THREE

A just and decisive child protection system

Introduction

Whilst the risks of harm cannot be eliminated, the system of child protection can and must do better for children.[51] Analysis of serious incidents shows that the same themes are often present when children experience serious harm, such as failing to understand what a child's daily life is like, poor information sharing, a lack of critical thinking and challenge and insufficient analysis of changing risk and need. These "knotty issues" are familiar to all those who work in child protection and have been highlighted over numerous reviews and reports (Child Safeguarding Practice Review Panel, 2021), yet they continue to reoccur.

Improving child protection is not the same as increasing the *amount* of child protection activity. Over the last 11 years child protection investigations have increased by 127%, however the number of these investigations that did not result in a child protection plan have increased by 211% over the same period, reaching 134,960 in 2020/21 (Department for Education, 2021a). Instead we need to focus on the *quality* and *accuracy* of child protection work - making the right decisions about where investigation is necessary and where support would be the most effective route to keep children safe.

Improving child protection will depend on the review's wider recommendations, particularly the Family Help offer, workforce and wider system recommendations.

The proposed model of Family Help set out in Chapter Two, will improve the safety of children by making sure families get the help they need to get through painful, dangerous or isolating times - whether this is an abusive relationship, struggles with mental health or a child being exploited. The majority of serious incidents in 2020 (64.5%) involved children already known to children's social care (Child Safeguarding Practice Review Panel, 2021). By bringing more help into families' lives delivered through a single multidisciplinary team, workers are more likely to build better relationships with families, develop a holistic understanding of the situations in which children are living, address the underlying reasons that families become involved in social care, and more accurately identify situations where there are more serious concerns. By making help less stigmatising and more meaningful, and by giving professionals more time with families, we will also increase the likelihood that families will want to engage with social care. By removing the arbitrary distinction between early help and social care, we will improve the ability of the system to respond to changing risk, without the inherent weakness in hand off points.

Second, our plans to realise the potential of the workforce set out in Chapter Seven, will increase social worker knowledge, skills and retention, get all social work managers spending time doing direct work with children and families, and improve the quality of and support for social work.

Third, by building a system that is better able to learn and use evidence, and that better holds local partners to account, we will improve organisational leadership and culture. By

51 The importance of effective child protection has recently come to the wider public's attention, with the tragic deaths of Arthur Labinjo-Hughes and Star Hobson. The Child Safeguarding Practice Review Panel will soon publish a national review to examine the circumstances leading up to both children's deaths, and will make recommendations about how local and national safeguarding practice and systems should change to protect children in the future. The national learning from the Panel's review has been made available to the independent review of children's social care (as agreed at the beginning of the national review) and has informed this report and its recommendations (Child Safeguarding Practice Review Panel 2021c). Both reviews have, however, worked independently to develop their recommendations. Government should consider the findings from both reviews in the round, in deciding how to take forward recommendations.

having clearer and more accountable multi-agency arrangements we enable better sharing of information and decision making about children. By ensuring that funding of children's social care reflects the needs of different areas, local authorities will have the resources they need to respond to significant harm. By intervening more decisively in inadequate and drifting authorities we will improve how individual local authorities keep children safe.

On their own however, these reforms will not be enough to build a just and decisive child protection system. In this chapter we set out specific changes that should be made to child protection to keep children safe and improve their outcomes:

- *for children where there is a risk of significant harm, cases will be co-worked between a Family Help social worker and a Expert Child Protection Practitioner who will provide support and make critical child protection decisions. Family Help work should continue as the risk to a child escalates and de-escalates, avoiding handovers and maintaining relationships*
- *clearer expectations on multi-agency capabilities for child protection*
- *a more tailored and coherent approach to keeping children at risk of extra familial harms safe, including multidisciplinary support, an updated child protection pathway, and defined expectations on multi-agency contributions. This will be accompanied by a better aligned and simplified national landscape*
- *a five year challenge on information sharing to improve knowledge and culture, reduce perceived legislative and regulatory barriers, and initiate practical and technological changes, in order to achieve frictionless sharing of information*
- *parental representation and support rolled out for parents in the child protection process, in order to improve engagement*
- *the family justice system will be supported to work better for children, with detailed and regular data, and Local Family Justice Boards used to understand the decisions made in court and their impact on children's outcomes. Proceedings will be adapted to be less adversarial, improving the engagement of parents*

3.1 An expert child protection response

Child protection social work requires **experienced, knowledgeable and skilled social workers**, who are able to weigh up evidence, take tough decisions and have sensitive and life changing conversations with families. They need to analyse information from different sources, identify

patterns and hold multiple possible scenarios in mind, test these against the evidence and meaningfully engage with a child, their parents, wider family and friends and other professionals. This could be to decide what to make of bruising to a child that a parent claims was an accident, or understanding whether coercive control is present in a relationship. The cost of poor decision making - whether it is a child remaining with their family and suffering harm, or a family being subject to unnecessarily child protection investigation and separation - is extremely high. Poor risk assessment and decision making occured in 41% of serious incidents in 2018/19 with gaps in practitioner knowledge and skill, including a lack of critical thinking and challenge identified as a key theme (Child Safeguarding Practice Review Panel, 2020). Despite this, child protection work is undertaken too often by our most inexperienced practitioners, who are early in their careers and often lack support to build their skills. Evidence suggests that newly qualified social workers tend to experience a "beginner's dip", making different decisions compared to experienced social workers and students (Devaney et al., 2017).

Support and supervision are crucial to social workers remaining curious and using good authority in their practice - where they are purposeful, clear about risk and able to focus on the child (Wilkins et al., 2018). Yet, 10% of social workers have not received any reflective supervision since joining their current employer, and one in four (24%) have reflective supervision less than every six weeks (Johnson, Claire et al., 2021). High workloads and a focus on compliance, too often means that supervision is focused on managerial oversight, processes and timescales, rather than meaningful reflection (The independent review of children's social care, 2022c; Wilkins et al., 2017). A survey of 772 social workers found that English social workers were the least likely to have confidence in their own or colleague's decisions, in comparison to American, Finnish and Norwegian child protection workers. It also found that English workers' decisions generally received less scrutiny from colleagues and multidisciplinary groups, and higher levels of authorisation from lawyers than other countries. It suggests that England's highly proceduralized and "vertical" accountability mechanisms have contributed towards a lack of confidence in decisions (Berrick et al., 2016). International evidence also suggests that in Finland, where co-working is common in child protection, there is more "supported" joint decision making (Falconer & Shardlow, 2018). Yet this is not the norm in England. Social workers nearly always carry out the most crucial part of their work alone, such as visiting families, navigating their own emotions and biases and making difficult judgements on families' circumstances based only on their own recollections (Ferguson, 2016; Ferguson, et al., 2020). Manageable caseloads and strong, enabling management are also crucial conditions for this high quality practice.

The main check on decision making in the child protection system is the child protection conference, which should bring together family members and professionals to decide whether the threshold for child protection is met. However, it is questionable whether child protection conferences are working effectively. Parents with lived experience who have spoken to the review have explained how conferences can leave them upset, confused and less likely to engage. Social workers tend to come to the conference with a set viewpoint and there is little disagreement between professionals or critical interrogation of information (Prince et al., 2005).

In our proposed reforms, Family Help Teams will continue to work with families throughout child protection processes and continue to support families if a child is removed. The focus is to stick with families and avoid handovers between services and professionals.

Critical to the success of this model is having the right expertise where a decision needs to be made about whether a child may be at risk of significant harm, and what action might need to be taken. This includes decisions at the “front door” when children are referred to children’s social

care with child protection concerns; when concerns of significant harm emerge about a family who is already being supported by Family Help; and at the point that decisions are taken about whether to start pre-proceedings (the gateway to care). These decision points are the crucial moments that can either lead to missed opportunities or unnecessary intervention in family life.

At these critical moments, we recommend that an Expert Child Protection Practitioner, who is an experienced social worker with demonstrated knowledge and skills, comes alongside Family Help to co-work and is responsible for making key decisions about what should happen to a child. The role of the Expert Child Protection Practitioner should be to undertake joint visits, chair child protection planning, and lead multi-agency professionals who will input into decisions about what should happen to a child.

In the future, new social workers would need to have passed a five year Early Career Framework to undertake this role, with social workers who entered the profession before its introduction recognised based on their experience. The Early Career Framework would give social workers knowledge on key topics (such as deep understanding of infant bruising or child sexual abuse) and skills in analysing risk. They would provide an experienced and specialist resource to investigate and make decisions about significant harm to children. Other professions and parts of social work have established specialist status for certain types of work, for example, the status of the Approved Mental Health Professional (AMHP) is recognised as having particular roles and responsibilities. Similar status should be conferred for those expected to make decisions about significant harm for children. The Early Career Framework and its wider benefits beyond improving the quality of child protection, such as improving retention, are explained in more detail in Chapter Seven.

Amendments to *Working Together* should also mean that the Expert Child Protection Practitioners would undertake the role of the child protection conference chair, making threshold decisions about child protection in a timely manner and with a deeper knowledge of the family. Independent representation for families should be provided separately and is discussed later in this chapter.

This model will, of course, be predicated on having enough expert social workers who are able to co-work alongside Family Help Teams. Details of the impact of our workforce recommendations are set out in Chapter Seven, but by widening the workforce who can do child in need work in Family Help (whilst retaining social workers as the lead in more complex situations), alongside reforms to some non-caseholding roles (such as Child Protection Chairs and Independent Reviewing Officers[52]), experienced social workers will be freed up and can undertake the Expert Child Protection Practitioner role.

This recommendation is our settled view on how to resolve the dilemma of how to combine help and protection.[53] We have concluded that these activities must exist together, because risk is dynamic and structural changes separating the two may make the system less safe. However, by combining a broad category of Family Help focused on providing support, with a distinctive expert role that co-works where there is a risk of significant harm to children, we create enough distance between the two functions, whilst also enabling continuity of relationships and avoiding handoffs between services.

52 Our recommendation regarding Independent Reviewing Officers is discussed in more detail in Chapter Five.

53 See the review's Case for Change and also the three dilemmas raised by the review: https://childrenssocialcare.independent-review.uk/thinking-out-loud-three-dilemmas/. Lady Hale, a key author of the Children Act 1989, has also made the same observation: "the aspiration of developing a partnership between children's services and families with children in need proved very difficult to achieve... The trouble is that, if efforts to work with families run into difficulties, the local authority can always resort to care proceedings and the families know that" (Hale, 2019).

Recommendation: *All cases of significant harm should be co-worked by an Expert Child Protection Practitioner who is responsible for making key decisions (in the future this would be someone who has completed our proposed Early Career Framework)*

3.2 Improving multi-agency contributions to child protection

Health, police, education and other partners must all play a role in child protection to ensure that the needs and risks to a child are fully understood and responded to. This includes sharing critical analysis and challenge across professional boundaries. Whilst legislation and guidance are clear about the duties of partners and agencies in cases of significant harm, this is too often not translating into practice.[54] This includes providing appropriate levels of resources within Multi-Agency Safeguarding Hubs, sending representatives to section 47 enquiries and sharing information (which is covered in more detail later in this chapter). Poor multi-agency working at child protection is a perennial issue that has been raised in every recent review that has considered child protection, from Laming to Munro and before.

Expert Child Protection Practitioners should be supported by more regular and direct involvement of a multi-agency workforce, such as child protection paediatricians and specialist police officers. There are different models for achieving this, whether this is having named professionals, co-located teams, or bringing professionals together into a single team. However, expectations for the features and capabilities of a joint multi-agency child protection response should be set out nationally in *Working Together*. Advice on effective partnership working should be included as part of the practice guides within the National Children's Social Care Framework.

Scrutiny of how each agency is contributing to achieving these capabilities - including their financial contributions - should be overseen at a strategic level by more focused and accountable multi-agency safeguarding arrangements, that include education as a statutory safeguarding partner. Our proposed reforms to the current multi-agency safeguarding arrangements are set out in detail in Chapter Eight.

Recommendation: *Working Together should set expectations on multi-agency capabilities for child protection and the National Children's Social Care Framework should set out effective practice models for joint working.*

54 The Children and Social Work Act 2017 places a joint and equal responsibility on the police, health and local authority as safeguarding partners. Working Together to Safeguard Children 2018 sets out clear responsibilities for all relevant agencies in responding to significant harm.

3.3 Tackling extra familial harms

Nathan

From violent childhood to county lines and tragedy

Nathan's parents had an extremely volatile and violent relationship. Some of his earliest memories are his mum stabbing his dad over a meal he didn't like and when his father was arrested for hospitalising his mum. Social workers were involved, however Nathan's mother managed to dupe them into thinking that things were okay, cleaning the house and buying food. For Nathan the smell of cleaning products was a sure sign that a visit was imminent. During visits he would hide under his bed with his little brother.

Nathan's parents separated when he was ten and his mum's drug use got worse. Nathan often had no food, heating or electricity. His sister tried her best to look after her brothers, but at 14 she went to stay with a friend's family, leaving Nathan to look after his little brother, getting food from neighbours or stealing from supermarkets. One day, an older boy on his estate commented on his trainers, which were hanging off his feet, offering to buy him a new pair. He started turning up with food or calling to play Xbox. After a while, he asked Nathan to work for him, delivering parcels and keeping things at his house. At 11 Nathan had money, he could buy clothes for his brother, feed them both and buy gifts.

Social workers tried to protect Nathan, he was placed in foster care at 13 and then stayed with his dad. He tried to "fit in" but ran away after an argument, returning to his estate and old acquaintances. He travelled all over the country though county lines, took part in a robbery, and at 15 received a short custodial sentence in a Young Offenders Institution (YOI).

Of all the professionals in Nathan's life, the only positive relationship he built was with a gang affiliations worker from the local council, who he felt understood and didn't judge him, but in Nathans' words it was "too late" he was already too involved. Nathan describes his interactions with the police as being harassed rather than helped. Following his release from the YOI, and an unsuccessful stay with his sister, Nathan returned to his home territory. He had nowhere to stay and crashed with a friend in a hostel. The friend was selling drugs and they both got caught up in an altercation that escalated. Nathan was chased and stabbed multiple times, he stabbed the other person who tragically died from his injuries, and Nathan received an eight year sentence for manslaughter. With support Nathan has been able to reflect on his life and make sense of his care experience. He has matured, worked hard through rehabilitation activities and is now a peer mentor for care experienced people in prison.

A leaving care support worker helped Nathan tell his story

Teenagers are the largest growing cohort in both child protection and care. Our best estimates suggest that almost one third of adolescents who entered care in 17/18 had an extra familial threat identified at assessment, a figure that was a seven percentage point increase on 14/15 (this excludes asylum seeking children) (Fitzsimons et al., 2022).

Many of the problems which lead teenagers facing extra familial harms to be unable to stay safely with their families, are common to all of children's social care: inadequate help and support when issues start; poor multi-agency working; not enough consideration of wider family networks to stop children entering care; and social workers without enough experience, knowledge, skills and support. Many children who face extra familial harm, also experience harm from within their family (as Nathan's story makes clear). The recommendations we make across the review will make a significant impact in how teenagers are kept safe from extra familial harms. However, there are some specific challenges in supporting this group of young people, that are either unique or particularly acute, which we believe require specific action.

Fragmented action and a lack of accountability

> ***"[There is a] conflict with agencies on who should be doing what and it affects the young person because they don't know who should be supporting them"*** - *social worker*

Whilst multi-agency working is a challenge for all of children's social care, when harm is in the community and parents have limited power, the role of other agencies becomes even more important. A young person might be facing exclusion from school, have a special educational need, be having frequent encounters with the police, have a youth offending team worker, be struggling with poor mental health or substance misuse, and also have social care involvement. This is illustrated by the Serious Case Review of Tashaûn Aird, who died at age 15 after being stabbed. Despite professionals having access to information that indicated escalating risk, including school exclusion and police intelligence that identified possible criminal exploitation, the Serious Case Review identified a lack of shared responsibility between safeguarding agencies and education to keep him safe (Spencer, 2020).

Through the review's deep dives we looked specifically at the responses to extra familial harms across ten local authorities. We found all areas building some level of bespoke response to try and share information and coordinate action between partners. Practitioners told us that they found these forums necessary given the range of different partners involved. However, they frequently expressed frustration about the time spent discussing dangers, without taking corresponding actions to address them. A practitioner put this well when they said: "*we're all brilliant at identifying exploitation now - we just don't do anything about it*" (The independent review of children's social care, 2022c). A similar point was made by Joint Targeted Area Inspections of Child Sexual Abuse and Child Sexual Exploitation (Ofsted, 2016).

This becomes more complicated for the role of the police, where there is a tension between enforcement and support and the boundaries between victim and perpetrator may be blurred. The police have a duty to safeguard children, whilst also ensuring they do not pose a serious risk to others. There is no clearly understood approach about how these two important, but sometimes conflicting duties should be balanced.[55] We continue to see serious incidents

55 *Working Together* provides the following guidance to police: "Children who are encountered as offenders, or alleged offenders, are entitled to the same safeguards and protection as any other child and due regard should be given to their safety and welfare at all times. For example, children who are apprehended in possession of Class A drugs may be victims of exploitation through county lines drug dealing."

where opportunities to protect children have been missed when the police encounter them because of offending.[56]

The difficulty engaging schools in keeping children safe was a frequent theme of our engagement, particularly around exclusion from school (The independent review of children's social care, 2022), which can be a point where vulnerability becomes acute (Child Safeguarding Practice Review Panel, 2020b).

Finally, the review has heard that the cliff edge of support at 18 makes it harder to engage older teenagers (The independent review of children's social care, 2022c). Exploitation and extra familial harm does not stop at 18 so this drop off of support can be a particular risk point (Firmin et al., 2019).

A framework that is unsuited for extra familial harms and blames parents

Through the review we have heard frequently that the existing child protection framework is not working for tackling extra familial harms (The independent review of children's social care, 2022c). This finding has been mirrored by the Child Safeguarding Practice Review Panel, who found that traditional tools and processes, such as child protection conferences, can be ineffective when responding to dangers outside of the home (Child Safeguarding Practice Review Panel, 2020b). Professionals have told us that the use of a child protection plan when a child is at risk from harms outside the home is stigmatising for parents (The independent review of children's social care, 2022c). Procedure encourages this because statutory data returns do not have a category for extra familial harms, and so practitioners often classify this as abuse and neglect at the end of a child protection conference. Practitioners have also told us that the traditional child protection approach, which focuses on undertaking an assessment to determine if a child meets a threshold within a set time period, does not work for young people where a more dogged approach to build a relationship and persuade them to engage may be needed (The independent review of children's social care, 2022c).

Across the review's deep dive visits we saw areas taking a variety of approaches, with some areas using child protection plans, even though they can be stigmatising to parents, as they help get multi-agency professionals around the table (The independent review of children's social care, 2022c). Other areas use child in need plans despite the situation constituting significant harm, as it is less stigmatising to parents.

Significant harm is a consequential threshold, and given the rise in identified extra familial harm, it is essential that procedures for child protection adapt and that the right duties are in place for partners to assist.[57] The consequence of continuing to use section 17 to respond to significant harm that comes from outside of the home, is that it will further distort how child in need work is assessed and overseen, a theme the review aims to address through reclaiming the original intention of section 17 as a broad, flexible "Family Help" category.

56 See for example: Jaden Moodie (2020) Waltham Forest; Archie Sheffield; Child Sam (Bickley, 2020; Cane & Sheffield Safeguarding Children Board, 2020; Drew & Waltham Forest Safeguarding Children Board, 2020).

57 Children Act 1989, section 47, part 9 puts a specific duty on partners to assist local authorities with their investigations if there is suspicion of significant harm.

A bespoke approach to extra familial harms

Whilst the basic legislative framework to tackle harms outside the home is sufficient, we need to change the policy and practice framework that sits beneath this to give greater clarity and support in how areas should deal with extra familial harms.[58]

Additional investment in Family Help should enable areas to develop a bespoke multidisciplinary response to extra familial harms

Our best hope of keeping young people safe is through providing them with the right support, that gets to the root cause of why the harm is occurring. In Chapter Two, we recommend an additional investment of £2 billion in multidisciplinary Family Help. To receive this funding, every area will need to demonstrate that their Family Help response is designed to meet the local needs of children and families, including young people at risk of extra familial harms. Given that the needs of this cohort may demand a different set of disciplines - for example youth work, mentoring, youth offending teams, CAMHS and child substance misuse practitioners - it will often be likely that the most effective model will be to have a specialist adolescent multidisciplinary team. This would help provide a more coordinated response and avoid the current dynamic of young people being passed between services.

This also presents an opportunity to encourage areas to develop a model where work continues beyond the young person's 18th birthday, up to the age or 25 or earlier if the problem is resolved sooner. This would build on the 0-25 model that exists for SEND and care leavers. Achieving this would need cooperation and resources from partners and local authority adult services to be viable. Elsewhere the review recommends we incentivise partners to provide matched funding towards reforms. These pooled resources could be used to bring extra familial harms services up to a 0-25 age cohort.

The introduction of a Child Community Safety Plan and support to improve the practice approach to responding to significant harm

A multidisciplinary response to extra familial harms should be supported by a clearer statutory framework. Many areas have already adopted specific "young people's plans" or "community risk plans", that have a different emphasis to traditional child protection plans, focusing more on the wider environment causing harm. Building on this, *Working Together* should be amended to introduce a pathway for harms outside the home, with specific provisions for how partners should approach these situations. This should have the same legal underpinning of section 47 and so would be a version of a child protection plan, but would provide for a different approach that makes clear that the primary harm is not attributed to the home, and puts emphasis on a more proactive approach from all partners to both keep the child safe and address contexts where children are at risk of harm. It should also provide for plans to continue beyond 18 where necessary.

The use of Child Community Safety Plans should be flexible enough to respond where there is significant harm that is both extra and intra familial. Alongside an improved statutory framework, a common practice approach that underpins Child Community Safety Plans should be developed and disseminated, building on the emerging work of Contextual Safeguarding (Firmin & Knowles, 2020) and other developing practice, and should be a topic for which the

58 The same conclusion is made by Carlene Firmin and Knowles (2020), who conclude the greatest barrier is not the legislation but the framework that sits beneath it.

National Children's Social Care Framework provides a practice guide. Responding effectively to extra familial harms will also form part of the Early Career Framework.

Set clear expectations for partnerships about what an effective area level response to extra familial harm should include

Finally, as well as support for individual young people at risk, partners need to work together better (and with their Community Safety Partnership) to keep children safe, as well as tackling harms facing children across their whole area. As set out earlier in the chapter, expectations for the features and capabilities of a joint multi-agency child protection response should be set out nationally in *Working Together*.

Given the challenges of coordinating action on extra familial harms, this should be a specific area where features of joint work should be set out, and partnerships should report on their joint progress as part of their annual report. We think the key features and capabilities that local multi-agency arrangements should have for extra familial harms are:

- respond to the causes of harms and vulnerability at a whole community level, making intelligent use of disruption within particular locations or with specific offenders, or using police intelligence to inform where there is a need to work with a peer group
- make sure important decisions about what happens to young people are taken in the round, putting their best interests at the centre. This must include how to respond to a young person who is a victim and an offender, or whether a school exclusion is appropriate
- integrate different organisational responses to minimise the number of plans, professionals and organisations that a young person has to deal with - especially for young people open to both youth offending teams and social care

Recommendation: *Investment in Family Help will provide resources for multidisciplinary responses to extra familial harms.*

Recommendation: *Government should amend Working Together to introduce a Child Community Safety Plan to clarify where primary harm is not attributable to families, supported by practice guides and the Early Career Framework.*

Recommendation: *There should be clearer expectations about partnership responses to extra familial harms across an area and this should be a priority area for learning.*

Hampshire Willow Team

Safeguarding children at risk of extra familial harm

Hampshire's Willow Team is a multi-agency specialist service for young people at risk of being Missing, Exploited and Trafficked (MET). The team is composed of qualified social workers, missing workers, qualified nurses, counsellors, and specialists in gang exit and substance misuse. Willow works jointly with district teams to support and safeguard children experiencing extra familial harm, to ensure they receive the right level of help and protection. The team is co-located within the Hampshire Multi-Agency Safeguarding Hub (MASH), and offers direct consultation for MASH colleagues at the front door.

The team has a strong partnership with the police, working with the Missing Exploited Trafficked (METT) police team around disruption and support for child exploitation and criminality. Willow workers undertake joint visits and direct work with police officers. This strong multi-agency approach enables the team to share live intelligence with the MASH, to identify and protect children most at risk. Willow also receives funding from the Violence Reduction Unit (VRU) and the Office of the Police & Crime Commissioner (OPCC) to support their operational work across the county.

The team uses their expertise to develop and deliver training on extra familial harm to local professionals. In the last year, Willow trained over 1,000 professionals and delivered education events to over 600 children.

In 2020/21 the Willow team was involved with supporting and safeguarding 145 children already open to Children's Services, and 428 children being assessed through section 17 and 47. In the last quarter of 2020/21, support from the Willow team has prevented ten children from entering care.

Simplifying the national landscape for extra familial harms

Some of the confusion in responding to extra familial harms locally stems from the complicated and often confused national approaches, with policy, funding and accountability split (and often not well aligned) between the Department for Education (DfE), Home Office (HO) and the Ministry of Justice (MoJ) in particular. Specific recommendations to simplify the system are made below.

Programmes and funding

As in Family Help, at present there are multiple funding streams and programmes aimed at supporting the same cohort of children. In recent years this has included Violence Reduction Units (VRU), the Trusted Relationships Fund, Project ADDER and SAFE taskforces. Sometimes funding is available at police force level and other times at local authority level, with individual criteria focused on specific harms or settings that make a response centred on the young person very difficult. If the development of local responses is going to succeed, government needs to give areas much greater freedom in how they use this funding, and achieve a clear set of cross government objectives. This is an area where government needs to show much greater alignment to ensure that decisions about young people are being taken in the round.

Recommendation: *Government should integrate funding aimed at preventing individual harms into a single local response to extra familial harms, including enabling areas to integrate their Violence Reduction Unit funding and infrastructure into their local response to extra familial harms.*

National Referral Mechanism

The review has frequently been told that the National Referral Mechanism (NRM), which is a centralised Home Office process for identifying potential victims of modern slavery including young people who are being exploited, is not working. There can be long delays in the decision making process (ADCS et al., 2021) and the Child Safeguarding Practice Review Panel have found that it is not well understood or used (Child Safeguarding Practice Review Panel, 2020b). The National Referral Mechanism devolving child decision making pilot programme is testing a localised approach by integrating the NRM decision making process into existing safeguarding structures in ten areas in the UK (Home Office, 2022). This means decisions about whether a child is a victim of modern slavery are made by the professionals involved in their care, and the process is closely aligned with local support and protection. While the evaluation of the National Referral Mechanism localisation pilot is not complete, there are positive messages about devolving processes to a local level (Crest, 2021). Unless there is a compelling reason not to proceed following the pilots, government should extend this to all areas.

Recommendation: *Subject to a positive evaluation of the pilot to devolve responsibility for the National Referral Mechanism decisions for child victims to local areas, government should roll this out to all areas.*

Simplify the experiences for young people in the youth justice system

The Taylor Review of the youth justice system in 2016, recommended that processes be simplified for young people in the youth justice system who are also involved with other services, with the aim that "ultimately, local authorities should create a one-child, one-plan system owned and contributed to by all relevant partners" (Taylor, 2016). Since the Taylor Review, there has been very limited progress. However, three local authorities have piloted integrated AssetPlus (the youth offending service system) and child in need assessments. These pilots have shown promising results, including improved collaboration between local services (Department for Education, 2020a). The government should not wait for further pilots given the obvious benefits of integration and the slow progress to date, and should extend this flexibility to integrate AssetPlus and child in need assessments to all areas. In Chapter Eight we also discuss the need for better national alignment on youth justice policy, including moving responsibility for this to the DfE.

Recommendation: *Government should implement the recommendations of the Taylor Review to simplify the experiences of children in the youth justice system, and as a first step, should roll out the flexibility to all local authorities to integrate AssetPlus Assessments with children in need assessments.*

3.4 Information sharing - a five year challenge

Teachers, doctors and nurses, health visitors, neighbours and the wider community are the eyes and ears of the child protection system, noticing when a child suddenly withdraws, comes to school hungry, has unexplained bruising, or is receiving unexpected gifts from adults. Services can only make good decisions and take appropriate action, if they have all the relevant information in one place and can consider it in the round to identify patterns and cumulative risks.

Challenges with information sharing are well documented. Poor critical information exchange was present in 40% of the serious incident notifications in 2018/19 and has featured in high profile inquiries, including the inquiries into the deaths of Victoria Climbié and Peter Connelly (Child Safeguarding Practice Review Panel, 2020). Information sharing is important not just because it protects children from significant harm, but because it also helps identify lower level needs more clearly so that children are provided with support (Crockett et al., 2013). Poor information exchange is not just a problem between partners, but also between local authorities when children move between areas.

We believe there are three barriers to successful information sharing. Each of these is hard to address and there is no single simple answer. However, there is a risk that complexity leads to inertia, when what is needed is steady and determined action to solve problems step by step and tackle barriers as we come to them.

Knowledge and culture

Too often practitioners do not understand or think enough about when they should share information and when they should respond to information they receive (Ofsted & Care Quality Commission, 2013; House of Lords: Public Services Committee, 2021). Staff turnover and inexperience can contribute to this. In the review's deep dives professionals told us that they find sharing information labour intensive and bureaucratic. They described receiving criticism when making referrals where a threshold was not met, and not getting feedback on the outcomes of referrals (The independent review of children's social care, 2022c). None of this supports open information sharing.

Across the review's recommendations, we are seeking to overcome structural barriers to effective practice, whether this is our suggestions around the front door to Family Help that encourages more conversations with professionals, the use of multidisciplinary teams within Family Help, reducing agency social work, or increasing practitioner skills. Getting these system changes right is at the foundation of good information sharing.

The Independent Inquiry into Child Sexual Abuse, due to publish this year, has been considering the value of mandatory reporting in relation to child sexual abuse. This is particularly pertinent when considering institutional and cultural barriers to disclosing this type of harm, and the Inquiry has a substantial evidence base underpinning its considerations in this area (Independent Inquiry into Child Sexual Abuse, 2019). Once the Inquiry concludes, government should consider existing calls for mandatory reporting with an open mind.

Perceived legislative and regulatory barriers

> ***"I think there remains fear over information sharing and the level of which can be shared - heightened when GDPR came in. MASH does greatly assist with this at that early stage but I do think there is still great anxiety especially when challenged that you could get in serious trouble for sharing certain pieces of information."***
> *- Participant in the review's workforce engagement*

Legislation and guidance allow for information to be shared for the purposes of safeguarding. Despite this, practitioners perceive it as a barrier and find organisational information sharing agreements confusing (House of Lords: Public Services Committee, 2021; Department for Education & Kantar Public, 2021). Whilst there are routes for sharing information without consent to safeguard and protect the wellbeing of children (most notably schedule 8(4) of the Data Protection Act 2018), agencies often only feel confident doing this where there are serious child protection concerns (House of Lords: Public Services Committee, 2021).

The legitimate interest test is another route that could be used by practitioners to share information. However, organisations find it time consuming and complex (Department for Digital, Culture, Media and Sport, 2021). We therefore support the Department for Digital, Culture, Media and Sport's (DCMS) proposed amendment to the UK General Data Protection Regulation, so that sharing information without consent for the purpose of safeguarding always passes the legitimate interest test. This would create a clear legal pathway to share information without consent and there would also be an opportunity to strengthen both *Working Together* and the DfE's guidance on information sharing for safeguarding professionals.

For this change in legislation to be effective we need a clearer common understanding of what is meant by the term 'safeguarding'. Evidence provided to the House of Lords Public Services Committee said that practitioners are confident when there are 'very clear safeguarding concerns' but are not clear on what to do when this threshold is not met (House of Lords: Public Services Committee, 2021). The review has heard similar views from practitioners and leaders, for instance that concerns must meet the significant harm threshold to meet this test. This is a misconception. 'Safeguarding' as a term is separate from any threshold for services (such as section 17 or section 47).[59] As such practitioners should be confident in sharing information with safeguarding partners and agencies, recognising that it is only through sharing information that they will build a richer picture of the day to day life of the child and family they are working with. *Working Together* should be amended to put this point beyond doubt and help professionals understand the meaning of this term.

Local implementation and governance is also critical. Yet, many areas are still not getting the basics right. Sir Alan Wood's recent review of arrangements found that some partnerships still do not have information sharing agreements in place, and research has shown that in other areas professionals consider them to be unclear or confusing (Wood, 2021; Department for Education & Kantar Public, 2021).

We therefore recommend that every local safeguarding arrangement should confirm to the Safeguarding Children Reform Implementation Board (SCRIB), the national partnership board that oversees implementation of safeguarding partners, that they have information sharing

59 This is backed up by the safeguarding amendment to the Data Protection Act 2018 under which the conditions of processing data are: (i) protecting an individual from neglect or physical, mental or emotional harm, or (ii) protecting the physical, mental or emotional well-being of an individual (Data Protection Act 2018, schedule 8 section 4).

agreements in place for the purpose of safeguarding. They should also confirm they have undertaken an audit of their information sharing practice so that they fully understand the barriers to information sharing locally. SCRIB should publish a list of all areas who have not done this by the end of 2022. There is a role for the government to support in this area by providing practical guidance on information sharing agreements and model templates based on local authorities who already do this well.

Technological barriers

> ***"Social work local authorities don't even have joined up systems to check children's records - whereas at least police have their Police National Computer system and don't have to continually phone colleagues in other areas to get basic information."***
> *- Participant in the review's workforce engagement*

Front-line professionals do not have the time to overcome technological and process barriers to sharing information. In our visits to local authorities and workforce engagement, practitioners frequently stated that clunky information technology (IT) systems meant that sharing information was extremely time consuming and often involved duplicated processes of submitting forms, or having to phone other professionals to find out information (The independent review of children's social care, 2022; 2022c). Practitioners up and down the country have asked the review to recommend IT systems that enable them to see the information they need from partners instantly.

There are different ways that the right technology can facilitate and automate information sharing and help practitioners make good decisions about the information they receive. It can give professionals a "single view" of a child, pulling information from different systems. Family Context is an example of this being developed in Leeds, Manchester and Stockport. It gives professionals instant access to the lead practitioner in other authorities and basic information on when services were last involved with a family.[60] In Bristol, the Think Family Database (profiled in Chapter Eight), enables professionals to see a range of information about children to help make good decisions. Research on Multi Agency Safeguarding Hubs (MASH) shows how integration of IT is seen to address a significant barrier to their success (Home Office, 2014).

Another way technology can be used is by introducing instant notifications for events that social workers and other professionals need to be aware of. For example, the Child Protection Information Sharing system alerts professionals where a child on a child protection plan attends an unscheduled NHS setting. This can be useful for professionals, making sure they get instant access to information they might not otherwise have.

Examples of good practice remain isolated. The government is currently funding a number of projects to improve data and technology in this area - including through Department for Levelling Up, Housing and Communities (DLUHC), Data Accelerator Fund and Local Digital - but they remain focused on individual authorities and regions (Ministry of Housing Communities & Local Government, 2021). What is needed is an ambitious collective objective to make progress on this issue nationally. We therefore recommend that the government sets a national target to use technology to achieve frictionless sharing of information between public agencies and organisations to keep children safe by 2027. The aim should be that practitioners have quick and direct access to important information from partners and other

60 https://www.localdigital.gov.uk/funded-project/building-family-context-in-childrens-services/

local authorities, which is needed to help them understand a full picture of what is happening to a child and take action to keep them safe.

In the time available to the review, we have not been able to do detailed work to set out exactly how this target could be achieved, but we have identified two components which will be necessary to achieve this.

First we need a **consistent identifier** to ensure that data can be easily, quickly and accurately linked. Without one number that links systems, data must be laboriously matched and the scope for true integration is limited.[61] This issue has been debated at length in the passage of the Health and Care Act 2022, with the NHS number proposed as a solution. The government has agreed to report to Parliament on the implementation of a consistent identifier within a year.[62] A good deal of consideration has already been given to this issue and a previous report commissioned by the DfE identified that the NHS number would meet many of the needs required (albeit with some limitations) (Valle et al., 2016). The NHS number also has the benefit that local authorities have already collected and matched the NHS number for the implementation of the Child Protection Information Sharing system. There will be no perfect solution and great should not be the enemy of good when it comes to making progress. Therefore, unless a compelling reason is found imminently not to do this, government must get on and implement the NHS number as the identifier. A unique identifier would also have the benefit of improving our ability to link data and make better use of the data that already exists.

Second, we need **coordinated action** to support local authorities, health, police and education to make the technical changes they need to achieve frictionless data sharing. In the NHS, NHS Digital has been pivotal in driving forward some of the most significant technological progress in information sharing because there is the infrastructure to make change happen. In Chapter Eight, we recommended a National Data and Technology Taskforce, co-owned with local authorities, to drive forward three data and technology priorities, including using technology to achieve frictionless sharing between partners systems and between local authorities by 2027. This Taskforce would work closely with NHS England and the police (who would also need to take coordinated action). The National Data and Technology Taskforce would need to precisely define what achieving the frictionless sharing of information would look like[63] (in consultation with the information commissioner), the right technological and legal approach to achieving it (e.g. whether this is achieved through interoperable systems or another route and whether common data standards and data quality agreements are needed), and the interim milestones that areas should meet. To ensure that all partners buy into this approach, the government should consider including a duty on partners to achieve this target in upcoming legislation. This would provide a way of binding everyone to achieving this. The Taskforce should set out proposed interim milestones within its first year and report to Parliament annually on progress.

61 There are examples like in Bristol that are using artificial intelligence to do matching based on their own algorithms; however, this is a more laborious and less accurate option that is only needed because of the lack of a consistent identifier.

62 See the Health and Care Act 2022 Part 6 S.175 - https://bills.parliament.uk/bills/3022

63 The target would need to define the circumstances where different information would be shared automatically to ensure that it is proportionate and public trust is maintained. For instance, that information is no longer shared when a child turns 18 or that particular health information is only shared in certain situations. The aim should be that practitioners have quick and direct access to important information from partners and other local authorities needed to help them understand a full picture of what is happening to a child and take action to keep them safe.

Recommendation: *Guidance and legislation on information sharing should be strengthened and local safeguarding partners should confirm they have information sharing agreements in place and have audited practice in this area.*

Recommendation: *Government should set a target to achieve frictionless sharing of information between local authority and partner systems and between different local authorities by 2027. To enable this they must take an imminent decision on whether to adopt the NHS number as a consistent identifier alongside work by the National Data and Technology Taskforce discussed in Chapter Eight.*

3.5 Improving parental engagement in child protection

The best route to keeping children safe when there is risk of significant harm, is to engage parents effectively in the child protection process, helping parents to realise and understand risk and supporting them to make change is central to ensuring a child's safety. When parents do not engage, it is harder to monitor, understand and respond to changing risks. Poor parental engagement with services is a key practice theme arising from analysis of serious incidents (Child Safeguarding Practice Review Panel, 2020). Sometimes when parents do not engage with child protection, or do so sporadically and superficially, it is to evade the detection of abuse because they are intent on harming their child. In other cases if services worked in a different way parents would engage and children would be more likely to be kept safe.

Through the review we have worked with Policy Lab to understand parents' experiences of the child protection system, alongside wider engagement with families. We have also heard from hundreds of parents through our broader engagement (The independent review of children's social care, 2022b). They describe their love for their children and strong desire to keep them at home, but also the extreme stress, unequal power dynamics and confusion that means they do not engage fully in child protection.

Sonia

A parent responding to our Call For ideas describes their experience of child protection processes

From the moment children's services entered our lives (unluckily for us in the wake of the Baby P scandal), we were assumed to be guilty and were treated as such. Instead of walking into our new family of three with an open mind, it felt like they saw a beautiful new baby and went forth looking for evidence to base an adoption case on. There are many other recommendations I'd love to see implemented but an ethos of impartiality is the biggest.

There was not one moment throughout our marathon ordeal that we felt like we were being treated fairly. It was antagonistic, accusatory, over the top, we were left with no privacy or dignity and forced to work against each other as parents with separate solicitors. There was never any sense that [we] were being objectively assessed. They made claims, imposed restrictions - then went looking for evidence to back them up.

Language, I feel, is so important and a policy change that needn't cost a fortune. I've still kept the four box files of paperwork from our case. They're sealed up in the loft because I can't bear my daughter to ever read the sort of language about her mother contained in them - but nor can I bring myself to throw away the evidence of how we were dealt with. The reports in those files are packed full of innuendo and loaded verbs like "she claimed" and "she denied". Just say "she said" - every time - take the implication out of it. Stop accusing married couples or grandparents and their children of "colluding" as if talking to one's family is an indication of untrustworthiness.

Don't make assumptions, don't twist words, don't make amateur psychiatric diagnoses, do give opinion by all means, but have respect for what is a fact and what is not. We were the lucky ones - we got to keep our child after a torturous three-year battle and thankfully she was too young to be aware of what was going on. But there seemed to be no consideration of the state they would leave her family in when they finally walked away - separated, exhausted, paranoid, angry, broken parents, trying to run two homes on two ruined careers.

There has to be a better way. If children's services had come into our family with an open mind and a genuine desire to help, it would undoubtedly still have been a distressing experience but one from which we might have eventually recovered. But the explosive damage to our family as a direct result of how combatively and prejudicially our case was handled has had lifelong consequences for all of us (including grandparents and the wider family) - but most profoundly for our child.

There are three important ways of improving parents' engagement in child protection and making it more dignified, with the role of the courts discussed later in the chapter.

First, adequate **help** must be offered to families to enable them to make changes, which our recommendations on increasing help will enable. Parents have told us frequently the feeling of powerlessness of being asked to leave an abusive relationship or deal with their mental health problems, with tight time constraints and without enough support (The independent review of children's social care, 2022b).

Second, the way that social workers, courts and other professionals interact with families must be **compassionate and respectful**. Families have told us their experience of social care over time has been dependent on the individual social worker they had (The independent review of children's social care, 2022b). Brilliant social workers who helped them to turn their lives around, and terrible experiences of fixed views that they could not change and that came with little support. This should be improved through improving individual worker skill, appropriate supervision and challenge, and organisational culture (covered in more detail in Chapter Seven). However, there are simple examples of good practice that should be promoted: the use of respectful language, giving parents (and where appropriate young people) the opportunity to see and agree minutes, and delivering important messages in person. In Chapter Eight, we recommend a new child and family satisfaction measure that should be used to continually learn and improve parental engagement.

Third, for many parents having **independent representation** that provides advocacy and enables them to navigate the emotionally charged child protection process is invaluable. A growing number of local authorities have models of parental representation and advocacy in place. International research shows that this can lead to: reduced maltreatment; better engagement in the court process; reductions of entry into care and increasing successful reunification and kinship placements; improved family engagement; reduced drug and alcohol use; and changes to how services worked with parents (Better Care Network & International Parent Advocacy Network, 2020). Through the review's work we have seen transformational examples of parental representation and support that have kept children safely with their families. These should be adopted nationally.

> ***"I found it so difficult going through such a traumatic experience being separated from my boys, whilst receiving no support. If I had received the support it would have made the whole process easier mentally and emotionally, I believe for some of us this could be the difference between getting our kids back or not."***
> *- Birth mum whose children are now living with kinship carers*

New Beginnings

Support and representation for parents in child protection

New Beginnings is a project that supports families in the child protection system. Their vision is to work closely with parents in particular so that they can develop the strength, knowledge and power to become the parents they want to be and in return, teach other parents how to do the same.

Their 24 week programme is designed to help parents understand how their past has affected their identity and the way they relate to their children. The group work sessions provide a safe and confidential space for parents to meet other parents who are in similar situations. Sessions help parents understand why they parent in the way that they do and develop new skills which can help them move forwards, exploring issues such as family, identity, attachment, trauma, coping strategies, and more.

Each parent is also allocated a key worker who becomes their first point of contact. The role of the key worker, who is an experienced social worker and therapeutic practitioner, is to carry out 1:1 sessions with parents to support them through the programme and the child protection process.

New Beginnings have learned that parents often find it difficult to navigate the child protection system because, quite simply, it can be very confusing. Key workers help parents better understand what is being said, get their own points across, and help other professionals hear the progress they are making.

When parents complete the programme, they are offered the opportunity to do an accredited peer mentoring training course so that they can share their knowledge and wisdom by mentoring new parents who join the project.

One parent the review met told us about the support they received from New Beginnings:

> ***"I asked for the help over four years ago and I thought I made the wrong choice but after being on the New Beginnings course it opened my eyes and made me realise that I made the right choice as they did so many things for me and helped me get over my past which I thought I had got past but hadn't. Even though I finished the course a long time ago they are still in my life when I need them which is a good thing"***

Recommendation: *The National Children's Social Care Framework practice guides should promote effective practice for engaging families. Parental representation should be offered to all families in child protection.*

3.6 The role of the courts

The courts play a critical role in child protection but are under significant pressure with long standing backlogs and the impact of COVID-19. With limited judicial time this means cases are taking longer to complete. Between July and September 2021, only 24% of public law cases were completed within the 26 weeks required under the Children and Families Act 2014 (Ministry of Justice, 2021).

There are multiple causes for this backlog, including variation in the quality and approach to pre-proceedings across local authorities, with only 24% of these cases being diverted from court (Masson et al., 2013; Thomas, 2018). Cases are also increasingly heard as urgent hearings, which impacts the quality of decision making, requires expert assessments to be carried out in proceedings, and adds further burdens to the court system (Pattinson et al., 2021). The negative impact of court proceedings on parents, and a lack of support following proceedings, means that 20% of mothers in the public family law system are returning to court within five years of a previous section 31 hearing (Harwin et al., 2018b).

Many of these challenges can be addressed by improving support and expertise available to children and families earlier on in the system:

- improving Family Help will mean that families will receive meaningful and effective support as soon as they enter the children's social care system, as will parents after proceedings if a child is taken from their care

- improving child protection with Expert Child Protection Practitioners co-working cases should also increase the quality of pre-proceedings work and in court assessments and submissions

- promoting alternatives to care, through the use of family group decision making and Family Network Plans (discussed in Chapter Four), should also mean children are kept safe with family and friends

In addition to this, there are some important actions that need to be taken in the family justice arena to improve how the courts work for children and families.

Improving decision making

There is significant regional variation in the types of orders made for children by courts. Data is not regularly published on this, however, analysis of a one off publication found that in the North West approximately 47% of children who were subject to care proceedings were placed on a Care Order at the end of the process, compared to 40% in the Midlands and 28% in London (2016/17). In the same year, children in the London circuit were more likely to be made subject to a supervision order (25%) than children in the Midlands (12%) and North West circuits (9%) (Harwin et al., 2018b). We also know that there are significant racial disparities in children entering care, which we struggle to adequately explain (Ahmed, James, et al., 2022; Bywaters et al., 2019). This level of variation is significant and we do not properly understand its drivers.

Whilst each case is individual and judges make decisions independently, we have heard from judges and others in the system that the lack of information on the orders handed down and the outcomes for those children means there is no effective learning mechanism to understand what the best decision is for a child (McFarlane, 2017). The work being completed by the President of the Family Division on increasing the transparency in the family division is positive but we need to go further, with a greater focus on data and feedback loops to understand the decisions made and children's outcomes (Courts and Tribunal Judiciary, 2021).

Data already collected by HM Courts & Tribunals Service (HMCTS) from the courts should be regularly published to bring transparency and understanding in order to improve the system. This data would include the type of application made, the final order for all section 31 court hearings

at a Designated Family Judge area level and basic demographic data such as the age, gender and ethnicity of a child. Data would be published in a manner that protected the confidentiality of the children and families' identity. Without this transparent information we do not know what decisions are being made and we cannot identify patterns. Clearly presented data could, for example, help judges understand if they are making more Care Orders than other parts of the country, or if they are making greater use of Supervision Orders, and therefore promote learning.

More also needs to be done to connect data sets to understand what leads children into entering the family justice system and which decisions turn out to be best for children. It is positive that the government has invested in data linkage through the Integrated Data Service being led by the ONS.[64] Linking family justice data with the new ECHILD database which brings together children's health, education and social care data should be the next step.[65]

The SAIL Databank in Wales

Linking data to understand children's journeys

The SAIL Databank holds and can anonymously link large population level datasets in Wales. This includes data on: family justice from CAFCASS Cymru, children in need, children in care and care leavers. It also holds education data and health data for children and adults.[66] This provides the capacity to properly understand children's journeys both into and following care proceedings, and show what more needs to be done to keep children away from courts and the impact of different orders on their outcomes. For instance, research on the health vulnerabilities of all parents with babies and infants in care proceedings found they were impacted by key gaps in low-level mental health support. Between 2011-2018 these parents were three times more likely to have common mental health conditions such as anxiety and depression (Griffiths et al., 2021).

National data is crucially important but we also need local approaches to impact how local family justice systems work. Local Family Justice Boards should be part of a learning loop given their unique position of bringing together the key players of local authorities, the judiciary, CAFCASS, private lawyers and others. Placing the outcomes of children at the centre of this process, local authorities should be required to regularly provide an update on children who have been through the family justice system. These will be a representative sample and they will share a holistic set of outcomes such as a child's wellbeing, health, education, and relationships with family members and friends, the type of home they are in (fostering or residential) and current legal status.

For these recommendations to work, the oversight of family justice needs to be sufficient. We have heard that Designated Family Judges struggle to step back and look strategically at how the family justice system is operating locally and take steps to make improvements. Equally their

64 See: https://www.gov.uk/service-standard-reports/integrated-data-service

65 https://www.adruk.org/our-work/browse-all-projects/echild-linking-childrens-health-and-education-data-for-england-142/

66 SAIL Databank - https://saildatabank.com/saildata/sail-datasets/

'observer role' in Local Family Justice Boards reduces their effectiveness as active participants in local practice improvement. This is a particular concern given the current pressures on family justice. Local family justice boards should be given the clear objective of improving practice and understanding drivers of regional variation to improve outcomes for children. The Public Law Working Group has shown the benefits of all parties coming together on the same level, and how the judiciary can take an active role in system improvement without compromising their independence. As such, the Designated Family Judge should be a full participant in Local Family Justice Boards. The role should be focused on supporting judicial decision making within their area by offering feedback on the overall approach taken by judges. Designated Family Judges need non-sitting days to undertake this work. This learning should be fed to the national Family Justice Board, who in turn should share an annual review of learning with areas for focus and development for the upcoming year.

Recommendation: *Improve the quality and consistency of local and judicial decision making through improving the quality and transparency of data and facilitating learning at a local level.*

Improving parents' understanding and engagement with proceedings

Whilst a child being removed will always be a devastating experience for parents, we know that proceedings can be unnecessarily combative and parents are often unclear on the process they are involved in (The independent review of children's social care, 2022b). Parents find the experience alienating and many do not have faith in the decision making process (Hunt, 2010). Parents with English as a second language and those with learning difficulties face particular issues (Booth et al., 2005; Brophy et al., 2005). If children are removed, the support for parents often stops (Broadhurst & Mason, 2020), and relationships between social workers, children and families are often broken (Broadhurst & Mason, 2017). This leads to parents being less likely to engage, more likely to have subsequent children removed, and negatively impacts on children when they spend time with their family, either during contact arrangements or when they leave care. Family Drug and Alcohol Courts (FDAC) have been an important innovation in this space, combining specialist support and a problem solving approach. They remain an important evidence based intervention to keep more children safely at home with their families.[67]

> ***"... As a birth parent who has been through the care system and courts I would have found emotional support so good at the time. It would of helped me feel fresh for meetings and court, like I had someone to turn to, away from the care system, courts or legal team as you feel like you're just left, you don't matter anymore. And as your child no longer lives in your care you feel rock bottom. All parents or anyone that's involved in this system should have support and it should be made part of the process so they know where to get it ..."*** - *Birth Parent*

67 The Family Drug and Alcohol Court improves parental engagement and outcomes for children. One study found 36% of mothers were reunited with their children in FDAC in comparison to 24% in normal proceedings, and that 40% of mothers in FDAC were no longer misusing substances, compared to 25%. For fathers, the figures were 25% in comparison to 5%. (Harwin et al., 2014). These positive outcomes have significant financial returns with £2.30 saved for every £1 invested. (Whitehead & Reeder, 2016).

> ***"If I had been given FDAC after my 3rd kid it might have made a huge step in the right direction."*** - *Parent*

Whilst the FDAC approach will not be suitable for all families, there is much we can learn from the problem solving approach that could be mainstreamed into family courts. This could include having a consistent judge throughout the proceedings; encouraging the use of peer advocacy; and facilitating more direct engagement between parents and the allocated judge (Harwin et al., 2014). Work looking at remote courts during COVID-19 also highlighted that some very simple changes can have a positive impact on parents' basic understanding of the process. This includes starting each hearing with a clear explanation about how the hearing will run so parties can engage effectively and can be heard, allowing time for lay parties to communicate with their representative and/or intermediary or advocate, and ensuring that the outcome of a hearing has been understood by the parties (Ryan et al., 2020).

Recommendation: *The Public Law Working Group should lead work to bring learning from Family Drug and Alcohol Courts and other problem solving approaches into public law proceedings, to make proceedings less adversarial and improve parents' engagement in the process.*