry has helped to gain the reflections of some of those most closely involved with the family on what worked well, and what needs to be changed across the system. In the two years since the deaths of the mother

and daughter, all of the agencies involved with the family have demonstrated how they have taken forward learning to prevent future deaths.

2.3 The independent reviewer would like to acknowledge how difficult it is for workers to have to keep revisiting such a tragic event. During the conversations with managers and practitioners the case details were discussed, and it became clear, to the reviewer, that the emotional impact on some individuals had not diminished, despite organisational support of staff. The reviewer was aware that there had been a practitioner event held during the earlier commissioned review which had not supported the participants to move forward in their learning, due to their grief. The reviewer agreed with the review panel that continued use of the case details were preventing the ability to reach a focus on the wider system learning. Therefore, the learning event held in April 2025 used a case study based on the themes identified in this review rather than any details of Adult H or Child H. This enabled the participants to discuss how they would approach a family with similar complexity of needs now.

2.4 The following key lines of enquiry were used as the focus for the review:

1. To what extent has the 'Think Family' approach been embedded within the local authority Child and Adult system, including education? What impact has this had on family members gaining immediate support in times of crisis?

2. How has this case impacted on the housing decisions for families where there is overcrowding and children or adults with highly complex needs?

3. How are the care and support needs of adults with mental health or substance misuse issues addressed? How are wider life issues included in decision making for support?

4. In families where there are children and adults with complex needs, how do agencies work together to assess and manage the risks? What are the expectations on the adults to be capable of attending to their child's complex needs, when they themselves have intensive needs? How are children identified and supported as young carers?

5. How can the system respond effectively to safeguard a child who has experienced childhood trauma, and is living with a significant long term health condition?

6. Is there a different way to approach the thresholds of need, across children and adults, and between services? E.g., is it appropriate to use early help, or universal services for a child with complex trauma and known for suicidal intentions?

7. How do agencies work together to achieve a sustainable plan for families when no longer within the safeguarding system? Including Primary Care involvement for child and adults with significant health needs.

8. How confident, and safe, do practitioners feel in being able to challenge and escalate decisions made within their organisation or by other organisations regarding the safeguarding of children and adults?

3. Child H and Adult H legacy

3.1 Adult H

3.1.1 Adult H was a 35-year-old white British woman who had a long history of alcohol misuse and depression. She died early in 2023 due to complications from long term alcohol misuse. She had been admitted to hospital two weeks prior to her death and had been transferred to the intensive care unit due to her deteriorating condition.

3.1.2 As a child, Adult H, had experienced her own mother misusing alcohol. Her mother remained a difficult feature in her life, with reports of domestic violence between the two of them, shortly before Adult H's mother died in 2022. The mother's death had an impact on Adult H, and she sought support from her GP who prescribed antidepressants which she was still taking at the time of her own death.

3.1.3 Adult H had a long history of alcohol misuse. She had a 12-week period of involvement with the drug and alcohol service in 2019, but did not access specialist support after that, although she did attend her GP surgery for support for depression. Adult H's alcohol misuse impacted her ability to be a consistently good parent to her own children.

3.1.4 It appears that Adult H was well known to children's services due to long term concerns about the welfare of her children. However, Adult H was not known to adult services, beyond her GP, in recent years. She had accessed support for her alcohol misuse when her children were made subject to a child protection plan in 2019 but had been discharged.

3.1.5 Adult H had a disordered life highlighted by the complex relationships with her mother, her children, and partners.

3.1.6 There is a gap for this review, in not being able to pinpoint what Adult H's wishes were for her life. Despite her difficult relationships, there was evidence that she kept in contact with her children's school, which would suggest that she wanted more for her children than she had in her own childhood. Just months before her own death, Adult H was bereaved through the death of her own mother, with whom she had a challenging, somewhat violent, relationship. Adult H sought help from her GP due to her grief but declined any bereavement counselling.

3.2 Child H

3.2.1 Child H was a 16-year-old white British girl who died just hours after witnessing her mother's death in hospital. Child H had indicated to professionals at the time of her mother's death that she would take her own life. She had disclosed suicidal ideation on several occasions over the previous year. She had a history of self-harm and emotional distress, which had been more evident in the weeks prior to her death. Child H had a diabetes diagnosis which needed daily monitoring and medication but was poorly managed. Child H had frequent admissions to hospital for medical intervention due to the poor home management of her condition.

3.2.2 Child H and her family had been known to Children and Families Social Care and other partner agencies for many years due to concerns around neglect, parental substance misuse, poor parental mental health and domestic abuse. Child H had previously been subject to a child protection plan and a child in need plan, until it was closed in 2022, when Child H was deemed to be permanently living with her father.

3.2.3 Child H had spent the last year of her life continuing to spend time with both parents, who were separated. At her mother's home, she had no bedroom. She slept on the sofa in the room used by her mother as a living room. At her father's home, Child H slept in a makeshift room as the property only had one bedroom, used by her father. Child H had a younger sibling who had diabetes as well. They did not always live with the same parent, but Child H was known to worry about her sibling.

3.2.4 Child H was known to self-harm and had counselling at school. She reported abuse by her mother and extra familial assaults during the last year of her life. Referrals were made to the Multi-Agency Safeguarding Hub (MASH) during this time. Assessments were undertaken but did not result in action following checks with Child H's parents.

3.2.5 The day before the deaths of Adult H and Child H, Child H reported to school staff:
'*both parents consistently persuade children's services that everything was ok by covering things up*.' She indicated that she was also frustrated that CAMHS had not seen her yet and was '*petrified*' that mother would die like her grandmother.

3.2.6 Child H was contacted by the Child and Adolescent Mental Health Service (CAMHS) on the day of her death. It was reported that she did not want to talk and was waiting for her in person appointment due 5 days later.

4. Family Views

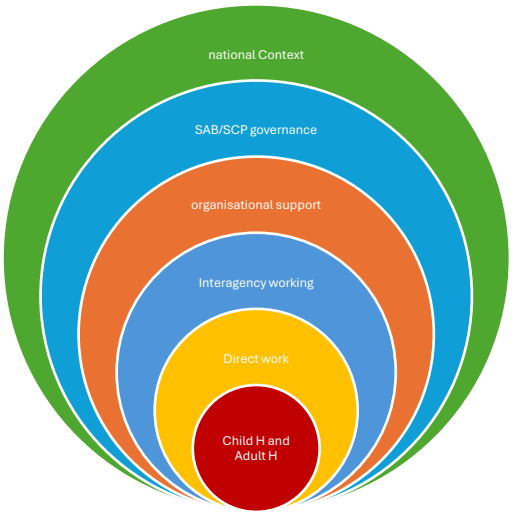
4.1 Child H's father was contacted about the review. It was hoped that both he and Child H's sibling would feel able to contribute to the review. No response has been received to the contact made by the SCP.

4.2 On behalf of the SCP and SAB, the independent reviewer offers condolences to the family. This report has limited information regarding the family as they have not been able to give their views on the experiences of Adult H and Child H.

4.3 From the information the independent reviewer has had access to, this is a family that represents those who find it hard to trust professionals. It is hoped that this report will support professional systems to think differently about how to reach families with complex needs, to offer effective support that can achieve a sustainable change for families.

5.Findings

The findings will be presented using the domain framework.[1]These focus on the case documents provided to the reviewer, conversations with managers and some practitioners involved with the family, and the outputs from a wider learning event in the local authority which used a case study based on the themes identified by the reviewer.



5.1 Direct work

5.1.1 For Adult H, there was only direct work by the GP practice in her final year of life, prior to her emergency hospital admission. The GP and Pharmacist provided personalised care to Adult H, for her needs. There appeared to be a

[1] Preston-Shoot, M., Braye, S., Doherty, C. And Stacey, H. (2024) National Analysis of Safeguarding Adult Reviews 2019-2023. London: Local Government Association and ADASS.

good relationship with Adult H, enabling her to be in control of her primary care treatment and offering referrals for bereavement support.

5.1.2 Adult H had asked for help in mid-2022, due to an increase in her alcohol use and fighting with her own mother, which had been reported to the police. She was referred to the drug and alcohol service, but did not access that, likely due to the impact of the sudden death of her mother just weeks later. This was not followed up apart from the GP offering to refer to bereavement services. It would have been difficult for Adult H to access a service she did not know, or where she needed to be proactive in engaging in the intervention.

5.1.3 Otherwise, there does not appear to have been direct work, by any agency, with Adult H since she had accessed treatment to reduce her alcohol use some years earlier, when her children were subject to a child protection plan. By 2022, the focus seems to have been on how her drinking was too much of a risk to the children and Children's Social Care were working with Child H's father more to provide support for the children. This meant that Adult H became somewhat invisible to the health and social care system, apart from the GP. In making Adult H invisible, this also placed the responsibility on Child H to watch out for her mother, thus placing the child at risk of harm due to having the burden of an adult's needs on her shoulders.

5.1.4 Child H had been known to multiple services for years. She was known to children's social care, and had the continuity of the same social worker until her case was closed late 2022. This closure of her case had the impact of losing a key professional who could have oversight of Child H's holistic needs and who could bring agencies together to address any risks of harm to the child. Other agencies continued to be involved with Child H but were then required to submit new referrals to the MASH when they were concerned about Child H's welfare.

5.1.5 Child H was known to CAMHS, having been assessed in November 2022, a phone check in on the day of her death, with an expected appointment which was due just days after Child H's death. She was registered with the same GP as her mother, and it was known that Child H had mental health issues which she reported were exacerbated by her mother's behaviour towards her. However, the communication with the family was either directly with Child H who was deemed to be Gillick competent, or her father who she was reported to live with. There does not appear to have been a good understanding, by agencies, of the relationship between the mother and daughter in the months before their deaths, because Child H was now deemed to be living with her father. When agencies, such as the school, attempted home visits, they did not gain access.

5.1.6 Child H was known to a specialist paediatric service in relation to her diabetes. The service knew about the family circumstances, in that the parents were separated and had different housing arrangements. The service was aware that Child H felt rejected by her mother when living with her father. There was a children's social care referral in June 2022, when Child H was admitted in an acute crisis, due to overcrowding at her father's home, with two adults, three children and multiple dogs reportedly living there. The experience of the service is that many of the children they care for have difficult family situations with children's social care involved. For Child H, as her sibling also moved from the mother's home to live with father, the service supported the family with a letter to the housing department due to the overcrowding.

5.1.7 For Child H, the paediatric service recognised that the control of her medical condition was never very good, but they offered options to see her frequently to provide support. This included seeing the Nurse Specialist and a youth worker, with whom she had a good rapport. In addition, her sibling who also suffered with diabetes, was also seen due to poor management of their condition during the time period under review. Yet, the GP records show that Child H's illness was well managed. This was a child who experienced medical crises, as did her sibling. This should have been considered within the multi-agency network as an indicator of the distress being experienced by the family. However, by November 2022, there was no structured multi-agency network around the family as children's social care had closed their work as the father had declined further child and family support, and it had not been considered that statutory child protection thresholds had been met.

5.1.8 The paediatric team reflected on Child H after her death. They concluded that they knew her for a long time and offered more support than others would receive. However, at the time, there was a gap in psychological support. This has improved since Child H's death. There is a clinical psychologist employed for the service and working to catch up on a back log of children. The service does have access to CAMHS, but this access is limited, although there is now a weekly psychosocial meeting with CAMHS. This should facilitate more holistic assessments of the children within the care of the service.

5.2 Interagency working

5.2.1 Child H had been subject to a Child in Need (CiN) plan, but this was closed during her transition to secondary school, in 2020. This was due to Child H moving in with her father and so the concerns were reduced. She appeared to be doing well in his care, and it was reported that the professional network agreed with the plan to step away.

5.2.2 However, it did not consider the impact of Child H's diabetes on her transition to secondary school, and the home situation. The school provided support for the family, working with both parents. At this point, Adult H was deemed to be in control of her alcohol and substance misuse.

5.2.3 In the last year of her life, Child H was known to have a serious chronic illness requiring constant supervision to manage the potential instability during teenage years; self-harming was reported in school, and by her father; low school attendance; reports of abuse by her mother and someone outside of the family.

5.2.4 The school reported that they made MASH referrals in respect of Child H. For these referrals, they used the mother's address. This demonstrates the complexity for raising concerns about children, when they are living between two homes following a parental separation, with the need for both addresses to be recorded in referrals and assessments.

5.2.5 It was reported that both parents would keep in contact with the school about Child H's attendance. Meanwhile, Child H was able to talk to school staff about her concerns, which led to the school doing a home visit to the mother's home. Child H had counselling at school and was waiting for a CAMHS assessment. She indicated to the school that she was worried about her sibling and was frustrated that referrals to children's social care resulted in no action.

5.2.6 Child H seemed to be moving frequently between the homes of her parents. By mid-2022, the professional network understood that Child H was living permanently, at her request, at her father's home, but remained in contact with her mother, and also her sibling was, for a time, living with their mother. At her father's property, Child H had a makeshift bedroom as there was only one formal bedroom. No one seems to have questioned why the father had not moved Child H or her sibling into the one bedroom and had the makeshift room himself. Had this been asked, it might have become apparent how the father's second family were also living in the property. When Child H lived with her mother, there was no room for her to be alone. She slept on a sofa in the living room where her mother would stay up late at night.

5.2.7 Child H was not recorded to be a young carer, despite having both parents with their own care and support needs, as well as her sibling. The school staff explained that, at the time, there was no support in place for young carers; however, now, there is mentoring available for young carers. The school reported that they provided support through home visits, counsellor, and their school nurse support. They reported that they did not have the full information about the family's issues but provided the same level of emotional wellbeing

support that they would for other children. They offered home visits to the family but were not given access to the homes by the parents, or Child H herself.

5.2.8 In the weeks before Child H's death, a MASH referral was made by the Adult Mental Health service as there were concerns about Child H's father's mental health and his account of Child H's self-harming. However, this was stepped down due to the MASH team speaking to the father about his mental health, and he was reported to have minimised this which resulted in children's social care deciding not to reopen the case. There seemed to be an absence of a holistic view of Child H, i.e., her disclosures of abuse, her diabetes being poorly managed, the parents' own issues. There was no escalation of concerns by any agency to enable an effective information sharing to support joint decision making on the necessary actions.

5.2.9 The challenge for services was the need for parental consent as there was not sufficient concerns raised to warrant statutory child protection investigations to be undertaken, apart from in relation to a disclosure by Child H of extra familial abuse.

5.2.10 Consent based services for children lead to difficulties when parents do not engage. For example, the school reflected that there is too much reliance on schools to step in where other agencies should be involved outside the school environment. Another example is that a child medical condition is not seen as a multi-agency issue. This misses the point that children with medical conditions need parents or carers who are able to support them to manage the condition.

5.2.11 CAMHS were delayed in progressing therapeutic intervention with Child H due to pressures on the service. However, contact was maintained with her to provide access to support.

5.2.12 When Child H was admitted to hospital for diabetic ketoacidosis, the medical emergency action was taken. However, it was viewed more through a health lens of poorly managed diabetes, rather than an indicator of wider neglect of a child that needed a multi-agency response. If a multi-agency response had been taken, then the impact of the parents' own significant care and support needs on their ability to manage their child's complex needs could have had a greater focus. Child H's medical needs were included in the child and family support in 2022, but as one of several factors. Had it been the main focus, adult services could have been involved in offering support to both Adult H and Child H's father for their own needs. In 2019, there had been concerns raised to children's social care, by the Diabetic Nurse, in relation to Adult H's alcohol

use and her not being able to care for Child H. This prompted Child H's move to her father's care.

5.2.13 There was also a lack of awareness of Child H's role as a young carer, supporting her mother when living with her, a woman going through depression, alcohol misuse and bereaved of her own mother.

5.2.14 Since Child H's death, CAMHS have improved how they respond to self-harm and crisis. There is more support from CAMHS within children's social care, via the ICT, to discuss children where there is no progress in their situation.

5.2.15 Housing worked with Child H's father to move to a larger property. The property the family were living in had been taken on by Child H's father as a single man. He was trying to accommodate Child H and her sibling. In addition, there was a new partner who also had children, living there. However, this was not known by housing, and they were not included in multi-agency meetings. This meant that housing followed their policy of tenants needing to take responsibility for applying for larger properties because there were no extenuating circumstances to move outside of that policy.

5.2.16 At the learning event, in April 2025, the participants reflected that there are good relationships between housing and Adult Social Care. In Child H's case, housing were involved regarding the father's tenancy, not Adult H's. Had adult's social care been involved for the father's care and support needs, there might have been an opportunity to reach a multi-agency agreement on who was best to support the family in gaining the best from their housing, or to access more appropriate housing for their needs.

5.2.17 Participants at the learning event, in April 2025 spoke about how willing agencies are to talk to each other and share information. This seems to be supported by the presence of safeguarding teams within agencies, to promote sharing information, and the inclusion of adult's social care in strategy meetings relating to children, when necessary. Additionally, the multi-agency risk assessment conferences are viewed as effective in supporting information sharing.

5.2.18 One group reflected that information about families should be shared, but this tends to be achieved in an 'organic' way rather than through set rules. This makes sense, that not every situation can be written into policy. The key focus is on the relationships between services, to enable professionals to use their judgement in what to share to support the progress of care for an adult and recognising the needs of children within the family.

5.2.19 In respect of Child H, there was sharing of information between agencies, but limited joint assessments and decision making due to assumptions that

children's social care always lead on decision making when there are concerns about children. There should be a greater understanding of the role of all agencies in sharing the responsibility for safeguarding children.

5.2.20 From a children's perspective, participants at the learning event recognised the expertise of Child Protection Chairs to bring agencies together at conferences, although some felt that there could be more clarity provided on how the needs of adults can be met properly when the focus is on the child. Nevertheless, there were views that a child is looked at within the holistic family system at conferences. Children's services said they had contacts in Adult Mental Health services which is helpful to connect when there are child safeguarding issues.

5.2.21 Child H was not considered under child protection in the last year of her life, apart from the s47 investigation in relation to extra familial abuse. There should have been more awareness of the need to view extra familial abuse as a child protection concern, and assess the risks for the child, alongside her family experience. Had there been a child protection conference during 2022, the chair could have promoted a focus on the complex needs of both parents, alongside parenting capacity assessment, to ensure that Child H was safeguarded.

5.2.22 At the learning event, there was some consideration of how well the Mental Capacity Act (MCA) is understood. Participants discussed how it is difficult when there is presumed capacity for adults, without being able to check that a person really understands what care is needed, for themselves and their children. The impact of mental health issues and substance misuse on a person's ability to make decisions about their care and support, has been widely documented in safeguarding adults reviews and the national analysis.[2]

5.2.23 A key quote from the national analysis of Safeguarding Adults Reviews holds great relevance to Child H's experience.

'..determinations that an individual had mental capacity sometimes meant that services 'walked away' without further consideration of their ability to keep themselves safe'[3]

5.2.24 For Child H, there seems to have been concerns about Adult H's behaviour, due to alcohol use, but this was addressed by supporting the move for the child to live with her father. There was no consideration of the extent to which the parents understood the impact of their decisions on the safety of their children. There was contact with Child H's father, but he was seen as a protective factor rather than someone with their own complex needs. When he

[2] Preston-Shoot, M. Braye, S. et al (2024) *Second national analysis of safeguarding adult reviews Final report: Stage 2 analysis. Analysis of learning*. LGA, ADASS, PCH.
[3] Preston-Shoot, M. Braye, S. et al (2024) *Second national analysis of safeguarding adult reviews Final report: Stage 2 analysis. Analysis of learning*. LGA, ADASS, PCH. P57.

declined support, services 'walked away' without a thorough understanding of how the father could keep his daughter safe.

5.2.25 It would be of benefit for the SAB to include work on the application of the MCA within the 'think family' work. Using a child focus might help practitioners to question the executive functioning of the parent who misusing substances or alcohol and their ability to parent the child safely.

5.2.26 Adult Social Care were not involved with Adult H or other adults in the family. However, it would have been of benefit for a referral for an assessment of Adult H's care and support needs to have been completed. Even some advice from Adult Social Care could have supported the work with the family.

5.2.27 The participants at the learning event demonstrated an ambition to develop a shared understanding of the threshold in children and adult services. This would build on the good work achieved across children's social care and adult's social care, e.g., being able to have shared access to records. Children's social care and adult's social care recognised the potential for more opportunities for joint home visits to be able to see the bigger picture of how a family functions. This would also help to ensure that there is a shared understanding of the difference between parental capacity and adult vulnerability.

5.3 Organisational Support

5.3.1 Children's Social Care undertook a thorough internal review of the work undertaken with Child H between 2022 and the deaths in early 2023 with the aim of identifying learning.

5.3.2 This report notes the impact of the Covid-19 pandemic. In 2022, the Covid-19 pandemic was coming to an end. At this time, many social workers had larger caseloads. This has changed now, following measures to recruit and retain staff.

5.3.3 Despite these challenges, for Child H, there was continuity in having the same social worker who had a good relationship with Child H's father and understood the family. The report recognises the challenges in providing regular, impactful, supervision for the social worker. Whilst there is clear evidence of taking a whole-family approach, including considering the impact of Adult H's alcoholism on the ability to parent effectively, her own potential care and support needs were not recognised as needing a referral to Adult Social Care. Additionally, the impact of the overcrowding at the father's home did not feature enough in the assessment of risk and harm.

5.3.4 Children's Social Care managers have reviewed how supervision is provided to social workers in the local safeguarding area. Now, there is a greater focus on exploring the family history during supervision and the use of systemic genograms to support this. For Child H, this could have identified the significance of the chaotic lifestyle she experienced, the trauma of her earlier childhood, the necessity for her to have good care of her diabetes, and the care and support needs of both of her parents in their own right.

5.3.5 There is evidence that the social worker raised concerns regarding the father's housing with the council's housing department. However, when the social worker raised the issue with housing, they reportedly said they could not act, and so this was not escalated within Children's Social Care. Housing informed the reviewer that the father was repeatedly given advice about how to apply for larger housing, but it is reliant on the tenant to act. Had the case been within the child protection system, then it could have been explored what impact the environment was having on the safety of the children in the home. Yet, there will be many child and family cases that do not reach the threshold for child protection, and so there is a risk that services are restricted in how to address housing issues that need to be addressed by parents. In such circumstances, it is crucial that housing join with the multi-agency network around the family to consider ways to provide additional support for the parents to access the appropriate housing for their children.

5.3.6 At the learning event, the closure of cases without responding to the referrer was discussed. For example, when closing cases, how do referrers know what information was gathered and how the decision was made? This reflects some of the issues in Child H's situation, once living with her father. The housing situation was not discussed across agencies. This meant that the overcrowding of the home was not assessed in terms of Child H's complex health needs.

5.3.7 Since Child H's death, Children's Social Care have reviewed their assessment processes and now, Child H's experience in her last year of life would have been considered at least as a child in need. Children's Social Care would also be more inclined to consider holding a professionals' meeting prior to closing a case relating to issues such as Child H experienced. This would provide opportunities for agencies to share concerns about adult issues impacting on the child's welfare and consider options to act to prevent harm, including the involvement of housing in the discussions.

5.3.8 CAMHS have strengthened their approach to children in crisis, since Child H's death. There is now oversight by the organisational safeguarding team of every child presenting in mental health crisis. The oversight uses a Think Family approach, with the safeguarding team checking the family history and advising

on MASH referrals or checking on safeguarding at the seven day follow up with the child. There is monthly supervision for the crisis team.

5.3.9 At the learning event, there was a discussion about how supervision means something different across agencies. Whereby, Children's Social Care and Adult Social Care would require regular supervision to allow effective management oversight of cases where there are escalating risks, this would not be the case in some health services.

5.3.10 For health services, complex medical needs would not necessarily meet the threshold for supervision, such as in Child H's situation. Some children with complex medical needs requiring extra parental support to keep them safe, might not be recognised as needing a referral or discussion with children's social care. Therefore, this remains an area for greater clarity within each agency as to how they ensure their staff have access to opportunities to talk through complex families to help to identify risks to children or adults with care and support needs.

5.4 SAB/SCP Governance

5.4.1 Although Adult H and Child H's father were well known to children's services, as parents, there was a limited focus on their own care and support needs, using a safeguarding adults lens. This illustrated that the 'think family' had not embedded in 2022/23 in the local safeguarding area.

5.4.2 In April 2025, a joint learning event was held for child and adult services. This enabled good discussions between services and teams about how risk is assessed within complex family contexts. Case studies were used to support the thinking of participants to place the following three themes into the context of their practice:

- Theme 1: 'Think Family'.
- Theme 2: Escalation of concerns.
- Theme 3: Working Together across the children and adults systems.

5.4.3 The feedback from the event was that it was helpful to use case studies to explore practice together, and that this would be of benefit with a wider group of frontline practitioners and managers.

5.4.4 This review has facilitated the SCP and SAB to come together. This should be the start of more joint work to fully understand the needs of families with complex needs. The recommendations in section 6 use the existing 'think family' principles as the basis for taking the learning forward from this review, as well as the areas of focus set out above.

5.4 National context

From a national perspective, there is evidence of learning about how the child and adult systems can work more effectively together to 'think family'.

5.4.1 Think Family

5.4.1.1 When an adult is overwhelmed by their mental health or substance misuse care and support needs, there needs to be exploration of, firstly, how this will impact on their ability to keep themselves safe; secondly, about the impact this will have on the adult's ability to parent effectively and to keep their child safe.

5.4.1.2 Consideration needs to be given to what the adult needs to support them to keep themselves safe, using the 6 principles of adult safeguarding[4] to work through this in a personalised way with the adult:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

5.4.2 Think Family

5.4.2.1 When there are concerns identified regarding a child's welfare, there needs to be a good understanding of the family dynamics before any closure of a 'case'. There needs to be a clear plan to support the child. E.g., a child with a poorly managed chronic illness, self-harm, low school attendance, living between homes of both parents.

5.4.2.2 There needs to be consideration of what the child needs to keep well and safe:

- A carer who supports management of chronic illnesses effectively
- Services which monitor management of chronic illness and escalate when there is evidence of continual poor management
- CAMHS
- Adult support to access school
- Safe space within each home

5.4.2.3 Children have said that they need:[5]

- vigilance: to have adults notice when things are troubling them

[4] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

[5] HM Govt. (2023) Working Together to Safeguard Children, Statutory Guidance. p12

- understanding and action: to understand what is happening; to be heard and understood; and to have that understanding acted upon
- stability: to be able to develop an ongoing stable relationship of trust with those helping them
- respect: to be treated with the expectation that they are competent rather than not
- information and engagement: to be informed about, and involved in procedures, decisions, concerns and plans
- explanation: to be informed of the outcome of assessments, and decisions and reasons when their views have not met with a positive response
- support: to be provided with support in their own right as well as a member of their family
- advocacy: to be provided with advocacy to assist them in putting forward their views
- protection: to be protected against all forms of abuse, exploitation, and discrimination

5.4.2.4 Working with parents and carers[6] requires:

- Effective partnership working with parents and carers happens when practitioners build strong, positive, trusting, and co-operative relationships.
- Verbal and non-verbal communication should be respectful, non-blaming, clear, inclusive, and adapted to parents and carers needs.
- Practitioners empower parents and carers to participate in decision-making to help, support and protect children.
- Practitioners involve parents, carers, families, and local communities in designing processes that affect them, including those focused on safeguarding children.

6. System learning and recommendations

6.1 Think Family

6.1.1 At the core of the learning from the experiences of Adult H, Child H and their wider family, is that there needs to be a 'think family' approach for families in similar circumstances. This could facilitate more effective assessments of the needs of the individual members of the family and then consider how the combined needs can be met to help the family to move forward safely.

[6] HM Govt. (2023) Working Together to Safeguard Children, Statutory Guidance. p15

6.1.2 Learning Event Findings

6.1.2.1 At the learning event in April 2025, the participants were given the following questions as suggestions to consider in relation to ‘Think Family’:

- Managing the risks in families where there are children and adults with complex needs.
- What are the expectations on the adults to be capable of attending to their child’s complex needs, when they themselves have intensive needs?
- Care and support needs of adults with mental health or substance misuse issues
- How are children identified and supported as young carers?
- In families where there are children and adults with complex needs, how do agencies work together to assess and manage the risks?

6.1.2.2 There seemed to be a good relationship between Children’s Social Care and Adult Social Care managers at the event, and constructive conversations between adult and children services regarding parental issues such as mental health and substance misuse.

6.1.2.3 The view of the participants was that there are no barriers to discussing families between Children’s Social Care and Adult Social Care. However, there were some questions about the difficulties children’s services can face in trying to locate some adult services, due to the service title not demonstrating the type of provision being offered.

6.1.2.4 At a manager level, the ambition to promote the ‘think family’ approach was apparent. The feedback for the event emphasised how the use of the case studies with practitioners would be of benefit to encourage the ‘think family’ approach. This would help to demonstrate how information about family members is not always known by the whole multi-agency network and needs to be collated to enable joint assessment and decision making.

6.1.2.5 At the event, Adult Mental Health services (AMH) indicated that they would refer to the children’s Multi-Agency Safeguarding Hub (MASH) if an adult patient is known to have children. This is positive, but there needs to be a joint understanding of what support would be offered to the adult to promote effective parenting to safeguard the child.

6.1.2.6 In Child H’s experience, Adult Mental Health did make a MASH referral just weeks before her death, due to their contact with her father. This did not lead to a joint child and adult plan for support of the family. In future, there should be consideration of joint visits between children’s social care and Adult Mental Health to consider the needs of both parent and child.

6.1.3 Areas for further consideration

There needs to be a consistent approach to agencies working with families, no matter whether their specific focus is on the adult or child. Questions could include:

- Who else is in the family?
- Who is reliant on the adult to provide parenting, care and support?
- Who can provide the parenting and care for the child with additional needs?
- How does the adult's own care and support needs impact on their parenting?
- What support does the adult need to deliver their parenting responsibilities?
- What understanding does the adult have of the impact of their care and support needs on their children?
- What are the risks of extra familial harm on the child, and how does this impact the whole family?
- How will information be shared across agencies involved with different family members?
- What will be the impact of not sharing information about different family members?

Recommendation 1

- The Safeguarding Children Partnership and Safeguarding Adults Board to undertake a 'Think Family' project. This would enable an evaluation of the impact of the 'think family' guidance and, from that, the development and implementation of further toolkits, training and audits across the children and adult systems.

- This should include consideration of how Making Safeguarding Personal can be used for the adults with care and support needs who are parents involved in the children's safeguarding processes.

6.1.4 To align with the 'think family' project, there are also three further recommendations which should be incorporated within the project as they also fit across the child and adult systems.

6.2 Young carers

6.2.1 A young carer is a person under 18 who provides or intends to provide care for another person[7]

6.2.2 Child H was not recognised as being a young carer. Indeed, she probably would not have given herself that label. However, she experienced both parents struggling to manage their own care and support needs. Therefore, she was in an adult role, even if it was to manage her own health needs, and she openly told professionals how she worried about her sibling.

6.2.3 In the local safeguarding area, it is estimated that at least 3,000 young carers – children and young people under 18 – provide essential care for a family member or friend due to illness, disability, mental health challenges, or substance misuse. Some of these children could be living in similar circumstance to those of Child H and her family.

Recommendation 2

As part of the 'Think Family' work, there should be an assumption that, where there are adults, or siblings, with care and support needs that a child will be taking on some level of caring role that would not be expected of a child. This should build on the work of the Safeguarding Children Partnership to support young carers and be widened to include the Safeguarding Adults Board. Between the two partnerships, there should be monitoring of the impact of the young carers work in the local authority in empowering children to reach adulthood safely.

6.3 multi-agency high risk panels

6.3.1 At the learning event, there was a consensus that high risk panels would be appropriate settings to bring agencies together to consider the options to offer support to families where there are complex needs for adults and children.

6.3.2 For Adult H and Child H, this could have been an opportunity to share the information about the risks posed for both parents and the children. Additionally, there could have been consideration of where the parents of Child H could find advice and support. For example, for those with drug and alcohol problems, there has been a contract for a legal outreach service which supports those using drug and alcohol or homelessness services with financial and housing advice. The service reports that there can be improvements in the individual's stress levels, feeling more independent, living environment and relationships. For Child H's parents, this might have been of benefit in seeking advice in relation to the accommodation needs of the family. As it was, the parents seem to have been limiting their contact with the professionals involved with the

[7] HM Govt. (2023) Working Together to Safeguard Children, Statutory Guidance.

family, perhaps to avoid the intrusion into their lives. However, this had no benefit to any member of the family and placed the children at greater risk of harm.

'The purpose of the service is to reduce service users' health and income inequalities, and improve their general wellbeing, through the resolution of their legal problems. It is our experience that when a service user's legal problems are being addressed, they are more able to engage with the treatment services and address the issues related to their alcohol and/or drug use.'[8]

Recommendation 3

In order for the Safeguarding Children Partnership and Safeguarding Adults Board to gain assurance that children and adults with complex needs are not placed at risk of harm due to not meeting the threshold for services, as part of the suggested 'think family' project, it is recommended that there is:

- An audit of children with complex health needs who have are known to Children's Social Care, who have parents with care and support needs due to alcohol or substance misuse.
- There should be an assessment of how services are working together to offer support to the families, and what joint risk assessment is undertaken when parents are declining support from services.
- Consideration of how the high-risk panels across the Safeguarding Children Partnership, Safeguarding Adults Board, and Community Safety Partnership manage referrals effectively.

6.4 Supervision and escalation of concerns

6.4.1 The learning event demonstrated a high level of managerial knowledge of the escalation process. There was a consensus that being able to talk between services facilitates safeguarding of children and adults. The use of high-risk panels is supported and recognised as being good practice.

6.4.2 The participants at the event presented a positive, knowledgeable approach to escalation of concerns. However, as there were a number of managers at the event, it was not clear if there is a consistent understanding of the process across front line practitioners in all agencies**.** This raises the question of how the Safeguarding children Partnership and Safeguarding Adults Board know the extent to which the escalation processes are embedded in practice.

6.4.3 At the learning event, it was shown that there is a disparity in how supervision is understood across the multi-agency system, which creates the risk that concerns are not always escalated as they have not been assessed as needing multi-agency safeguarding intervention. This links with how some

[8] Release: Drugs, the law and your rights. Legal Outreach service Activities and Outcomes report January 2025.

services use thresholds or criteria to be met before a child or adult can have access to the service, which places the risk that a child could be at risk of harm due to their parent or carer not receiving the care and support they need to keep themselves and their family safe; or that a child could be at significant risk of harm due to the cumulative impact of potential neglect of their needs not being identified by services.

6.4.4 Supervision processes are defined differently across agencies. Therefore, it is important that there are shared principles of effective supervision that can be implemented through the various approaches.

6.4.5 For safeguarding children, the statutory guidance[9] states that:

'Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role.'

6.4.6 In order to achieve this, staff need access to supervision which is sufficient in helping staff to carry out their responsibilities to safeguarding children or adults.

6.4.7 The statutory guidance[10] emphasises that:

'Effective supervision can play a critical role in ensuring a clear focus on a child's welfare and support practitioners to reflect critically on the impact of their decisions on the child and their family.'

6.4.8 Each agency should have a culture of continually learning and developing its staff. Core to this is for there to be arrangements in place for staff to be able to have access to supervision and learning opportunities which support staff to undertake critical analysis of their assessment of the needs of the children or adults with whom they are working.

Recommendation 4

The Safeguarding Children Partnership and Safeguarding Adults Board should use the 'think family' work to bring agencies together to:

- Agree safeguarding supervision principles
- Gain assurance of the effectiveness of safeguarding supervision processes across the multi-agency system
- Develop opportunities for multi-agency critical analysis of complex cases. This could be achieved through the use of a series of case studies and for each agency to set out in what circumstances the case would reach supervision within their agency.
- Establish joint supervision sessions for child and adult cases that are rated as high risk by either Children's Social Care, Adult Social Care or both.

[9] HM Government (2023) Working Together to Safeguard Children
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[10] HM Government (2023) Working Together to Safeguard Children
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2