Hull Safeguarding Children Partnership

Serious Case Review Report: Child C

Executive Summary

Introduction

This Executive Summary has been written with a view to providing the Hull Safeguarding Children Partnership and other organisations similarly committed to safeguarding children and young people with learning points to enable practice development, improved multi agency systems and the best possible outcomes for children and young people.

This Executive Summary relates to a Serious Case Review from the pre COVID 19 period. Whilst there has been a delay in publishing this Serious Case Review Executive Summary, there has been no delay in work being undertaken to address important changes in multi-agency practice identified in the Review. The improvement actions taken are summarised in the table which can be found in Appendix A of this Executive Summary.

Detailed, identifiable discussion of the individuals concerned has been excluded, in order to protect their rights and to be sensitive to their experience and continued loss.

1. Child C: What happened and why this review took place

Child C was a happy, cherished child, who was part of a large extended family.

Child C was found unresponsive at home and attempts by family members, the ambulance service and hospital staff were unsuccessful in reviving the child.

The Designated Paediatrician for the Child Death Review process convened a multi-agency Rapid Response meeting in relation to Child C's death. The collective view of professionals was that there were no identified suspicious circumstances and that Child C's death was a tragic accident. Following a post-mortem, the cause of death was recorded as '*Sudden Unexpected Death in Childhood (SUDIC*).

Some months later, information was shared by family members about a non-accidental injury to another child in the family, along with allegations of domestic abuse to mother by her partner. In the light of this new information, a police investigation commenced in relation to Child C's death, the injury to Child C's sibling and the allegations of domestic abuse. A decision was made at this time by Hull Safeguarding Children Partnership to initiate a Serious Case Review in relation to Child C.

The Serious Case Review was completed within prescribed timescales. However, the criminal investigation took considerably longer and concluded that there was insufficient evidence to pursue a prosecution in relation to Child C's death. The coroner's final conclusion was that Child C's cause of death was *unascertained* due to there being insufficient evidence to allow for another conclusion.

Child C's mother participated in the Serious Case Review and provided invaluable insight into the support she and her children received and needed prior to Child C's death.

2. Child C's home circumstances and family

Relevant factors in relation to Child C's family include:

- a young mother who had experienced a number of significant challenges as a child that inevitably impacted on her own parenting
- a mother who unquestionably loved her children, who professionals described as always clean and tidy
- a mother who was often the sole carer for her children
- domestic abuse of mother by her partners
- the risks the children faced from mother's abusive partners and from witnessing domestic abuse
- Child C's father did not appear to be involved in Child C's life once he and Child C's mother had separated.

Support provided to Child C and their family:

Child C's family received contact and support from services provided by several agencies in Hull who work with families in need of early help:

- Hull City Council Early Years support.
- Hull City Council Children's Social Care
- Hull and East Yorkshire Hospitals NHS Trust[1]
- The family's GP surgery.
- Hull City Council Housing.
- City Healthcare Partnership CIC (Community Interest Company).
- Family Nurse Partnership (for first time young mothers and their families).
- Catch 22.
- Hull Domestic Abuse Partnership (DAP).

3. Practitioner views about what could have made a difference

A practitioner event with participation by seventeen practitioners from across the multi-agency partnership was an important part of the learning process for this Serious Case Review, and commitment to learning within the event was high.

Overarching themes in relation to professionals were identified:

- A perceived lack of support, experience, and training in identifying and predicting risk
- A culture of responding to incidents, rather than seeing the whole history
- Identification of limited multi-agency working
- A lack of confidence in challenging parents and other significant adults
- Limited safeguarding supervision provided for frontline practitioners
- Confusion about safeguarding responsibilities in sharing information.

[1] Now known as Hull University Teaching Hospital NHS Trust

Practice issues identified:

- Agencies working alone, focusing on their own service response: not responding to a whole set of needs and risks, but dealing with incidents or service requests, such as for benefits or housing without reference to partner agencies.
- The challenge of having time during pressured and timed visits to the family to discuss sensitive issues that require patience and delicacy.
- The broader responsibility for working together to prevent harm was understood in principle, but practitioners felt it was not easy to raise a concern about risk that would initiate a multi-agency meeting focused on **preventing** harm.
- Confusion in relation to the Data Protection Act 2018 and the requirements of General Data Protection Regulation (GDPR): there was a lack of understanding of the importance of sharing information about *risk of harm*, as well as *actual harm* and that this is a *safeguarding duty*, rather than a data protection matter.
- Collaborative working is needed in order to achieve good outcomes for children and young people.
- The need for regular supervision that is valued, timely and reflective was seen as essential to effective safeguarding, although organisational capacity was cited the biggest barrier to achieving this.

Practitioner ideas and thoughts about possible solutions to identified barriers and challenges:

- Hold more multi-agency meetings to share information about safeguarding concerns, especially as part of early help
- Think about and explore parents' histories and look for patterns to predict, identify, understand, mitigate against, and reduce risk through multi-agency safeguarding planning
- Hold networking sessions for practitioners to learn from each other and build relationships
- Provide more training and development opportunities about how to work with risk
- Provide reflective practice opportunities for frontline practitioners to develop their understanding of neglect and their confidence in challenging adults in a child's life
- Share information about the different roles, responsibilities, and potential interventions available to the various agencies that work together to safeguard children
- Agencies to make supervision a priority and to develop different approaches to case reflective supervision in all agencies according to roles
  Be clear when working with families which practitioner is leading the case and the roles and the shared responsibilities of all of those within the safeguarding process.

4. Review findings and analysis

The review learning themes are set out below:

1. Identifying, assessing, managing, communicating, and working with risk
   a. Identifying children as parents of children; remembering who they are and what that may mean
   b. Domestic abuse
   c. Neglect

2. The child's voice; the need for a continual focus on and consideration of the child's lived experience

3. Collaborative safeguarding: practitioners understanding their own and others' roles and responsibilities as set out within legislation and the multi-agency policy and procedure.

4.1 Identifying, assessing, managing, communicating, and working with risk

Risk assessment is fundamental to safeguarding children: unless practitioners know what the risks of harm are for a child, then they cannot seek to address and mitigate that risk and therefore that harm.

Working Together 2018[2] states that, *'…. the purpose of the assessment is always:*

• to gather important information about a child and family
• to analyse their needs and/or the nature and level of any risk and harm being suffered by the child
• to decide whether the child is a child in need (section 17) or is suffering or likely to suffer significant harm (section 47)
• to provide support to address those needs to improve the child's outcomes and welfare and where necessary to make them safe'.

4.1a Identifying, assessing, managing, communicating, and working with risk: Young Parents

Child C's mother was a young and vulnerable parent. A significant feature of this review has been the absence of a holistic assessment of the family, with consideration being given to Child C's mother's age, history of trauma and its impact upon her and therefore providing an understanding of safeguarding duties towards her as well as her children.

Learning point (1):

Where young people of similar ages and over thirteen are participating in sexual relationships, agencies should assess risk and provide advice and support. Where there is a known breach of the Sexual Offences Act (2003), multi-agency safeguarding procedures, including criminal justice responses should be followed. Support for young women in these circumstances achieves best outcomes when it is provided on a multi-agency and collaborative basis.

The review noted that all agencies treated Child C's mother as an adult and that assessments did not identify her needs or those of her children in relation to her age and previous difficulties. This meant that risks of significant harm that they all faced were not identified. Assessments should seek to understand the parent's past history and use this to inform assessment of risk and an understanding of the needs of the children.

[2] *'Working Together to Safeguard Children',* HM Government, 2018

Learning point (2):

A good quality risk assessment, by any agency, requires a practitioner to focus on not only the most visible or pressing incidents; a family's whole history, analysis of patterns of risk, consideration of less "obvious" details must also be explored.

Learning point (3)

Where a parent has experienced a childhood with traumatic features, those assessing risk should seek to understand that trauma and use this to inform:
(i) their assessment of risk of harm to the parent's child (ren)
(ii) how to support the parent to safeguarding their child (ren), using the knowledge of the parent's Adverse Childhood Experiences (ACEs) to inform an effective safeguarding plan.

4.1.b Identifying, assessing, managing, communicating, and working with risk - domestic abuse

Child C witnessed domestic abuse and there was no apparent consideration by agencies of the impact of this abuse on any children in the family, although practical help with housing, early help support from a children's centre, support from the Family Nurse Partnership (FNP), along with other targeted responses to incidences of domestic abuse were evident.

The safeguarding partnership needs to consider how well practitioners are assessing and addressing risk, analysing what is known and what they are told, considering history, research, the views of other agencies and the wishes and feelings of the child. This review has identified an absence of risk assessment, analysis, and proportionate response.

Learning point (4):

A culture of risk assessment develops over time and influences practice in all agencies working to safeguard children and young people; any change and development needs to address all safeguarding agencies and all need to work together to strengthen the system and ensure that frontline practitioners are working to develop that culture and play their role within it.

The review reflected on the response of statutory agencies to parents of children who are victims of domestic abuse. There is a potential dissonance between practitioners' child protection responsibilities and the need to support mothers to recover, build their confidence and heal while also finding the resilience to protect their children. Despite being victims, parents in these circumstances are also often regarded as perpetrators of neglect of their children, adding to their stress and poor self-esteem.

While there is no question that their children need to be protected from the significant harm of living with domestic abuse and action must be taken if children are repeatedly placed in danger, the approach could be more compassionate and flexible, enabling greater trust in statutory services by people in these circumstances and potentially achieving greater honesty about the risks children are facing.

Every agency has a role to play in supporting the whole family when they experience domestic abuse; in Child C's experience, that multi-agency, wrap-around, child and risk-focused approach was absent. When working with families in similar circumstances, early support and intervention is vital and agencies need to consistently come together, through the Hull Early Help Framework, using the Outcomes Star tool to work with a family to understand the level of need and risks, identifying the strengths and support required to facilitate change. This is a multi-agency role that is the responsibility of all of those working with families in need of early help.

Learning Point (5)

Safeguarding children in families where domestic abuse is a feature of their lives needs to be multi-agency and undertaken by trained, supported, supervised practitioners at an early stage, ideally initially through the Early Help framework. Collaborative working with clearly identified lead practitioners, all working with families, helps identify the wider picture and develop safeguarding plans that are well-understood, collaborative, robust, compassionate, sensitive, and sustainable.

The Multi-agency Risk Assessment Conference (MARAC) is convened every four weeks in Hull to coordinate community response to a person experiencing domestic abuse. The review panel was clear that Child C's mother should have been referred to MARAC. This did not happen because risks were not identified.

The review panel reflected on the importance of practitioners across all agencies understanding indicators, risks and domestic abuse interventions that achieve positive outcomes. It was noted that there are challenges in understanding and communicating effectively about coercive control. Some of the features of coercive control are precisely what makes it hard to identify; the abuser is often able to exploit a person's existing vulnerabilities, presenting control as 'love' and manipulating others in a person's life to imply that they are mentally unwell, possessive, or mistaken. The stress of experiencing this abuse also impacts significantly on a person's ability to speak up, on their confidence and on their support network.

Learning Point (6)

Practitioners need to have an informed approach to safeguarding and supporting children experiencing the impact of domestic abuse at home. This requires them to be knowledgeable about:
a) identifying and addressing risks associated with domestic abuse
b) referring to MARAC, and
c) understanding the impact of domestic abuse on children and mothers, including that of coercive control.

4.1.c Identifying, assessing, managing, communicating, and working with risk-neglect

Perceptions of childhood neglect stem from knowledge of nationally well-known serious case reviews that have been published in recent years of children who experienced extremely neglectful lives and who died as a result of that neglect of their basic needs, in particular, nutrition, clothing, cleanliness.

Child C was undoubtedly loved and well-cared for: well-fed, observed by practitioners to have '*good attachment'* with mother and described by a number of practitioners as being, '*well-dressed / clean / tidy / immaculate'.* However, neglect is also about protecting children from harm and can be difficult to identify, particularly when it is hidden by parents having needs of their own and crises take practitioners' focus onto practical issues of concern.

For Child C, the focus of practitioner engagement with the family was largely on housing needs that originated from the family's experience of domestic abuse. There was therefore extensive and commendable activity by a range of agencies, from both the statutory and third sectors to address those needs. While there is no question that this was important, this activity took place in the absence of consideration of the extent of protective factors in the family's lives, of identification of risk of harm and the ability of Child C's mother to protect her children.

Practitioners did not consider or question Child C's mother's ability to make safe choices in respect of her relationships. They did not share their knowledge of what was happening in the family and did not analyse it to reflect on what it told them about the lived experience of the children in the household.

This is key to agencies' consideration of neglect in Child C's lived experience: the significance and severity of the risk of harm from mothers' partners was not identified, information about abusive men in the children's home was not identified and shared, and so, the impact of neglect was not seen or addressed. Furthermore, understanding the cumulative nature of neglect and its developing impact on children's well-being is of fundamental importance when working to support children and young people at risk of abuse and neglect.

The Hull Safeguarding Children Partnership has undertaken significant work in developing a neglect strategy, associated toolkit and delivering training to many practitioners. This work needs to continue to ensure that practitioners refine their understanding and practice to address neglect that takes place over time and develops in significance and impact.

Learning point (7):
Neglect takes many forms; a child can be nicely dressed and well-fed but still neglected. To identify risks and understand all forms of neglect it is necessary for practitioners to see the whole context of a child's life, to be aware of the history of a family and of the lived experience of the child.

Learning Point (8):
'Professional curiosity' is not an 'add-on' but an essential part of safeguarding practice. By conducting clear, honest conversations with adults, where respectfully challenging questions are asked of adults in a child's life, practitioner confidence will grow and a culture of respectful challenge will develop.

4.2 The child's voice; the need for a continual focus on and consideration of the child's lived experience

It is not clear from the information provided to this review by agencies what an average day was like for Child C. It is only from discussion with C's mother that the review learned about Child C's likes, dislikes and personality.

A lack of curiosity about the day-to -day lives of the family was prevalent in the approach of all agencies, despite increasing knowledge of the domestic abuse that was taking place within the home.

The review considers that the reason for the absence of Child C's voice from agencies' knowledge of this family is due to three factors:

i. Practitioners were focused on practical responses to the family's needs; for example, housing solutions and therefore, there was a focus on adult concerns and problems
ii. The lack of identification of risks meant that services were not tuning into the daily experience of Child C; and,
iii. Practitioners were viewing the children's experiences through the lens of single incidents focused on service provision to their mother rather than on risk to the children.

The absence of consideration of the lived experience of the children in this family was notable in every agency interaction which suggests this is an area of significant development for all agencies. Whilst it is more difficult to gain the views of pre-school children and babies, it is essential that practitioners seek to place themselves in the child's shoes and understand their lived experience – this will make a difference to practice and ultimately to identifying and understanding risk of harm to children and young people.

Learning point (9):
Practitioners need to place themselves in the shoes of the children they are supporting and consider, how might it feel to be them? What is difficult? What is positive? What are the strengths to be built on in their lives? What are the areas of harm or risk that need addressing?
Managers need to ensure this happens consistently and that practitioners are given support to do so.

4.3 Collaborative safeguarding: practitioners' understanding their own and others roles and responsibilities as set out within legislation and the multi-agency policy and procedures

Working Together (2018) states that, *'In order that organisations, agencies and practitioners collaborate effectively, it is vital that everyone working with children and families, including those who work with parents/carers, understands the role they should play and the role of other practitioners. They should be aware of, and comply with, the published arrangements set out by the local safeguarding partners'*.

In the time that Child C was known to agencies, there was one occasion where there was a statutory response as set out in guidance and in the local inter-agency safeguarding children procedures. This involved enquiries which were appropriately concluded without further intervention.

The incidents of domestic abuse that were reported were not handled within a collaborative framework which meant that each concern was responded to as a separate incident and that the history was not considered and the potential for cumulative harm not recognised.

The lack of a collaborative structure around agencies' work meant that there was no place for this information to be shared. This was an issue that would have benefitted from discussion in supervision, but there was an apparent lack of reflective supervision provided to practitioners coupled with a lack of clear management oversight, guidance, and rigour. This is vital in ensuring quality safeguarding responses to children in circumstances such as these.

Practitioners referred to the difficulty in accessing supervision, especially when the services were pressured and immediate concerns for families had to take precedence. Effective management oversight, critical reflection, challenge, and quality supervision is vital in safeguarding, in both the interests of children and the well-being of practitioners.

Good quality supervision should enable:

- A focus on the child
- Avoidance of drift
- Maintenance of a degree of objectivity, identify patterns (rather than just responding to incidents)
- Challenge to fixed views
- Adherence to standards
- Assurance of practice
- Testing and assessment of the evidence-base for assessment and decisions; and
- Address the emotional impact of work.

Learning point (10):

Effective supervision is vital to the achievement of good outcomes in safeguarding: managers / clinical supervisors need oversight of practitioner effectiveness and impact, to guide and support practitioners and ensure shared responsibility and accountability.

Safeguarding achieves good outcomes for children when it is a multi-agency and collaborative approach. While several different agencies were involved in the support of this family at different points, they were largely working without reference to each other. The workers from DAP and Catch 22 were the exception. Multi-agency meetings were not regularly convened during Child C's life, and the absence of collaborative working is linked to the lack of identification of potential risk. Each contact with the family, (with the exception of the FNP programme, DAP & Catch 22) was viewed as a first contact and so, risks were not seen to have escalated and the need for multi-agency discussions not identified. By discussing concerns at an early stage in a multi-agency meeting, intuitive responses can be counter-balanced by the views of others with different evidential and cultural perspectives.

Practice could have been greatly enhanced had there been a multi-agency meeting at a number of points of contact with the family to discuss the presenting risks to the children; this would have allowed for discussion that would ensure consistent understanding of the current situation, the range of different risks presented with the views of all the family members at the core of the discussion. It would have allowed for development of a realistic, strong partnership risk assessment and management plan, with contingency built in.

The benefits to this approach are that it:

- Enables people's voices to be heard – all of those involved
- Acknowledges and enables shared understanding of the perspectives of all those concerned
- Develops a shared understanding of the lived experience of the children and their perspectives, informing the knowledge and analytical assessment of risk across partnerships and within families
- Supports agencies and families to make informed decisions based on risk and the options available to respond to and reduce that risk
- Builds upon family's strengths and resources, the support of family and other informal networks while also addressing risks and harm.

Learning point (11):
Multi-agency discussions that provide inter-agency opportunities to discuss a family's situation, that prompt asking questions and probing complex situations, identifying risks and strengths, offering opportunities to challenge are essential to good, effective safeguarding.

7. Conclusion

There is significant learning from this case for all practitioners working with families where parental experience of childhood trauma impacts on parenting capacity and exposes children to domestic abuse and thereby neglect.

In the time period covered by this Review, Child C's mother was young and vulnerable but keen to do well for her children. Whilst she cooperated with professionals trying to help her, she did not understand the impact of domestic abuse on her children or fully understand the issues from her own childhood experiences. Whilst it can be hard for practitioners working with these complex issues, confidence, born of good supervision and reflection makes a real difference.

Practitioners need to work honestly and clearly with families in these circumstances, being sensitive to their needs whilst working collaboratively within statutory frameworks and multi-agency policy and procedures. They need to be clear that their role is to identify risks, challenge respectfully, use their curiosity to ask difficult questions, consider the child's lived experience and ultimately to work together to develop plans that support families to develop resilience in the best interests of their children.

Hull Safeguarding Children Partnership's response to the 11 Learning Points identified in this Serious Case Review is contained in the summary of improvement action taken appended

(Appendix A) to this Executive Summary. There has been significant progress made in relation to addressing the Learning Points.

Appendix A - Summary of Key Improvement Action

Learning Point	Summary of Key Related Improvement Action
1. Where young people of similar ages and over thirteen are participating in sexual relationships, agencies should assess risk and provide advice and support. Where there is a known breach of the Sexual Offences Act (2003), multi-agency safeguarding procedures, including criminal justice responses should be followed. Support for young women in these circumstances achieves best outcomes when it is provided on a multi-agency and collaborative basis.	Multi-agency child sexual exploitation training is provided. Training is updated regularly based on national research and legislation. The Sexual Exploitation Risk Assessment tool is utilised in Gynaecology and Emergency Departments. Routine screening questions are now asked to young people under the age of 18 years to consider risk, alongside a risk assessment tool. Audits and surveys take place to ensure that staff are aware of their safeguarding responsibilities. There is an embedded risk assessment tool to assess risk of sexual exploitation which is used by practitioners. Under HSCP arrangements there are strategic and operational groups to co-ordinate activity across the partnership in relation to CSE. This includes ensuring a multi-agency training response across Hull.
2. A good quality risk assessment, by any agency, requires a practitioner to focus on not only the most visible or pressing incidents; a family's whole history, analysis of patterns of risk, consideration of less "obvious" details must also be explored. **And** 4. A culture of risk assessment develops over time and influences practice in all agencies working to safeguard children and young people; any change and development needs to address all safeguarding agencies and all need to work together to strengthen the system and ensure that frontline practitioners are working to develop that culture and play their role within it.	The 'Signs of Safety' social work practice model has been implemented across the partnership in Hull. Implementation has been supported by a substantial programme of briefings (including partner agency briefings) and two-day training. Briefings and training continue as the model is becoming embedded. A common language and shared understanding of harm/danger, and also strengths & safety, is developing across the partnership, helping to strengthen shared assessment of risk. Work to embed the model is ongoing with practice intensives, continuous training, practice leader development programme and refined audit tools focusing on the model. Practitioners have engaged in practice learning programmes, provided over 2-years by Research in Practice, including a focus on analysis and assessment. Auditing activity takes place within safeguarding agencies to consider the effectiveness of responding to risk. This includes a regular programme of multi-agency auditing activity through HSCP. Humberside Police have established the Vulnerability Hub, which is fully operational and resourced. The Vulnerability Hub conducts all secondary risk assessments and attends all strategy and multi-agency risk assessment meetings to assess, and provide a co-ordinated response, from a police perspective, to the risk posed to children.
3. Where a parent has experienced a childhood with traumatic features, those assessing risk should seek to understand that trauma and use this to inform: (i) their assessment of risk of harm to the parent's child (ren)	There is a high-level strategic commitment to 'Trauma-Informed City', so that practice across all services (including adults) is informed by an understanding of the impact of trauma (including adverse childhood experiences) on parents and children.

Learning Point	Summary of Key Related Improvement Action
(ii) how to support the parent to safeguarding their child (ren), using the knowledge of the parent's Adverse Childhood Experiences (ACEs) to inform an effective safeguarding plan.	A two-day conference on trauma-informed practice and approaches has been hosted by the Learning Partnership for school leaders and partner agencies. A suite of training on understanding the impact of trauma and what that means for practice, is provided by specialist trainers. A trauma-informed practice group has now been formed under collaborative arrangements within Hull to ensure a co-ordinated, strategic response to trauma informed practice.
5. Safeguarding children in families where domestic abuse is a feature of their lives needs to be multi-agency and undertaken by trained, supported, supervised practitioners at an early stage, ideally initially through the Early Help framework. Collaborative working with clearly identified lead practitioners, all working with families helps identify the wider picture and develop safeguarding plans that are well-understood, collaborative, robust, compassionate, sensitive and sustainable. **And** 6. Practitioners need to have an informed approach to safeguarding and supporting children experiencing the impact of domestic abuse at home. This requires them to be knowledgeable about: a) identifying and addressing risks associated with domestic abuse; b) referring to MARAC and; c) understanding the impact of domestic abuse on children and mothers, including that of coercive control.	The impact on children of domestic abuse is one of the five HSCP strategic priorities and the HSCP Executive Board commissioned independent scrutiny to support improvement work. The review findings and recommendations were widely shared and led to a strengthened focus on children within the new Domestic Abuse Strategy. The strategy has been launched, supported by a series of Humber-wide launch events. These are well attended and, via testimony & theatre production focus on the lived experiences of children growing up in households where there is domestic abuse in the adult relationships. Specialist domestic abuse roles have been developed to work alongside social workers in locality teams. 'Champions' have been identified across a range of agencies and are undertaking two-day training for the role. Their role is to help support & advise practitioners, to ensure a well-informed approach to supporting children experiencing the impact of domestic abuse. A specialist role (funded by DfE) is supporting the development of practice and awareness across all of Hull's schools. HSCP domestic abuse training is fully updated and includes a focus on identifying and understanding the impact of coercive control. Health, early help and VCS providers have undertaken 'routine enquiry' training. Health providers also provide level 1 & 2 domestic abuse training which covers coercive control and routine enquiry. All agencies are encouraged to use DASH to inform their assessment of risk when domestic abuse is a feature – the tool is part of their risk assessment toolbox. Learning has taken place to ensure that police, health and local authority practitioners are aware of their responsibility to refer to MARAC when the referral criteria is met. Humberside Police prioritise vulnerability training for all officers and staff. It is a key theme running through all training programmes, from initial officer training to Continuous Professional Development (CPD) provided to officers at several points throughout the year. This includes a recent briefing and guidance issued in relation to risks to unborn children and consideration for officers attending reports of domestic abuse.
7. Neglect takes many forms; a child can be nicely dressed and well-fed but still neglected. To identify risks and understand all forms of neglect it is necessary for practitioners to see the whole context of a child's life, to	Neglect is one of the five strategic priorities for HSCP. There has been significant work undertaken and completed to refresh the local neglect toolkit – this has been a

Learning Point	Summary of Key Related Improvement Action
be aware of the history of a family and of the lived experience of the child.	collaborative and co-produced piece of work with input from across the partnership. Briefings have been held across the safeguarding partnership to raise awareness of neglect and to ensure a collaborative response. Information has also been widely cascaded via HSCP newsletters. HSCP neglect training has been updated and incorporates the more recent learning, the new toolkit and a 7-minute guide on learning about neglect (locally and nationally) which has been produced to compliment learning.
8. 'Professional curiosity' is not an 'add-on' but an essential part of safeguarding practice. By conducting clear, honest conversations with adults, where respectfully challenging questions are asked of adults in a child's life, practitioner confidence will grow and a culture of respectful challenge will develop.	Training in relation to professional curiosity has taken place for practitioners. Signs of safety training and ongoing development also reminds practitioners to have 'brave' conversations and to dig beneath the surface to understand the child's lived experience. The need for practitioners to be professionally curious, and what this means, is covered in HSCP safeguarding level 1 training and the equivalent within health services.
9. Practitioners need to place themselves in the shoes of the children they are supporting and consider, how might it feel to be them? What is difficult? What is positive? What are the strengths to be built on in their lives? What are the areas of harm or risk that need addressing? Managers need to ensure this happens consistently and that practitioners are given support to do so.	The Hull Signs of Safety practice model explicitly places the child, and their lived experience, at the centre of practice. Work continues to embed the model. 'Three houses' and other Signs of Safety direct work tools are now much more widely used. The use of 'words & pictures' is also growing. Practitioner confidence in direct work with children has been developed. 'Mind of my own' apps are also now being widely used across children's safeguarding – these provide an important additional tool for children to use to help adults understand what life is like for them.
10. Effective supervision is vital to the achievement of good outcomes in safeguarding: managers / clinical supervisors need oversight of practitioner effectiveness and impact, to guide and support practitioners and ensure shared responsibility and accountability.	The supervision standards for social workers have been updated. New training for supervisors & supervisees is available. The quality of supervision is assessed via the monthly audit programme. Robust arrangements are in place across health providers for safeguarding supervision. Work has been undertaken to update the escalation and resolution guidance. This has involved joint working with a neighbouring authority to ensure a consistent approach for all agencies, cross-boundary.
11. Multi-agency discussions that provide inter-agency opportunities to discuss a family's situation, that prompt asking questions and probing complex situations, identifying risks and strengths, offering opportunities to challenge are essential to good, effective safeguarding.	HSCP Executive Board has scrutinised the effectiveness of partner engagement at strategy meetings, child in need meetings, child protection conferences and core groups &, separately, the effectiveness of joint working within early help. The multi-agency guidance on effective strategy meetings has been updated and training has been provided to key decision-makers and safeguarding leads across the partnership.