Child Safeguarding Practice Review

A thematic review examining the quality of child protection investigations in Bristol.

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1. Introduction & background to the review

1.1. This summary reports sets out the findings and learning as a result of a Child Safeguarding Practice Review (CSPR) that was commissioned by the Keeping Bristol Safe Partnership (KBSP).

1.2. In December 2022 a four-month-old child sadly died. The child, who for the purpose of this review will be known as Child A, was the youngest in a large family with multiple children under 18 years. The family are black British with Jamaican heritage. Agency records have confirmed that there had been periods of early help, child in need and child protection involvement with the older siblings since 2003, but there had been no contact or referrals with social care or early help between 2018 and April 2022. Issues noted during previous involvement included multiple concerns about a range of complex issues - domestic abuse, potential cannabis use by the parents, physical harm and harsh parenting of the children, neglect, emotional abuse, and poor supervision.

1.3. A thorough and systematic Rapid Review was carried out by the Partnership. The Rapid Review noted a range of pre-disposing vulnerabilities, situational risk factors but also protective factors for the family and professional involvement over the years. Considerable learning was identified, with associated improvement action. Ultimately, the cause of Child A's death was determined not to be as a result of abuse or neglect.

1.4. The quality and effectiveness of the initial multi-agency response to the death of Child A, and subsequent early stages of investigation, was highlighted as a concern during the Rapid Review. This was made more complicated due to the high level of uncertainty about the cause of death and reliance on medical professionals to provide an explanation. Given concerns about the quality and effectiveness of the multi-agency response, it was agreed a CSPR should be undertaken. In order to better understand the reasoning behind this decision, the following commentary and analysis from the Rapid Review is helpful by way of setting the context.

> *'… Following A's death, a joint agency response was triggered. This was initially coordinated by the Emergency Duty Team out of hours over the weekend and then transferred to the allocated social work team on the Monday morning. The police also transferred the investigation on the Monday morning from the Investigations team to Operation Ruby, the specialist child abuse investigation team. A multi-agency strategy was called the day of Child A's death by EDT and three follow up strategy meetings being held over the following 10 days.*
>
> *This has raised differences in professional opinion about the quality of the multi-agency response and highlighted some potential concerns about joint working by core statutory partners. It is important to recognise that all agencies faced significant challenges in responding to a complex and unexplained death in tragic circumstances. … The minutes of strategy meetings do not provide clear next steps. … The rationale for multi-agency safety plans for the siblings were not well evidenced … There were also points where significant changes in the safety plan were made and this was not communicated or planned for in advance by the police with social care.*
>
> *Although police had seized relevant evidence, they were not in agreement about taking further investigative steps in relation to systematically excluding or confirming hypotheses which would have supported safeguarding decisions for the other children as they felt there was a need to wait for the medical reports. Therefore, an investigative timeline of events for use by the teams was not developed and formal statements were not taken from parents. … there was no systematic joint investigation plan from social care and Operation Ruby … Medical findings from tests such as the skeletal survey took longer than initially anticipated by the multi-agency group and little discussion was had about what the analysis of risk would be were results inconclusive … .'*

1.5. Given these findings from the Rapid Review, the KBSP determined that the review should take a thematic approach as a way of better understanding the key barriers and system pressures that exist to consistently

achieving good quality child protection investigations. The decision to take this thematic approach, as permitted by both statutory and non-statutory[1] guidance, was further reinforced when placed in the context of other existing evidence, for example the findings from local audit and inspection[2] or peer review[3], which indicates that there is a need to strengthen multi-agency working around the initial stages of child protection interventions.

2. Arrangements for the review, including lines of enquiry

2.1. The decision to conduct a thematic CSPR followed the conclusion of the Rapid Review held at the end of December 2022 This decision was supported by the Child Safeguarding Practice Review Panel[4]. The following steps were then taken:

- The Keeping Bristol Safe Partnership appointed Kevin Ball[5] as the Independent Reviewer, in April 2023.
- An initial scoping meeting was held in April 2023 during which arrangements for the review were confirmed.
- Further meetings involving representatives from relevant agencies were held in May, June, and August, to support the smooth and timely completion of the review, as well as reflect on emerging information.
- Seeking information reports from relevant agencies involved with the family, but also those that are, more broadly, key partners in the initial response to child protection investigations in Bristol, was worthwhile; as such relevant agencies submitted information reports against the agreed lines of enquiry.
- Two separate, but linked, facilitated multi-agency workshops were held in July 2023.
    - Firstly, a session for practitioners who had involvement with child protection investigations across the local area, some of whom had contact with the family; this allowed the practitioner perspective to inform the analysis and findings. As part of this session, practitioners from the multi-agency network were asked to discuss and develop a root definition that embodied what a good quality child protection investigation looks like. They were then asked to map, using a time-line approach, the process for initiating, conducting, and seeing through a multi-agency investigation, with a particular focus on capturing key tasks and associated barriers or challenges.
    - Secondly, a session was held for designated post holders and managers that had a key role in influencing the quality and effectiveness of the multi-agency response to initial child protection investigations, some of whom had involvement in the case that triggered the review. Again, they were asked to develop a root definition of what embodied a good quality child protection investigation, and then explore opportunities for strengthening policy, procedure, and practice.
- Following a Review Panel held in August 2023, the KBSP determined that there would be value in undertaking a concise audit of nine cases examining a number of key aspects relating to joint investigations. This was completed internally during October 2023, and the findings then shared with the Independent Reviewer in November.

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[1] Working Together to Safeguard Children, 2018, HM Government & Child Safeguarding Practice Review Panel guidance for safeguarding partners, September 2022, HM Government.

[2] Ofsted, Inspection of Bristol local authority children's services, Inspection dates: 16 to 27 January 2023, Inspection report

[3] Local Government Association, Bristol City Council Children & Families Services Peer Challenge: 12th to 15th October 2021, Feedback Report

[4] Child Safeguarding Practice Review Panel is established under the Children & Social Work Act 2017.

[5] Kevin Ball is an experienced independent consultant, chair, reviewer and scrutineer. He is an approved reviewer for the Child Safeguarding Practice Review Panel national pool of reviewers.

- Methods and thinking taken from a Soft Systems Methodology[6] have been used to conduct this review. The process has therefore not only been system focused, but also collaborative, inclusive, and generative.

2.2. The following services and agencies have contributed to this Review:

- Avon & Somerset Police
- Bristol City Council Children & Families Services
- Bristol City Council Safeguarding in Education Team (on behalf of Designated Safeguarding Leads in schools)
- Bristol, North Somerset & South Gloucestershire Integrated Care Board (on behalf of GPs)
- The Emergency Duty Team, run by South Gloucestershire Council
- Sirona Care & Health (Health Visitors, School Nurses & Paediatricians)
- North Bristol NHS Trust (Acute Health Services including Midwifery Services & Neonatal Intensive Care)
- University Hospitals Bristol and Weston NHS Foundation Trust (acute health services)
- The Probation Service.

2.3. The following lines of enquiry were agreed, and from which findings and analysis have been synthesised;

1. How do current demands and system pressures impact our joint working in child protection and how might we mitigate these?
2. How might we improve the quality and consistency of multi-agency Strategy discussions?
3. How can out of hours and in hours services be resourced or supported to work effectively together?
4. What opportunities are there to address and improve joint working?
5. How can we improve joint investigation planning in complex family circumstances when there is significant harm to a child e.g., large families or multiple interconnected families?

3. Findings & analysis

1. As a starting point, setting out expectations placed on statutory agencies is key. Statutory guidance[7] states,

'… Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies such as the referring agency … to determine the child's welfare and plan rapid future action if there is reasonable cause to suspect the child is suffering or is likely to suffer significant harm … [and] to decide whether and what type of action is required to safeguard and promote the welfare of a child …'.

2. Practice wisdom reminds us that inherent within the above definition are levels of inevitable uncertainty, whether that be needing to wait for a medical opinion about cause of injuries/death but which still may not provide certainty, and dealing with unknowns. Research[8] refers to *this '… uncertainty is an inevitable part of life in an area like child protection. Indeed, this is what the idea of probability is for. When we can't say for certain what may happen at some point in the future, we are reduced to considering the likelihood of it … uncertainty is particularly hard to bear when there is so very much at stake ….'* Therefore, the need to ensure the highest quality and maximum

[6] Soft Systems Methodology, Chapter 5 by Checkland, P., & Poulter, J., in Systems Approaches to managing change: A Practical Guide, Reynolds, M., & Holwell, S., 2010, Springer, London.

[7] Working Together to Safeguard Children, 2018, p. 41, HM Government.

[8] Beckett, C., in Calder, M., Contemporary risk assessment in safeguarding children, p. 41, 2008, Russell House Publishing.

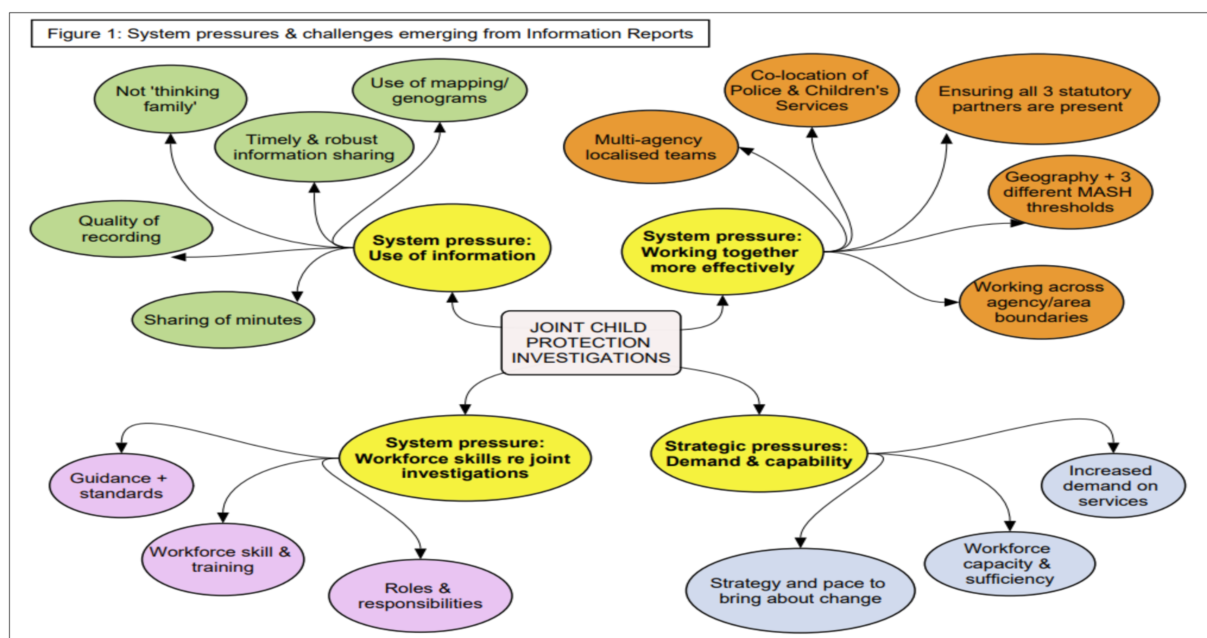
effectiveness of multi-agency working at the critical early stages of child protection investigations, resulting in sensible, compassionate, and proportionate safety planning which are in the best interests of children, is vital.

3. As previously noted, the KBSP identified that good quality child protection investigations not consistently being achieved. To examine this issue, concepts from a Soft Systems Methodology have been applied as a means of teasing out what the barriers, but also remedies, might be; '*… Soft Systems Methodology (SSM) is an approach for tackling problematical, messy situations of all kinds. It is an action-oriented process of inquiry into problematic situations in which users learn their way from finding out about the situation, to taking action to improve it. The learning emerges via an organised process in which the situation is explored … and structured by using, … questions to ask in the real situation …'*[9]. Therefore, gaining the participation and perspectives of those professionals that are part of the situation has been important to help disentangle the different features.

4. Performance data has been provided for the purposes of this review. Intentionally, this report will not replicate all that data, however there is value in highlighting some headlines which set challenges and key barriers faced by the three key statutory agencies in context. Headlines include:

- Bristol City Council Children & Families Services report a steady, and significant increase, in the number of Strategy discussions over the last 3 years, from 903 in 2019, to 1358 in 2021, and 1623 in 2022.
- Avon & Somerset Police have increased staffing in Operation Ruby[10] to respond to the 38% increase (November 2022 to April 2023) in investigative demands.
- Sirona Care & Health have seen a 26% increase in Strategy discussions (which includes an increase in complexity of discussions) and a 28% increase in child protection medical examinations across the three local authority areas they cover, and between January – December 2022. They faced a total of 352 requests for parallel Strategy discussions across their organisational footprint.

5. Information reports have been submitted by key agencies. From analysis of those reports, system pressures and challenges have been identified in relation to the lines of enquiry. Figure 1 below illustrates these.



[9] Soft Systems Methodology, Chapter 5, p. 191 – 192, by Checkland, P., & Poulter, J., in Systems Approaches to managing change: A Practical Guide, Reynolds, M., & Holwell, S., 2010, Springer, London.

[10] Operation Ruby is a the specialist and dedicated child protection team within Avon & Somerset Police.

6. Themes captured expose what are described as system pressures (highlighted in yellow in Figure 1 above) i.e. use of information, working together more effectively, & workforce skills regarding joint investigations; these reflect the key barriers which exist to achieving consistently good quality joint child protection investigations in Bristol. Many of the key barriers captured in this review correlate with the findings from the recent Child Protection in England[11] review. The following sections provide insights into these key barriers based on an analysis of Information Reports but also views shared by those that attended the workshop sessions. Issues described as strategic challenges, are considered, and woven into the following sections.

7. As an initial finding, there was a clear desire and commitment, expressed via both Information reports but also those that attended the workshop sessions, to strengthen arrangements where-ever possible. This is important to hear; a desire and commitment to change, driven by those that operate within the system on a day-to-day basis, is a pre-cursor to change and improvement activity being successful – if the desire and commitment was not there, successful change would be much harder and likely take longer to implement and embed.

3.1. System pressure & practice challenge: Working together more effectively

3.1.1. The findings set out below, which reflect practice challenges and key barriers, should be considered in context of findings from the two recent national reviews which examined working arrangements across the multi-agency landscape. Of relevance are the findings from the Child Protection in England[12] report which recommends Multi-Agency Child Protection Units being established in every local authority area, '*… integrated and co-located multi-agency teams staffed by experienced child protection professionals …*,' reflecting the need for '*… fully integrated multi-agency investigation and decision making, end-to-end across the child protection process; embedded in both structures and cultures … .*' This sits alongside a recommendation by the Independent Review of Children's Social Care[13] regarding the development of multi-disciplinary Family Help Teams. The Government are currently consulting on amending statutory guidance[14] to reflect the findings and recommendations from these national reviews.

3.1.2. Information Reports submitted highlight a number of issues which undermine effective joint working; these include workforce sufficiency alongside demand for services, implementation of a strategic approach which promotes earlier help and a subsequent redesign of service provision, organisational structures across the three core partner agencies, and the impact of Covid-19. Underlying this complex interplay of issues, are useful reflections from the Council Children & Family Services '*… Over the first year of COVID we saw significant impact on our child protection system with a major reduction in all child protection work from reductions in referrals, through to reduction in assessments, reduction in strategy meetings, reduction in s47 and reduction in child protection plans. … A combination of children hidden from services due to being out of education and the benefits of significant investment in our early help system is thought to have contributed to this change. Over 2021 this position started to revert …*' Following a Local Government Association peer review '*… our application of threshold was inconsistent … and the culture of working at the lowest level of intervention collaboratively with families … was misinterpreted by some teams and had led to some children being worked with as child in need where child protection enquiries were required …*'; such an issue will have had ramifications across partner agencies understanding about how the

[11] Child Protection in England, National review into the murders of Arthur Labinjo-Hughes and Star Hobson, 2022, Child Safeguarding Practice Review Panel, HM Government.

[12] Child Protection in England, National review into the murders of Arthur Labinjo-Hughes and Star Hobson, 2022, Child Safeguarding Practice Review Panel, HM Government.

[13] The independent review of children's social care – Final report Research report, May 2022.

[14] Working Together to Safeguard Children, 2023, HM Government.

continuum of need is responded to as a multi-agency network and is a key barrier. Given this, the KBSP may wish to re-emphasise key messages about the continuum of need with the workforce and help professionals understand the threshold boundaries when stepping up or down, intervention. Review of the documents on the KBSP website under the 'threshold guidance' link, reveal five different documents[15] associated with understanding thresholds – and which contain a total of 74 pages (a combination of a core overarching document and matrices of need by developmental stage); the Partnership is currently rationalising and simplifying these which is likely to better support professionals responding to initial concerns. There is, for example, no specific mention of contextual safeguarding i.e. those risks young people may face from outside the family home, and how agencies, as a collective, might respond to initial concerns and subsequent investigations.

3.1.3. Concerns have been raised that current working arrangements i.e. hybrid working/home working/and workforce capacity, limit the ability for key professionals to consistently, and effectively come together, to plan and follow-through with good quality child protection investigations; this is a key barrier. Notable comments from the Police and Children & Family Services are set out below, which also identify a potential solution.

- The Council Children & Family Services commented *'… we believe that many issues would be mitigated through co-location. We would recommend piloting police decision makers from Operation Ruby being embedded within the Area Social Work teams. We believe this would enable Police to be involved in real time decisions and planning about responding to urgent child protection concerns and would make our response more efficient and effective. We believe this would enable relationships to be built, better coordination of resource and good joint planning. We also think the Partnership should ensure that all agencies are back working full time in person in the MASH as we are of the view that police and health staff working from home still has impacted the quality of front door responses to referrals and this impacts the initial trajectory of the response to the child …'*
- The Police also refer to co-location and there appears to be consensus about the benefits, and an expressed desire to explore this model of working further *'… There are potential solutions to create more joined up working with partners, including development of Public Protection Units, co-location, developing closer working relationships and joint training … Strategies are currently still held remotely with different agencies sat in different locations. This is not conducive to building that Multi-Agency Safeguarding Team. If co-located with the right roles (Decisions Makers and Safeguarding Officers from the Lighthouse Safeguarding Unit) these relationships would build, conversations would happen organically and strategies would be organised quicker as timings could be agreed in person, instead of the delay that emailing naturally brings … .'*

3.1.4. Re-establishing colocation in person as standard in the MASH is achievable and supported through the current infrastructure of the front door. In respect of child protection teams, the suggested potential remedy of co-location may be feasible in the Bristol area, however, it must be acknowledged that Avon & Somerset Police cover five local authority areas. This may make implementing co-location more challenging, especially given the levels of demand, and would need to be resourced to effectively deliver this aspirant remedy. Health care agencies also cover a wider footprint than just the Bristol area. The concept of co-locating does reflect the drive, seen via the consultation document on revised statutory guidance[16], to place even greater emphasis on the multi-agency response to child protection concerns and potentially points to a system re-design rather than just changes to day to day working practices.

3.1.5. Whilst other agencies that submitted Information Reports did not express explicit views about co-location, reflections from Information Reports but also workshops, did include a clear wish to be more efficient in how key agencies worked together at the initial stages of a child protection investigation; this included reflections by

[15] Working together to get the Right Help at the Right Time for the Right Duration, Bristol Multi Agency Threshold Guidance, April 2018.

[16] Working Together to Safeguard Children, 2023, HM Government.

agencies about their own internal pathways and processes that would, or could, lead to a more efficient and effective processes of engaging with partner agencies. University Hospitals Bristol & Weston NHSF Trust stated, for example '*… A shared MASH approach, ideally across the three local authorities, may lead to a more consistent approach with staff with the right level of experience ….*' Sirona Care & Health commented '*… The Sirona Safeguarding Children's Leads and the Named Doctor for Safeguarding children are in the process of reviewing the pathway of delegation for a single point of access for strategy discussions in collaboration with health partners and the ICB ….*' A revised pathway of delegation has great potential going forward, and this too has been noted by the Council Children & Family Services who have reflected '*… We are supporting the move to a multi-disciplinary hub to improve the health offer however this will require coordination across multiple health providers. Currently the agreement for this coordination and systems and functions for arranging and ensuring the appropriate health representation is being established ….*' Unless universal, and agreed by every single health care provider in the area, a scheme of delegation would only provide a partial remedy as Sirona Care & Health would not be able to make decisions for all health agencies i.e. those where there may be specialist input. This potential remedy therefore needs to be explored further.

3.1.6. Results from the concise case audit undertaken in October 2023 highlight, overall, a positive set of findings about working together; however, in three cases it was noted that there were opportunities for strengthened decision making on cases which would have resulted in better multi-agency collaboration, particularly between the Police and the Council Children & Families Services.

3.1.7. Other key barriers (and possible solutions) were raised about working together more effectively, and include;

- *Insufficient opportunities for multi-agency training*: A strong view was expressed during both workshop sessions that there needed to be more opportunities to undertake multi-agency training specifically in respect of improving workforce skill and knowledge about joint working within the specialist areas associated with joint investigations. There is currently an extensive multi-agency training offer but this has only limited specific training focused on section 47 assessments and child protection investigations with greater focus placed on the wider multi-agency working.

- *Practicing in a safe environment, outside of real-life scenarios:* Linked to the previous points, the Police commented on a recent simulated exercise which supported greater working relationship and which has the potential to increase knowledge and confidence when working together in real life scenarios '*… [we] facilitated Hydra MACIE (Multi Agency Child Investigation Exercise). All our 5 local authority areas were invited along with health and education colleagues from across the force area and out investigation teams. This exercise ran mock strategies in a safe learning environment; this enabled attendees to have working discussions with other professionals from different areas to share best practice. More of this type of practical multi-agency training, especially for new starters would help to improve the quality of multi-agency strategies ….*' Usefully, the Council Children & Family Services report that three more cohorts have completed such exercises.

- *Multiple points of vulnerability:* The Council Children & Families Services report that currently '*… Strategy discussions are requested by any of the social work teams as required. There are around 35 managers in the service who may be requesting a strategy meeting at any time across a wide range of services …*'. Consideration should be given to amending the local authority administrative process that surrounds Strategy discussions by, for example, developing shared multi-agency technological solutions for supporting the coordination and booking of requests for Strategy discussions needed by the Children & Families Service. This could have the benefit of standardising the process, steer consistency and improve quality, but also strengthen performance monitoring, timeliness, and resource management.

3.2. System pressures & practice challenge: The use of information

3.2.1. The use of information, in its broadest sense, emerges as a theme from review of Information Reports and workshop discussions as a challenge and barrier. Issues raised do vary, but mostly concern the variable quality and the timeliness of information sharing between agencies at the point of initial child protection concerns arising; recording practices are also reported as being inconsistent; a finding that was supported from the results of the concise case audit. In turn, these then might impact how information is used, analysed, and translated into decision making and safety planning for children. The importance of information sharing persists as a finding from research and policy[17]. Information sharing was raised as an area for improvement in a recent thematic CSPR[18] conducted in the local area, highlighting the persisting and challenging nature of working in a complex safeguarding system.

3.2.2. The Safeguarding in Education Service for the Council reflected *'… Professionals who work in different settings to those their siblings attend (who may not be the subject to concerns or due to their age) are not always invited. A think family approach is not always taken ….'* This reflects the challenges of balancing proportionately of information sharing and maintaining the focus on a timely effective s47 investigation and the involvement of wider networks. A similar view was expressed by the NHS Bristol, North Somerset & South Gloucestershire Integrated Care Board on behalf of GPs *'… As Primary Care givers, we are not always aware of safeguarding concerns and are not always routinely invited to Initial Child Protection Conferences. Feedback from meetings can be inconsistent from primary care point of view – we don't always know in a timely fashion (if at all) what the outcomes are and this can present challenges when interacting with families / reviewing other aspects of care ….'* This view, as reflected by the ICB on behalf of GPs may need further testing as the Council Children & Families Services have offered a contrasting perspective, in that GPs are routinely informed and invited.

3.2.3. The Probation Service expressed a view that reflects findings made following local inspection[19] but also national review[20] of the Probation Service as a whole *'… The process for obtaining safeguarding information in relation to children resident with or having contact with a person on probation is not fully established';* thereby highlighting potential risk to the safety of children which may go unchecked at the critical stage of initiating a child protection investigation. A new regional Probation Service team are working with partners to improve this issue.

3.2.4. Positively, North Bristol NHS Trust commented on a situation that demonstrates that improvement about invitations to Strategy discussions is possible, once escalated. Between October and December 2022, the Trust *'… attended 18 strategy meetings in respect of unborn babies; this represented a typical frequency of participation in strategy meetings. The previous quarter there had been two strategy meetings held for unborn babies in Bristol, to which maternity were not invited ….'* This recent example highlights the importance and benefit of challenge and escalation by professionals and that it can be a force for positive change.

3.2.5. The Council Children & Families Services have expressed a number of relevant points which relate to the good use of information or information exchange processes, but highlighting barriers. These include *'… chairing of strategy meetings can be inconsistent and not consistently recorded* [supported by the findings of the concise

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[17] Improving multi agency information sharing: Government policy on information sharing and the use of a consistent child identifier, July 2023, HM Government.

[18] Cross-Border Peer-on-Peer Abuse and Child Criminal Exploitation: A Thematic Child Safeguarding Practice Review For Keeping Bristol Safe Partnership, South Gloucestershire Children's Partnership and North Somerset Safeguarding Children Partnership, Dr Julie Harris, University of Bedfordshire, 2021.

[19] An inspection of probation services in: Bristol and South Gloucestershire PDU The Probation Service – South West region HM Inspectorate of Probation, August 2023.

[20] HM Inspectorate of Probation Annual Report 2022/2023.

case audit]. *We recognise this is an area of development for our managers … we are curious as to whether technology would support us to share strategy minutes more quickly … and whether a strategy request system such as use of a SharePoint to share documents and requests would be better and prevent reliance on email inboxes … conflicting shift patterns of Police investigation team staff and social workers leads to operational challenges and sharing of information in a timely way … .'* A further important point about the hand-over between the Out of Hours and day time services has also been flagged as contributing to inconsistent practices '*… generally we receive information in a timely way however recording is not standardised in EDT and does not mirror in hours recording systems … this means that complex information can be misinterpreted or we risk 'starting again' with our assessments of risk … .'* Again, it is important to acknowledge that the EDT service covers a greater geographical footprint than just the Bristol area – however, the standardisation of information sharing procedures and document templates may prove to be beneficial to all partner agencies to promote timeliness and accuracy of information sharing.

3.2.6. It is worth acknowledging a recent Government research report[21] about improving multi-agency information sharing, which offers indicators about the possible direction of travel for local areas in respect of using, and sharing, information about children. The research highlights five barriers to information sharing; systems and processes, perceptions about legislation, practice confidence, leadership and culture, capacity, and resource. The use of technological systems i.e. software and databases, is explored with promising findings from those areas that have piloted such approaches. Additionally, the Partnership will need to be mindful of the current Government consultation[22] on revising guidance *'Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers'*, and the likely implications this will have for any new local initiatives. Given the likely direction of travel about improvements to be made regarding multi-agency information sharing (but also multi-agency working arrangements), some of the structural changes referred to above in sections 3.7 – 3.12, e.g. co-location, partners across the Bristol footprint may wish to build on current ambitions[23], and take a strategic approach to information sharing arrangements, which in turn, will have the potential to enhance the quality of child protection investigations. Importantly, no matter how great the technological improvements that are made, it will be vital to nurture and invest time with those individuals that are end users, by providing them with training and real time support – not only in how to use the IT systems and processes, but also how to use the information they may access to better support more effective child protection investigations.

3.2.7. The inconsistent use of genograms was raised by a number of agencies as a problem; including Sirona Care & Health, the Council Children & Families Services, University Hospitals Bristol & Weston NHS Foundation Trust, North Bristol NHS Trust, and the Police. The use of other tools, to aid thinking through visual representation or as a way of setting out information may be an area that can be strengthened to support stronger analysis. For example, mind mapping information about children and families where the issues may be especially complex is likely to encourage a stronger analysis, mapping hotspots where exploitation or contextual safeguarding concerns may be prevalent, or matrix analysis tools which help examine the relationship between one factor or another (their intersecting impact) i.e. a discrepancy matrix when faced with what is known about a family, not known, ambiguous and what information is missing. By not using such tools to aid analysis, there is a chance of starting an investigative process or safety planning, with incomplete information. The Partnership may wish to develop a suite of such tools to support practitioners and managers, with a minimum expectation that genograms are used in

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[21] Improving multi agency information sharing: Government policy on information sharing and the use of a consistent child identifier, July 2023, HM Government.

[22] Information sharing advice for safeguarding practitioners, HM Government consultation, closing 06/09/2023, Consultation

[23] Bristol City Council with Somerset Council were funded by the Department for Education as part of the Data and Digital Solutions Fund (DDSF) to deliver a model Safeguarding Data Sharing Agreement template and guidance, Data Sharing Agreements – Important information for professionals (somerset.gov.uk)

every Strategy discussion and subsequent investigation. Such tools should also explicitly encourage consideration about equality and diversity issues, and protected characteristics.

3.2.8. The concise case audit generally highlighted a positive set of results, although findings suggest that information sharing at the point of convening a Strategy discussion, by ensuring a stronger invitation and representation, could be improved. In turn, this impacted on actions and plans that flowed out of the discussion.

3.3. System pressures & practice challenge: Workforce skills regarding joint investigations

3.3.1. Information Reports, plus discussions during workshop sessions, highlighted a theme and practice barrier relating to practitioner skill and knowledge about undertaking joint investigations; this does link closely to workforce capacity and sufficiency.

3.3.2. The Police cite workforce capacity as an ongoing issue of concern with newly created posts in Operation Ruby increasing and being filled – this inevitably brings challenges around the need to train, and upskill new staff into their role, invariably creating challenges around skill and knowledge levels until embedded into practice. With the flux and flow of workforce, this remains an ongoing challenge for not only the Police, but all agencies that experience similar testing workforce recruitment and retention difficulties. Similar issues have been specifically highlighted by the Council Children & Families Services with a social work vacancy rate of 18.3% (as of 31/03/23) with some teams having a more acute situation of vacancy rates above 20%. Sirona Health & Care have used performance data to evidence that the current model and approach to responding to child protection enquiries is vulnerable and is a risk; with an average 3000 Strategy discussions per year, 250/month, 50/week, 12/day, from the three local authority areas they cover. Whilst this has been recognised, escalated, and has a plan to mitigate these risks, it does highlight the importance of workforce skill, knowledge, and confidence, for all agencies involved in child protection investigations. The local authority performance data also highlights a steady increase in Strategy discussions over the last two years, noting *'… our experience is that it has been increasingly challenging to arrange Strategy meetings with core partners as their capacity has reduced. This is despite significant improvements in attendance through the move to Teams ….'*

3.3.3. Achieving consistently good quality joint child protection investigations is reliant on having a sufficiently skilled and knowledgeable workforce. This has been highlighted by the recent Child Protection in England[24] report. The ability to interpret threshold guidance, with the concept of significant harm being at the centre, and applying a rigorous and critical eye to concerns, is key to providing children with the right help, at the right time. Research[25] supports the view that these practice challenges are perennial.

3.3.4. Given the workforce pressures, summarily described above, having clear guidance and standards that steer practitioners and managers is a fundamental necessity. Current guidance around the procedural pathway is provided by Working Together to Safeguard Children[26], which is then interpreted and transferred into local procedural guidance[27]. There does not appear to be any other, more detailed guidance to support practitioners and managers regarding quality measures for each step of the procedural pathway. Of note, the Royal College of

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[24] Child Protection in England, National review into the murders of Arthur Labinjo-Hughes and Star Hobson, 2022, Child Safeguarding Practice Review Panel, HM Government.

[25] a) Good practice in Section 47 inquiries, Archer. J, in Risk in Child Protection: Assessment challenges and frameworks for practice, Calder, M. 2016, Jessica Kingsley; b) Serious case reviews - 1998 to 2019: continuities, changes and challenges, 2022, Dickens, J., Taylor, J., Cook, L., Cossar, J., Garstang, J., and Rimmer, J., HM Government; c) Child Protection in England, National review into the murders of Arthur Labinjo-Hughes and Star Hobson, 2022, Child Safeguarding Practice Review Panel, HM Government.

[26] Working Together to Safeguard Children, 2018, HM Government.

[27] Bristol Safeguarding Partnership Procedures - South West Child Protection Procedures

Paediatrics and Child Health (RCPCH) and the Child Protection Special Interest Group (CPSIG) have published a set of standards[28] about the service delivery aspects of child protection medical assessments with the aim of reducing unwanted variation. Additionally, there is detailed guidance provided by the National Police Chief's Council and the Ministry of Justice for Achieving Best Evidence[29] when, and if, an investigation reaches that stage – however, not all child protection investigations will follow a criminal route. The College of Policing also helpfully provide Authorised Professional Practice guidance[30] on their webpages, specifically relating to investigations management. More detailed guidance does therefore exist once the threshold has been passed requiring very specific aspects of formal intervention – but, prior to this stage, there appears to be a gap especially at a multi-agency level.

3.3.5. The Police and the Council Children & Families Services have expressed a need for further guidance to be available which sets out what a good single or joint child protection investigation should consist of. The issues of standards and consistency have also been raised in the recent Child Protection in England[31] report which recommended the need for a set of multi-agency practice standards for child protection. The Government are currently consulting on the development of such standards, along with revisions to statutory guidance[32].

3.3.6. In anticipation of this issue being raised, practitioners and leaders were asked, as a starting point, during the reflective workshop sessions to consider a root definition that embodies what a good quality child protection investigation might look like in Bristol. Two statements were proposed as a starting point for further work;

A good quality child protection investigation is child centred, timely, considered and provides a structured response that gathers all relevant information from a range of sources and captures the voice of the child. It is open minded and non-judgmental, identifies strengths and concerns, which result in agreed outcomes.

A good quality child protection investigation is child focused, proportionate, multi-agency and systemic where quality information is shared and held in a timely manner. It will have a plan that sets out who is doing what, and when. Best practice would see professionals having capacity for reflective discussion and planning.

3.3.7. Participants were also asked to identify what key features a good quality child protection investigation includes. Figure 2 below provides a storm of words used; again, providing a starting point to build and develop a concise set of standards which may assist the workforce. Clearly, the development of a set of national standards may supersede any developments undertaken by the KBSP, however there may still be merit in exploring these principles further, either as an interim measure, or to share via training, briefings or workshop sessions which focus on the multi-agency response to concerns.

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[28] Good practice service delivery standards for the management of children referred for child protection medical assessments, October 2020, Royal College of Paediatrics & Child Health and Child Protection Special Interest Group, Service delivery standards, 2020

[29] Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Guidance on Using Special Measures, January 2022, National Police Chief's Council & Ministry of Justice.

[30] College of Policing, accessed 14/08/2023, Further investigation webpages

[31] Child Protection in England, National review into the murders of Arthur Labinjo-Hughes and Star Hobson, 2022, Child Safeguarding Practice Review Panel, HM Government.

[32] Working Together to Safeguard Children, 2023, HM Government.

Figure 2: Word storm of key features of a good quality child protection investigation

3.3.8. As previously noted, there was a strong theme about the need for more multi-agency training opportunities expressed by both practitioners and leaders during reflective sessions; this included training around the more basic elements of multi-agency work, including working together and roles & responsibilities, as well as more complex and specialised elements such as achieving best evidence, investigative processes, analytical thinking, and chairing skills. The KBSP currently delivers an extensive programme of multi-agency training and development in relation to safeguarding and child protection. While the request for more joint training was backed up by Information Reports submitted it is likely that there is a linkage between the capacity challenges in key child protection service and the gaps in these teams being able to take up the training offer. Providing refreshed training and development opportunities would also become a logical necessity of implementing any new guidance, standards, or changes to the local organisational architecture responsible for child protection investigations i.e. co-location. The review recognised that specific training in joint investigations for social workers, police and paediatricians was more limited to the SCAIDP (Specialist Child Abuse Investigation Development Programme) offered by the Police with social work input and this had insufficient capacity to meet the size of the social work workforce in the area. Developing a joint training strategy based on a training needs analysis across key members of the workforce specific to skills related to joint investigation would be a sensible starting point for further understanding about what additional training might be beneficial to strengthening practice for this practice area. The review has been advised that a training needs analysis was completed in 2022 however feedback from current training attendees, via post course surveys, suggest there are still gaps in training. Consideration about how this might then be delivered to a multi-agency workforce which is not coterminous and of significantly differing size would be needed once training needs have been identified.

3.3.9. The Police comment on the issue of chairing and its pivotal role at the outset of the child protection process, noting '*… checking and agreeing minutes from strategy discussions including rationales' for decisions made for actions and safety plans, need to be improved. Greater clarity is needed around who is doing what, by when and why, with an agreed mechanism to feedback to relevant partners. Although all statutory agencies have responsibility, it could ultimately be within the role of the Chair to ensure this is achieved for each strategy … .'* Findings from the concise case audit reflect these views, and highlights the necessity of chairs having the skills, knowledge, and experience to effectively undertake the role, and being able to adopt an investigative mindset, especially when responding to more challenging and complex abuse scenarios.

3.3.10. Relevant to all of the above points, was a request by the majority of agencies that contributed to this review, for greater clarity about the roles and responsibilities of those that might be involved in child protection investigations. The Council Children & Families Services *'There is currently confusion about the different health roles and when they should be attending for example paediatricians based at the SARC have given different guidance about their availability for strategy meetings ….'* The Council Safeguarding in Education Service report *'… Largely schools report that they are invited if they have referred into Childrens Social Care. This tends to reflect mainstream education. Post 16, Alternative Providers, and those who are education professionals (education welfare/Statutory SEND team) do not tend to get invited [to strategy meetings]. This is possibly because social workers are unaware of their roles, responsibilities and or involvement'*. Sirona Care & Health state *'… There is often a lack of understanding regarding the role of Public Health Nurses, and this can result in unrealistic expectations and demands ….'* In addition to those specific roles mentioned, helping non-health provision-based service providers i.e. Police and Children & Families Service gain a better understanding about the role terminology and expectations across the whole Bristol, North Somerset, and South Gloucestershire footprint. With the current multiple roles and teams within the Police it will also be helpful for clarity about the different roles and responsibilities of various personnel that might respond to child protection investigations and Strategy discussions requests. Added to this, is a core requirement for all non-Police practitioners to recognise the role and responsibility the Police have in investigating potential crimes; views were expressed at the workshops about the importance of the differing and potentially competing agency priorities i.e. the Police needing to preserve evidence. Building some of this information into the revised threshold guidance/continuum of need document, may be sensible.

3.3.11. From an independent perspective, the use of a Strategy discussion approach which recognised the complexity in the case that triggered this review, was problematic. There were a number of factors, all of which were known at the time and do not just emerge with the benefit of hindsight, which caused difficulty; they include, the sudden and unexplained death of a young child in suspicious circumstances, multiple other children in the household with differing needs, the incident occurring over a weekend and therefore a predictable need to hand over complex information within two key agencies that would be involved (Police and Children's Services). This suggests that the 'standard' Strategy discussion approach was not sufficiently robust to deal with the complexity, and there was no prompt written into guidance or procedure, which suggested to the professionals involved at the time, that something different was needed. The Police have expressed the essence of the circumstances they faced and from which, it may be argued, demonstrate the need for strengthened procedural guidance *'… in this situation where there was an extremely significant incident related to one child it is possible to see how we lose sight of other children, the parents, and their individual, rather than collective needs. Large or multiple interconnected family arrangements introduce a significant level of complexity that necessitate a high level of information sharing and decision about each individual to ensure the right information is available for holistic decision-making ….'* Although the use of the Organised & Complex Abuse Protocol[33] may seem disproportionate or not quite aligned with the circumstances of the trigger case (or others where there may be a similar level of complexity) there is merit in considering whether additional guidance for the 'standard' route and response might be beneficial. This would make more explicit options for dealing with issues such as complexity, resourcing, evaluating risk and safety for a household where there were multiple children under 18 years, issues of capacity and consent, equality, diversity, and protected characteristics, and weighing benefits versus harm decisions having considered their intersecting impact. Applying the principles and concept of a Strategic Management Group plus an Investigation Management Group approach in such circumstances may seem unwieldy but it does allow conversations and decisions to be made at the correct level within organisations. The Partnership may therefore wish to strengthen current guidance about Strategy discussions and child protection investigations to support a more flexible

[33] Bristol Safeguarding Partnership Procedures, South West Child Protection Procedures, Organized & Complex Abuse

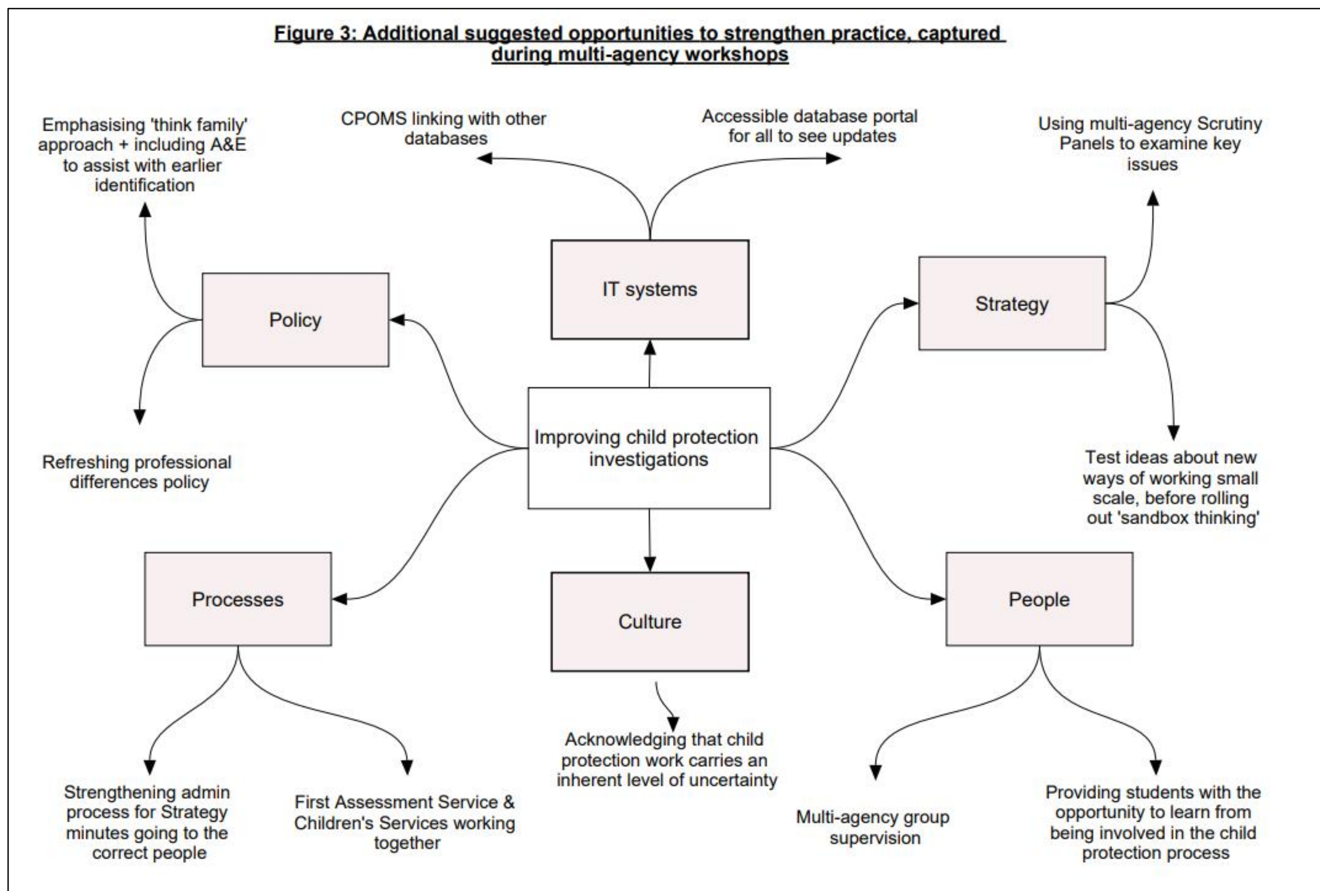
approach. Existing, or new training, should include input about the use of this refreshed procedural guidance to bolster knowledge and confidence of its application.

3.3.12. Figure 3 below highlights additional suggested opportunities to strengthen practice – these were captured during the multi-agency workshops, and may be useful for the Partnership to further explore. These highlight areas that span policy, process, culture, people, strategy, and information technology. Some of these suggestions are just that – ideas on which to hold further discussions. For example, the use of sandbox thinking – a methodology for testing new ideas on a small scale to understand the consequences of the ideas before rolling them out on a larger scale. This may be an approach to consider when formulating a plan, should co-location be seen as viable. Another example includes the use of scrutiny panels, as a means of exercising group curiosity and analysis; this could be used as a method for scrutinising data and quality assurance of child protection investigations to highlight strengths and vulnerabilities. A final example from the additional suggestions raised, relates to involving students and what was described as 'normalising' the child protection process. This suggestion was founded on the view that a child protection enquiry, whilst requiring refined skills, knowledge, and experience, should be seen as an opportunity for students to learn[34], gain insight and experience by shadowing more experienced practitioners – thereby not compartmentalising it as an activity that is reserved, but seen on a continuum of professional intervention. The KBSP may wish to examine these additional suggestions in further detail, to decide which ones may contribute to improving working arrangements.

3.3.13. In terms of applying some weighting to these suggestions, and which proportionately, may have the greatest impact in supporting improvements to child protection investigations, the following three ideas are highlighted;

i. *Multi-agency group supervision:* The suggestion made refers to 'supervision'; however, it could be a model of multi-agency group work, which could be applied in a range of scenarios, e.g. complex families where new, or recent concerns have emerged, and which have resulted in a Child Protection Plan, cases that appear stuck and the multi-agency network might benefit from fresh thinking or analysis. Fundamentally, it would provide a safe space opportunity to slow thinking down, reflect on situations which may be complex or stuck, and supporting professionals working effectively as a group. Supervision, action learning, facilitated learning conversations – are just three models.
ii. *Multi-agency Scrutiny Panels:* These could be established to examine a focused topic, such as Strategy discussions and child protection investigations. Insights, data, knowledge, and experiences (either case level or organisational level) could also be brought for discussion and scrutiny. Such sessions would need clear terms of reference and could involve practitioners, managers or designated post-holders.
iii. *IT systems:* The use of information technology systems which support timely and effective sharing of information with relevant professionals in the early stages of a child protection investigation is likely to benefit from further local exploration.

[34] Jansen, A., 'It's So Complex!': Understanding the Challenges of Child Protection Work as Experienced by Newly Graduated Professionals, The British Journal of Social Work, Volume 48, Issue 6, September 2018, Pages 1524–1540.



4. Learning captured as a result of conducting this review.

4.1. As previously mentioned, learning was identified during the Rapid Review phase of this review which was particularly pertinent to the specific case which triggered the need for a review. This CSPR has however taken a broader and more systemic view, and reviewed one aspect of the procedural pathway by exploring what the key barriers might be to achieving consistently good quality child protection investigations in the Bristol area.

4.2. Individual agencies that have submitted Information Reports have each highlighted opportunities for learning and improvement based on the lines of enquiry which were established for this review; this report does not need to duplicate those individual opportunities. A concise case audit was also subsequently carried out which reinforces many of the views put forward in the Information Reports about areas for practice improvements. Based on an independent and systematic review of all information gathered, learning has been captured about key barriers, but also where there is a clear consensus about the need for change at a system level. Points captured below have been based on either the views of the independent reviewer, or the perspectives and consensus of those most closely involved in the day-to-day practice of investigating child protection concerns in the Bristol area. The process of system review has therefore encouraged what research[35] refers to as 'collaborative planning', *'… collaborative planning encourages groups to collectively negotiate, make deeper interests explicit, and shift from starting positions towards both compromise and creative new solutions …'*.

a) There is an appetite for change and improvement, and working towards being more efficient and effective as a Partnership. This is, in part, reflected in Figure 3 above, which offers a range of additional suggestions from the workshop sessions about opportunities for change and growth. Pace and momentum are key to capitalising on this appetite.

[35] Zellner, M., & Scott D. Campbell (2015) Planning for deep-rooted problems: What can we learn from aligning complex systems and wicked problems?, Planning Theory & Practice, 16:4, 457-478.

b) As a legacy from Covid-19 but also organisational restructuring which reframed intervention with children and families, the professional network may not have been fully prepared to respond to the changing levels of need for some children and families, and quite unwittingly, interventions may not have provided the right help at the right time. The current threshold guidance is overly complicated.

c) Professionals involved in the initial stages of child protection investigations want to work together more efficiently and more effectively. The idea of co-location, in whatever shape or form given local circumstances, has been proposed as a way of remedying current barriers and promoting a shared language, improving confidence, and supporting a more aligned operating culture – all of which lend themselves to consistently achieving good quality child protection investigations. This aligns with the likely direction of travel at a national level.

d) The chairing of Strategy discussions is seen as critical to the initial stages of achieving consistently good quality child protection investigations.

e) There has been a call for greater knowledge and skills about how to conduct multi-agency child protection investigations. Areas such as chairing skills, working together, investigative, and analytical skills, and understanding roles and responsibilities have been raised as needing to be strengthened; this call is set within the context of workforce flux and flow and needing to ensure newer members of the workforce gain the best experience when conducting joint investigative work. Bringing representatives from the multi-agency network together outside of the real-life scenario, whether that be through formal and mandatory training sessions, or mock simulations to rehearse, grow confidence, but also find a common good standard of practice, has also been identified as an important step to shifting culture and building a competent workforce.

f) Within the Children & Families Service there are up to 35 different managers from a range of teams or services that can request a Strategy discussion; this, quite unwittingly can result in a point of organisational vulnerability in the multi-agency management of resources.

g) The use of genograms and mapping as a means of disentangling networks and supporting good quality analysis, planning and decision making, has been highlighted as an important activity to be standard at every Strategy discussion. The Chair should take responsibility for ensuring this happens. Similarly, a standard agenda and template should be devised which steers expectations of Chairs and participants when involved in Strategy discussions.

h) Mapping and explaining the different agency roles and responsibilities, especially across health-based service provision, has been raised as something that would be helpful to avoid confusion but also misplaced expectations by other agencies.

i) The development of quality standards, or descriptors relating to the child protection process could be helpful to the multi-agency network. Such standards or measures may assist key partner agencies to better understand pathway vulnerabilities, and target remedial action. Developing a root definition of what a good quality child protection investigation is, and a concise associated set of standards expected for child protection investigations may help the workforce be more consistent in the way they approach initial concerns about a child's safety.

j) Adapting the Strategy discussion approach when the professional network is faced with a complex set of circumstances where concerns about a child's, or children's, welfare are raised and the situation is likely to require the involvement of multiple agencies, may have value. The use of an approach similar to the Organised & Complex Abuse Protocol may be relevant; it's application and usage should not be restrictive if it supports professionals make a strong start to investigating a complex set of circumstances that are likely to be resource intensive.

k) Acknowledging that there will always be elements of uncertainty within child protection work is a must – expecting certainty given the often powerful emotional and cognitive factors at play when working in a complex human operated system is unhelpful. Skillful risk assessment in such scenarios will be important to help mitigate and manage the uncertainty.

5. Recommendations about next steps

5.1. From independent evaluation, the following recommendations are made in order to strengthen arrangements and overcome the key barriers that have been identified;

a) The KBSP Executive to commit to discussions about the feasibility and resourcing required to achieve co-location of the joint child protection response. Explorations should include considering as a priority, models for closer joint working if co-location is determined not to be possible due to resources/capacity at this time.
b) The KBSP Executive should seek assurance that there is information and data available which supports the regular review of the quality and standard of child protection investigations; this should include focused scrutiny of policy, systems, processes, and practice.
c) The KBSP should review and embed, what is currently referred to as 'the Bristol Multi-Agency Threshold Guidance' (2018) to reflect a continuum of need, to support the workforce's understanding about the different levels of intervention.
d) A 3 – 5 year workforce strategy specifically for those professionals involved in child protection work should be developed. As part of that strategy, a training needs analysis examining core aspects of working together in a multi-agency environment should be conducted by KBSP, on which to then build a strategy which supports a systematic plan of improvement. The analysis should include key questions on areas such as chairing of Strategy discussions, investigative skills, analytical skills, barriers to effective joint working, roles and responsibilities, what makes a good referral, dealing with complex child/family scenarios, children's lived experiences whilst subject of investigations.
e) Bristol City Council Children & Families Service should explore improvement to booking systems for Strategy discussions, aligning existing systems and the organising, recording, and sharing with partners to better enable consistency and partner engagement. Any developments should recognise the regional footprint of other core partners.
f) The Partnership should compile a selection of analysis tools to support practitioners and managers achieve stronger analysis for use from the point of Strategy discussions onwards. The use of genograms, as a minimum standard, should become expected practice with them being consistently used. This should be built into policy and procedural guidance, and the Chair should be tasked with ensuring this is achieved.
g) A standard agenda and template should be devised which steers expectations of Chairs and participants when involved in Strategy discussions. The agenda and template should allow for more complex scenarios and steer the Chair to consider complexity.
h) The KBSP should develop and disseminate a resource, which easily represents and explains the different agency roles, responsibilities & expectations to help reduce perceptions of disconnect between agencies and key roles.
i) The Partnership should explore developing a sustainable model of multi-agency group supervision/group analysis which can support stronger working relationships.