Summary Briefing

1. Reason for Review:

The LCSPR was commissioned following escalating risks to DB (aged 15 at the time), including criminal exploitation, significant drug use, repeated missing episodes, instability in care arrangements and concerns about unsafe adults and environments.

2. Key Learning Themes

A. Parental Expertise, Distress and Trauma

- Parental distress must be recognised as an indicator of fear, trauma or overwhelm—not hostility.
- Parents often hold the most accurate intelligence about unsafe adults, locations, peer networks and exploitation indicators.
- Professionals need curiosity to understand what parental behaviour *means*, not just how it appears.
- Parents require consistent, targeted and practical support when managing cumulative harm and fear.

B. Cumulative Harm and the Need for Coherent Planning

- DB's harm accumulated over many years through instability, trauma, exploitation, missed emotional-health support, and fragmented professional responses.
- Multiple parallel processes (CIN, CP, exploitation, missing-from-home, youth justice, school plans) operated without a single coordinated plan. This fragmentation obscured the true level of danger and prevented coordinated, authoritative action. Safeguarding arrangements should be coordinated so risk can be overseen through a single, coherent framework.
- Emotional-health intervention should be early, proactive and sustained.

C. Practice Quality, Trauma-Informed Work and Adultification

- Assessments lacked updated analysis and too often relied on cut-and-paste material.
- Trauma-informed approaches must be grounded in the child's lived experience and cumulative patterns, not isolated incidents.
- Adultification affected how DB's behaviours were interpreted—his constrained choices were seen as "risky decisions" rather than indicators of exploitation and trauma.

D. Contextual Safeguarding

- Intelligence held by parents, peers and the community was not systematically synthesised or used to disrupt risk.
- Unsafe adults, peer groups, community locations and online influences were known but not acted upon collectively.
- Mapping occurred, but disruption action did not follow.
- Social media influences and multiple phones were known risk factors but lacked sustained analysis.

Practitioners should

- be supported to maintain curiosity about parental distress rather than interpreting it as hostility or resistance.
- remain open to the full range of reasons that might be driving a parent's emotional distress, recognising that emotional presentation may be signalling underlying concerns and shaping engagement, seeking to understand what the behaviour may be signalling and working with the parent based on that understanding.
- be supported when raising concerns or experiencing conflict, and their voices should be listened to.

Supervision should

- be reflective supervision that enables them to discuss risk, uncertainty and emotional impact safely and without fear of negative consequences.
- strengthen an open, reflective climate so staff can speak plainly about risk, uncertainty and concerns without fear of blame.
- strengthen psychological safety, particularly when parental behaviour is challenging or when conflict and high emotional distress are present.

Workplace

- culture should be one where staff know they will be listened to, treated with respect and supported when they raise complex issues or challenge practice should be encouraged.

Leadership and management

- Relational continuity should be prioritised, so children do not experience multiple changes of worker.
- Management guidance should clearly define the difference between strategic leadership, operational involvement and frontline decision-making, so children and families understand who is making decisions and why.
- Staff across agencies should feel able to raise concerns about inappropriate senior operational involvement, blurred boundaries or confusing decision-making structures, knowing these concerns will be heard and acted on.
- Senior leaders should provide consistent organisational containment through clear expectations, visible support and emotionally steady leadership.

3. What Good Practice Looks Like

✓ There was generally good information sharing, largely appropriate multi-agency relationships and shared recognition of the seriousness of the concerns.

✓ Recent progress demonstrates what can be achieved when stability, trusted relationships, clear hierarchical decision-making boundaries and clearer direction are established.

4. Actions for Practitioners

✓ analyse cumulative patterns rather than isolated incidents.

✓ Approach parental distress with curiosity, recognising trauma and protective intent. Seek to understand what behaviour may be signalling and work with the parent based on that understanding.

- ✓ Ensure assessments include current information, emotional health, trauma, exploitation and contextual factors.
- ✓ Promote stability: minimise worker changes, prioritise relational continuity and maintain a consistent lead professional.
- ✓ Reflect openly in supervision on uncertainty and emotional impact.

5. Resources & Support

- ➢ Training opportunities: Safeguarding Childrens Partnership Training offer

6. Points for consideration

- ➢ How does this learning apply to your role/agency?
- ➢ What changes can you make in your practice?
- ➢ How will you recognise and address cumulative harm, not just individual incidents?
- ➢ How will you ensure parental intelligence is systematically gathered, heard and acted upon?
- ➢ How will you enable staff to voice concerns, challenge decisions and raise issues confidently?

7. Recommendations ; an action plan will be developed through the Child Safeguarding Practice Review group to respond to the below recommendations.

Recommendation	Possible Early Success Measures
1. Strengthen multi-agency planning through one shared plan	• A single coordinated plan is in place for children with contextual and cumulative harm.
	• Parallel processes (e.g., exploitation, MFH, CIN/CP) feeding into one shared plan.
	• Practitioners report improved clarity about direction and responsibilities.
2. Strengthen psychological safety across the partnership	• Increased practitioner confidence to raise concerns and discuss uncertainty.
	• Supervision records show reflective discussions and boundary considerations.
	• Clear escalation routes understood by staff.
	• Evidence that parental feedback is used constructively for learning within clear and supported boundaries.
3. Clarify leadership roles, boundaries and expectations	• Written guidance on senior visibility and operational involvement has been agreed and circulated.
	• Staff feedback reflects improved clarity about decision-making routes.

	• Practitioners feel supported rather than replaced by senior leaders.
4. Strengthen contextual safeguarding and disruption activity	• Regular mapping activity that leads to disruption, not just recording.
	• Parent/community intelligence is consistently used in planning.
	• Clear understanding of the implications of NRM decisions in practice.
5. Improve early trauma recognition and sustained emotional health support	• Missed appointments trigger proactive follow-up.
	• Emotional needs are included in every assessment and plan.
	• Parents experiencing distress or exhaustion were offered targeted support.
	• Where relationships with parents have been strained, there is evidence of structured opportunities for parental feedback and learning, with clear purpose, boundaries and support for families and practitioners
6. Strengthen permanence planning and reduce instability	• Earlier discussions of permanence when instability emerges. • Clear criteria for when Section 20 is insufficient. • Fewer placement moves and improved planning of transitions.