

*May 2023*

**Working with Families where Engagement is Challenging**

There was a pattern of parents declining services, missed appointments, and professionals reporting that parents could be confrontational and aggressive. The Rapid Review also identified that information provided by parents was not always truthful. These behaviours created difficulties in engaging with parents and putting support in place, particularly where this support was on a voluntary basis. Professionals are encouraged to use their professional curiosity and be persistent to identify disguised compliance and where families are hard to engage, so that they can adapt their approach with the family. Where parents are behaving in an aggressive, resistant, or confrontational manner, professional should record this and share observations with other professionals as it may indicate families that are difficult to engage and where problems may be hidden.

**Good Practice**

Good practice was identified in engaging parents where phone contact was made with parents where visits were declined. This supported better engagement, regular contact, and building relationships with the family.

**Identifying Child Neglect and Cumulative Impact of Harm**

There was a history of child welfare and safeguarding concerns, including minor injuries and supervision of young children, which suggested a possible pattern of child neglect, but this never met the threshold for child protection or child in need. The family was offered Early Help on multiple occasions, which they declined. It was found that a Child and Family Assessment did not fully consider the family’s history and previous concerns. Assessments should always consider the family’s history, cumulative impact of neglect, and understand the children’s lived experiences.

**About the Rapid Review**

A Rapid Review is completed by the Local Safeguarding Children Partnership when a child suffers serious harm or dies, and abuse or neglect is known or suspected. The purpose of the Rapid Review is to identify learning among agencies involved with the family, so that improvements can be made to avoid these incidents happening again. At the conclusion of a Rapid Review, the Safeguarding Partners make a decision on whether the criteria is met to commission a Child Safeguarding Practice Review (Working Together to Safeguard Children 2018).

The sections below explain the learning identified in this rapid review, which professionals should take into account in their daily practice. The Safeguarding Partners decided that this case did not meet the criteria for a Child Safeguarding Practice Review.

**Background**

In this case, a baby under the age of 12 months was admitted to hospital due to what was suspected to be a non-accidental head injury while in the care of parents. While the baby recovered, a Serious Incident Notification was made by the local authority due to the serious harm at the time of the incident and concerns of child abuse. The family had been involved with different agencies and were in receipt of support from health services at the time of the incident. There were previous child safeguarding concerns relating to the baby’s older siblings, however these concerns never met the threshold for children social care.

**Further Reading & Resources**

[ICON – Babies Cry You Can Cope – Advice and Support](https://iconcope.org/)

[Curiosity – College of Policing](https://www.college.police.uk/guidance/vulnerability-related-risks/curiosity)

[Professional Curiosity – Learning Briefing](https://www.herefordshiresafeguardingboards.org.uk/documents/professional-curiosity-learning-briefing-february-2023)

[Disguised Compliance, coercive control and families who are resistant to change- West Midlands Safeguarding Children Group](https://westmidlands.procedures.org.uk/pkplx/regional-safeguarding-guidance/disguised-compliance-coercive-control-and-families-who-are-hostile-or-resistant-to-change)

**Information Sharing – Discharge / Case closures**

The Rapid Review identified that multi-agency information sharing was compromised when the family was discharged or their case was closed to a service, but that closure/ discharge information was not shared with other professionals involved. This meant that professionals working with the family did not have a full understanding of what support the family were receiving, and assumed that support was in place that was not there. Agency closure procedures should ensure that discharge/closure information is shared with all professionals involved so that there is a shared understanding of the support the family is receiving and alternative support can be offered if available.

