Risks, Responses and Review: Analysis and Key Recommendations from Child Practice Reviews

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Abstract

Where children suffer significant harm resulting in serious and permanent damage or death within their families, a Child Practice Review (CPR) provides the opportunity to understand issues and improve professional and organisational practice.

This poster summarises the findings of an analytical review of 33 Child Practice Reviews (CPRs) that were undertaken by the six Regional Safeguarding Boards (RSBs) in Wales between 2013 and 2021. Mixed-methods analyses examined key risk factors, multi-agency responses and the review process.

Aims & Objectives

Aim: examine the harms being perpetrated on children and the challenges and barriers within multi-agency safeguarding to inform and facilitate a more effective safeguarding response. Key objectives in addressing this aim will examine:

- Trends in child and family characteristics.
- Intelligence and information held by agencies in contact with the child and/or family.
- Barriers, pressures, and challenges which may impact upon safeguarding identification and responses.

Methods

1. Risk: Index Child and Family Characteristics within CPRs. Descriptive and inferential analysis to identify trends within child/family characteristics and risk indicators.
2. Response: Organisational and Agency Involvement. Descriptive and thematic analyses identifying organisations/agency awareness of the child and/or family.
3. Review: Quality of CPRs. Descriptive and thematic analysis examined information contained within CPRs regarding learning and action.

Results (1)

Risk Factors:

- 21/33 (63.6%) resulted in death of child.
- Suicide highest harm type recorded (21.2%).
- Other (medical/health issues, 18.2%).
- Non-Fatal Physical Abuse (15.2%).
- Highest age category <1 years (41.7%).
- Fifth were 0-3 months, and >13 years.
- 75.8% had sibling, with 45.5% large sibling group (3 or more children).

Results (2)

Common Vulnerabilities Recorded:
Child(ren): Emotional abuse (17), neglect (14), poor home conditions (13), witnessed DA (12).
Parent/Carer: Drugs/alcohol (15), mental health issues (13), domestic abuse relationship (13)..

A PROXSCAL analysis was carried out on 17 child vulnerabilities with evidence of co- occurring vulnerability factors for the Index Child within the CPRs: those more internally experienced by the child, and those vulnerabilities/experiences inflicted upon the child.

Analysis of recommendations within CPRs (Figure 2) identified highest frequency of 'lack of whole family approaches' and 'lack of professional curiosity'.

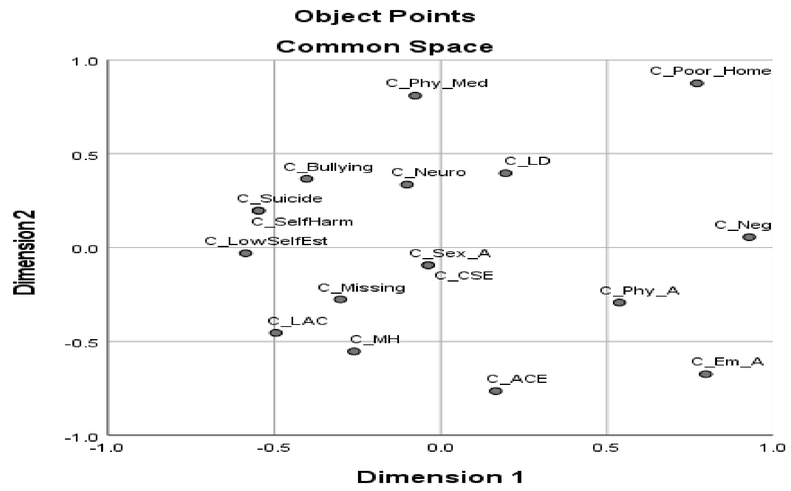


Figure 1. (Results 2) Visual Representation of co-occurring child vulnerabilities

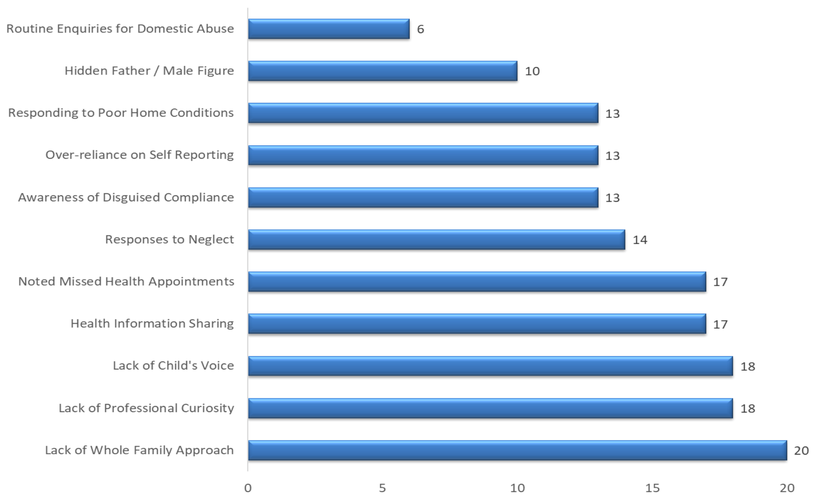


Figure 2. (Results 4) Frequency of recommendations within CPRs .

Results (3)

Four main themes identified (thematic analysis): (1) Practitioner and agency challenges (2) Structures and Process barriers (3) wider influences on practice and processes, (4) identified good practice.

Thematic analysis informed development of key priority areas to increase awareness of the nature of multi-agency working:

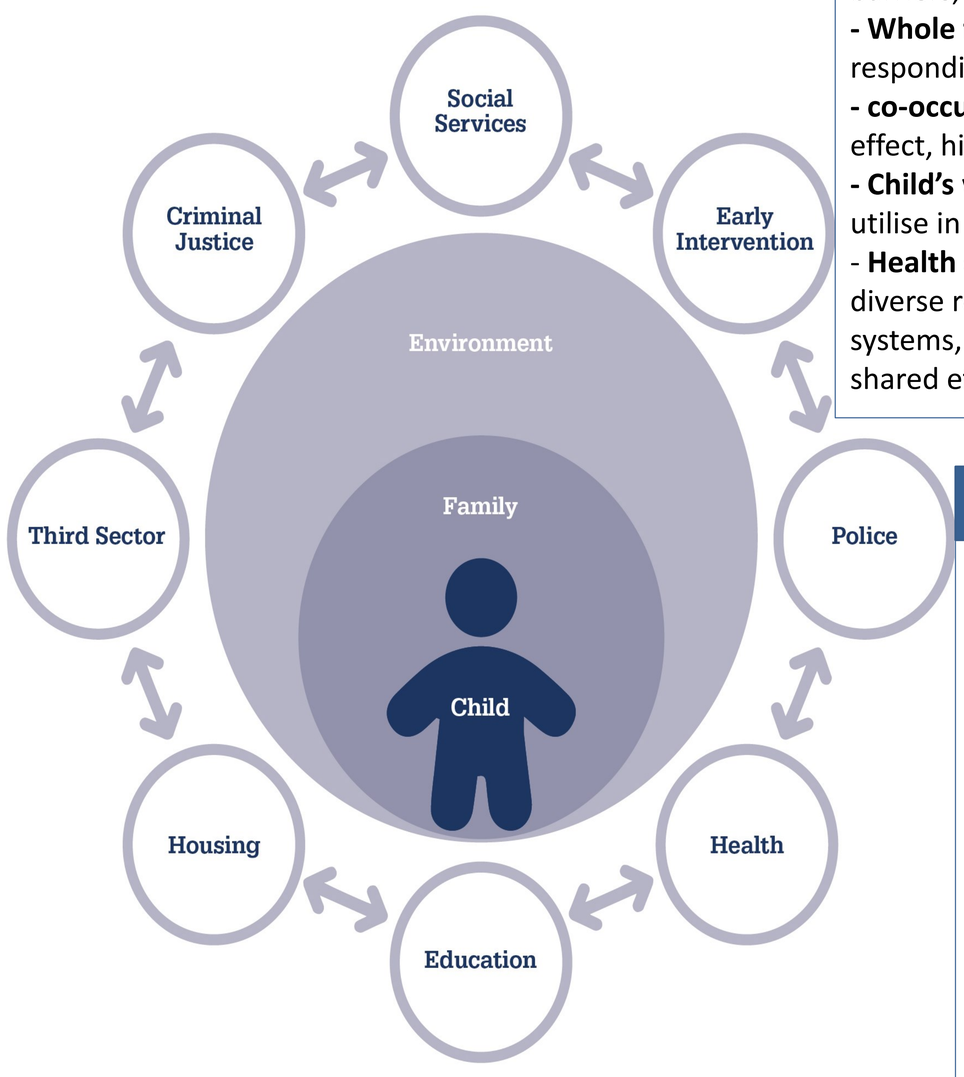


Figure 3. Model of Multi-agency Connections, Considerations and Complexities.

Results (4)

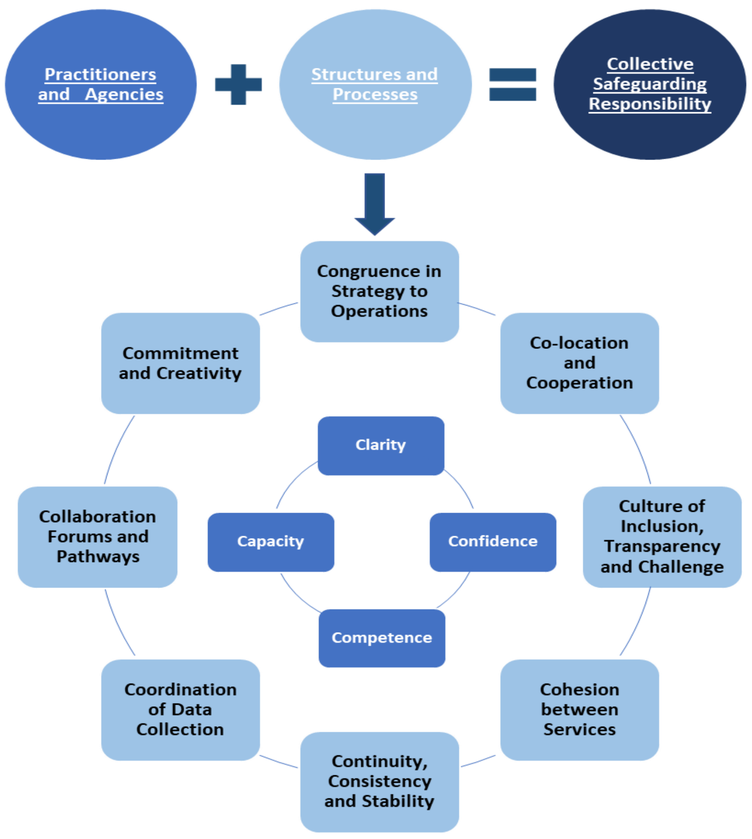
Key priority challenges from thematic analysis:
- **Professional curiosity:** ambiguous, does not acknowledge potential organisational/structural barriers, lack of capacity/experience.
- **Whole family focus:** understanding, recording and responding to lived experience of whole family.
- **co-occurring harms & interacting risks:** cumulative effect, historical, enduring (chronic) risks (neglect).
- **Child's voice**: how to better capture, record and utilise in active decision making, outcomes shared.
- **Health complexity:** recognition of segregated by diverse remits, complex structures, fragmented IT systems, with information known but not able to be shared effectively/efficiently.

Conclusions

This research identified key actionable recommendations for safeguarding professionals working with children and families in preventing the most tragic outcomes. We have developed several models to more effectively respond to risks and challenges encountered for practitioners working with children.

We unpick issues such as 'professional curiosity' and consider solutions using best practice to navigate these barriers, including The Collective Safeguarding Responsibility Model: 12Cs (Ball & McManus, 2023) to help translate recommendations into practice.

The Collective Safeguarding Responsibility Model: 12Cs



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The 12Cs Model Brochure

Child Practice Review Reports