OSCB Learning Event

Working with dads and male carers

Delegate Pack

9th February 2018
Unipart, Oxford

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<th>Time</th>
<th>Event</th>
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<td>08.30 - 09.15</td>
<td>Arrival, Registration and Coffee/Tea</td>
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<tr>
<td>09:15 - 09:25</td>
<td>Welcome and Introduction</td>
<td>Alison Chapman, Designated Nurse and Safeguarding Lead</td>
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<td>09:25 – 10:05</td>
<td><strong>Dads in the Safeguarding Network</strong></td>
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<td><strong>Whole Family Approach</strong></td>
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<td><strong>Fathers in Substance Misuse Treatment</strong></td>
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<td>Andrew Jones, Independent Chair</td>
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<td>James Carter, Think Family Coordinator</td>
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<td>Sarah Hicks and Wendy Austin, Turning Point Safeguarding Coordinators</td>
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<td>10.05 - 10.15</td>
<td>Film: How Dad Friendly is Our School? Tips for including fathers</td>
<td>Fathers Network Scotland: Year of the Dad</td>
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<td>Reflective questions for practitioners</td>
<td>Alison Chapman</td>
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<td>10.15 – 10.45</td>
<td><strong>Involving Dads: NSPCC Perspective</strong></td>
<td>Dr Karen Bateson, NSPCC</td>
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<td>10.45 - 11.15</td>
<td>Refreshment Break</td>
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<td>11.15 - 12.15</td>
<td>Ask A Dad</td>
<td>Young Dads Collective</td>
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<td>12.15 - 12.30</td>
<td>Round up and closing</td>
<td>Alison Chapman</td>
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<td>12.30</td>
<td>End of Event - Close</td>
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Speakers

Alison Chapman, Designated Nurse and Safeguarding Lead

Alison has been Designated Nurse and Safeguarding Lead with Oxfordshire Clinical Commissioning Group since 2013. Her previous roles include Lead Nurse at Oxford University Hospital and Lecturer Practitioner in children’s nursing education at Oxford Brookes University.

Alison delivers safeguarding training and is Chair of Oxfordshire Safeguarding Children Board Training Sub-group.

Andrew Jones, Senior Independent Chair/Independent Reviewing Officer

Andrew has been a Social Worker and manager for 33 years. In this time he has managed a care unit for children with Asperger’s, worked as an Education Social Work Manager, Specialist IRO for children in residential care, specialist schools and secure units, and LADO Service Manager. He has also had a small private counselling practice, specialising in clinical supervision for practitioners.

His current role of Senior Independent Chair/Independent Reviewing Officer includes responsibility for bringing together children, families, carers and professionals, to effectively plan children’s care, review processes and ensure children’s wishes and feelings are given full consideration.

As such Andrew has significant experience of supervising and supporting social workers, promoting the voice of the child, engaging family members in care planning and review, and challenging poor practice.

James Carter, Think Family Coordinator

Since 2016 James has been responsible for the co-ordination of Oxfordshire County Council’s whole family approach, to ensure children and young people are not viewed in isolation and, wherever appropriate, action is taken to address issues that affect the whole family.

James has held a variety of roles within Children’s Services over the past 16 years, including Youth Justice Worker, Family Inclusion Project Manager and Early Intervention Service Manager. Throughout his career he has championed father inclusive practice and the importance of understanding family functioning/interdependency to inform and focus child-centred practice.

Sarah Hicks & Wendy Austin, Safeguarding Coordinators, Turning Point

Sarah Hicks & Wendy Austin have worked as Safeguarding Coordinators in Turning Point since the summer of 2017. They carry a case load of the services’ most complex safeguarding clients. They have been instrumental in developing and delivering the Parenting Group following feedback from clients and Children’s Social
Care. Sarah & Wendy support & advise the staff regarding safeguarding concerns as well as maintaining & auditing the Safeguarding registers for each hub & shared care GP practices. Countywide they input into the MASH and the Domestic Abuse Triage meetings. In addition, they liaise with other services regarding safeguarding and adult substance use.

Turning Point Roads to Recovery is an all-purpose drug and alcohol treatment service located across Oxfordshire. There are hubs in Oxford, Didcot, Witney and Banbury, as well as satellite services in other localities. Workers also support the GP shared care service. Each hub delivers open access services for all including: a weekly programme of group sessions, clinical interventions, harm reduction services, keyworking appointments, ETE support, and specialist prescribing. Anyone concerned about their own substance misuse or another’s can contact the service directly for further information.

Dr Karen Bateson, Development and Impact Manager, NSPCC

Dr Karen Bateson is a Development Manager with the NSPCC, leading on the development work for their Together for Childhood programme to prevent child abuse and neglect. Karen was previously a Consultant Clinical Child Psychologist in the NHS, and has over 23 years’ experience of working with families facing adversity, training, supervision, consultancy and project management.

Her special interests are the science, evidence, policy and practice of early intervention, including trauma-informed systems, engaging fathers, antenatal and early years interventions, neuroscience and attachment.

You can connect with Karen on Twitter @karenjbateson

Young Dads Collective, The Family and Childcare Trust

The Family and Childcare Trust is the leading national charity in the field of policy, research and advocacy on childcare and family issues, working closely with government, local authorities, businesses and charities to achieve positive and long-lasting change for families across the UK.

Young Dads Collective works to reduce the levels of isolation and poverty experienced by young dads and at the same time develop our skills for the workplace. We believe that as ‘experts by experience’ young dads are the best people to make change for themselves and their peers. We employ a small team of young dads under 25 years old, to enable them to share their knowledge and experiences with practitioners, service providers and policy makers and to influence change in policy and practice. We create a space in which our team can provide the ‘authentic’ voice for young dads, while also offering kinship and personal support to members who, in many cases, would otherwise not have been heard. Through the YDC, members develop their employability skill sets improving the life chances for themselves and their children.
Learning from the Serious Case Review for Child Q

Summary:

This case concerned a 14-month old child who died, as the result of drowning, having been left unattended in the bath. The child is referred to as Child Q in order to protect her identity.

Child Q lived with her mother and an older half-sibling. At the time of Q’s death, both children were subject of a Child Protection (CP) Plan, due to significant concerns about neglect and parental inability to protect them from harm.

Child Q’s mother had a difficult personal history, and there was little consistent support from her wider family, whereas Q’s father and paternal relatives were involved in regular ‘respite’ care for Q. The family received a good level of support from a range of professionals.

The concerns about Mother’s ability to care for her children centred around her immaturity, her (poorly understood) level of drug and alcohol misuse, her periodic depression, and her exposure of the children to unsuitable teenagers and adults. There was a large network of universal and specialist services working with the family, with Children’s Centres taking a prominent role in ‘teaching’ parenting skills and monitoring the children’s care. However, Mother was an inconsistent user of services, and found it hard to sustain any improvements. She moved twice in the children’s early years, with her last move placing the family in a more isolated situation. These moves meant that relations with professionals were broken and had to be built up again.

Findings:

❖ The Child Protection Plan for Neglect did not consistently spell out the specific risks to the children and the consequences if the desired outcomes for their improved safety were not achieved.

❖ Professionals were not consistently and sufficiently pro-active in response to incidents and allegations regarding the children, based on their perception that they ‘didn’t have enough evidence’ to pursue the incident.

❖ A delay in the process and timeliness of robust handover between professionals group when the family moved resulted in interruption of the knowledge about the family and the case, and lead to unintended ‘start again’ for the new professionals.
The input and cooperation of the mother, was prioritized at the expense of not engaging the other parent (father) in the child protection process.

The commitment to working in partnership with parents in Oxfordshire inadvertently led to an assumption that professionals could not meet together, without parents being present, when they had concerns regarding case management.

A delay in timely and consistent sharing of CP plans and minutes.

There was no agreed use of a multi-agency tool to capture a chronology of significant events, this made it more difficult to assess risk to the children and parental patterns which demonstrate poor capacity to change.

Key areas for improvement:

- Challenges in dealing with inconsistent and neglectful parenting.
- Professionals' lack of curiosity or challenge in relation to self-reported explanations of harm to the child/ren.
- Need to involve fathers better as a protective factor.
- Loss of continuity of service (and records) when families move across boundaries.

Themes in common with other reviews:

- **Parental neglect** - challenges faced by professionals working with vulnerable families where neglect is an embedded issue.
- **Fathers/male carers** – communication with and involvement of fathers and male carers and the importance of thinking carefully about the role of the father in the family system.
- **Parental mental health** – the impact of the parent’s mental health problems on the safety and wellbeing of the child.
- **Substance abuse** – understanding of substance misuse and interventions, the changing levels of risk, and the impact on the child.
Learning points for practitioners: Think Child

- **Assessments:** Always make an assessment of what a father or male partner and his family can offer to a child (positives), as well as of the risks he or they may pose.
- **Responses to incidents:** Ensure that you speak to a child alone in relation to any allegation of harm or physical signs of harm and follow Child Protection procedures. Escalate concerns and be confident in following up to confirm your concerns have been heard.
- **Communication:** Always share information about allegations of harm or physical signs of harm with the allocated Social Worker for the child.

Learning points for managers

- **Management:** Ensure that neglect cases have clear plans – with desired outcomes, timescales, etc. – which are reviewed robustly on a regular basis, taking account of new evidence and increased risk.
- **Risk assessment:** Review the risk assessment after any incidents to ensure that it reflects and addresses ongoing concerns.
- **Supervision:** Ensure that reflective supervision is carried out in neglect cases, with a focus on the lived experiences of the child/ren.
- **Tools:** Promote the use of chronologies as a vital tool in tracking progress in neglect cases.
- **Training:** Support (and expect) practitioners to undertake training for responding to neglect and physical injury.

Key messages for inter-agency learning

- It is vital to share information about any physical marks on a child with your safeguarding lead and with the allocated social worker. Ensure your discussions are recorded and be confident to chase up as necessary.
- Agencies should feedback to Children’s Social Care when they do not receive minutes of formal meetings (CP Conferences and Core Groups, and Strategy Meetings) within the required time.
- Any professional from any agency can request a professionals meeting without a parent being present if there is a need to do so.
In relation to **neglect**: Practitioners need to have an open mind about the possibility of neglect having a fatal or very serious outcome for a child but deal with neglect cases in a confident, systematic and compassionate manner.¹

- The Neglect Toolkit (and all the lessons from the Neglect pilot) should be widely embedded in practice across agencies.
- Ensure that neglect is not accepted and normalised when working with families.

**Time to reflect…**

Stop and think – is the risk assessment robust and being regularly reviewed? Is the child protection plan up to task and is there evidence that it is making a difference to the child?

Analyse and assess the risks that arise when a vulnerable family moves across boundaries and all professionals change: risks include loss of knowledge and understanding of the family; loss of professional relationships with the mother and children, and among the professional network; the risk of 'start again' syndrome.

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Please click the links below for resources available:


- All Babies Count: the Dad Project - How to support dads during pregnancy and the first year [https://www.nspcc.org.uk/services-and-resources/research-and-resources/2014/all-babies-count-dad-project/](https://www.nspcc.org.uk/services-and-resources/research-and-resources/2014/all-babies-count-dad-project/)


- Are we nearly there yet, Dad? Supporting young dads’ journeys through fatherhood [http://portal.oxfordshire.gov.uk/content/publicnet/other_sites/oscb/documents/new/parents/Fathers/are_we_nearly_there_yet_dad.pdf](http://portal.oxfordshire.gov.uk/content/publicnet/other_sites/oscb/documents/new/parents/Fathers/are_we_nearly_there_yet_dad.pdf)

- Fatherhood Commission - Links between young people’s relationships with their fathers and their mothers, and their well-being and self-esteem [https://www.childrenssociety.org.uk/sites/default/files/tcs/research_docs/fatherhood_commission.pdf](https://www.childrenssociety.org.uk/sites/default/files/tcs/research_docs/fatherhood_commission.pdf)


- Andrews, Martin (206) Future-proofing fathers work: A report on fathers work in Oxfordshire, commissioned by Oxfordshire Parenting Forum [http://oxfordshireparentingforum.blogspot.co.uk/p/resources.html](http://oxfordshireparentingforum.blogspot.co.uk/p/resources.html)

- Research in Practice: Working effectively with men in families – including fathers in children's social care: Frontline Briefing (2017), Hardcopies £12 or £8.40 for partners, downloadable files £12 + VAT or free to partners and Working effectively with men in families – practice pointers for including


• Multi-agency safeguarding procedures – The OSCB multi-agency procedures cover a wide variety of situations you may encounter. You can access them at http://oxfordshirescb.proceduresonline.com/