

Protecting and Supporting Families in Health and Care

BMHP5021

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Introduction

Protecting and supporting families in the healthcare is based on the helping children and young people to stay safe, healthy and supported (Doyle *et al.*, 2023).

The analysis will focus on the case-5 of Theo, highlighting the perception of well-being in case.

It is mainly focused on team-working for protecting vulnerable individuals and improving their well-being.

Further, it will draft on the importance of partnership and communication in health-care. A critical analysis for the study and information will be included in it. Lastly, recommendations will be given for improving the multi and inter-disciplinary nature of services.

Case Overview and purpose of meeting

The case regarding Theo is related to deep concerns involving safeguarding (including difficulties with multi-agency involvement), concerns surrounding domestic abuse and family arguments.

There was ample opportunity for social workers and health visitors, the police, team managers, representatives of CAFCASS and others to work together.

They work with the aim to pass on information, to observe the nature of the threat and to be able to provide early support through bricks.

The lack of services was detriment to the satisfactory safeguarding of Theo and his family. This multi-agency meeting is to discuss the case; to review how effective is the professional response; to highlight learning points and to make recommendations in relation to partnership working, safeguarding practice and protection and wellbeing for vulnerable children and families.

Well-being of perception

In Theo's instance, the well-being of the children and the family was significantly impacted by domestic abuse, domestic neglect, emotional harm and inadequate safeguarding actions.

Theo and his sister Ruby were in need of a safe, stable and nurturing environment to meet the consistent needs of their physical, emotional and developmental needs.

However, there was a pattern of conflict in the family as well as repeated domestic abuse, which negatively impacted their sense of safety and wellbeing within the family (Ferreira *et al.*, 2023).

The family had numerous contacts with professionals, such as social workers, health visitors, police and CAFCASS, but these were not always effective or coordinated to reduce the risks for the children.

Children's wellbeing was characterised by feeling safe, valued, and cared for in a steady manner by trusted adults. Theo's ability to communicate and articulate his experiences was limited, especially due to him being a young child, highlighting the importance of professionals to recognise concerns around the safety of children by careful assessment as well as information sharing. Living in a setting of unstable and abusive relationships also hurt Ruby emotionally. There were difficult relations amongst the parents and domestic abuse, with a significant impact on their ability to provide safe and appropriate care. There were some identified risks, but opportunities for earlier inter-agency input and improved collaboration between agencies were not picked up. So the family's overall well being kept plummeting and ended tragically. Theo's case illustrates how the wellbeing of children relies on fulfilling their needs as well as on timely record of safeguarding, good partnership working and having the welfare of the child at the centre of all professional decisions.

Importance of partnership working and communication

Partnership and good communication skills are crucial to the protection of children and to effectively supporting families (Seekamp *et al.*, 2023).

In Theo's case there were several agencies working with the family these included social workers, health visitors, police officers, team managers, and CAFCASS.

The professionals working with the children had access to different information relating to domestic abuse, parenting issues and children's welfare.

But it was shown how between agencies communication was not always timely, consistent and effective to fully be able to assess what level of risk they faced to Theo and Ruby.

It is essential for professionals to ensure that they share information which is relevant to their work and challenge issues if they feel they need to, while collaborating to build a proactive safeguarding plan. Unfortunately, in Theo's case, there were missed opportunities to be able to offer critical information and to rethink the family's situation. Some concerns were addressed one-by-one instead of at once, which led to lack of collective decisions and poor timely actions. Better integration of professional work would have facilitated a better risk assessment and enabled earlier protective action to be taken.

Regular meetings, up-to-date record keeping, proper professional accountability are part of good communication (Kelvin-Agwu *et al.*, 2024).

There should have been more stringency by team managers in reviewing and challenging decisions if risks remained significant.

Similarly all agencies should have had ongoing communication to enable safeguarding concerns to be reported and acted on quickly. Theo's case raises the issue of that one person's job of protecting is not enough. Children's protection and care is life-saving and requires multi-agency co-ordinated working, whole agency communication, shared responsibility and timely decision making. Working in partnership enhances risk assessments, strengthens child protection capabilities and assures the child's welfare is the top priority for any professional making decisions about the child.

Critical analysis of case study

Owens and Lloyd (2023), stated that safeguarding is dependent on the multi-agency effective working together, timely intervention and early assessment for the health and wellbeing of children, young people and families.

Identify risks, share information in a timely manner and with coordination with a care plan in place based on child's needs.

However, Lloyd *et al.* (2023), opposed that policies including all three of the Children Acts are designed to ensure that agencies work cooperatively, prioritising the welfare of the child and acting swiftly when it is suspected that the child's welfare needs are being neglected.

They are also highly dependent on regular reviewing, challenge from others and effective supervision to ensure that the risks are identified and dealt with effectively.

For Theo, although a number of agencies were involved, including social workers, health visitors, the police, team managers and CAFCASS, principles of safeguarding were not consistently followed. While concerns were identified about issues of domestic abuse and family instability, there was a lack of communication and joint decision-making to develop a picture of all risks. There was an underestimation of the reality of the situation, and opportunities to intervene and challenge the nature of the skills at an earlier point on the continuum were not taken up. Lack of effective information sharing meant agencies were not at their best to act proactively and keep Theo safe from harm. Team Management oversight also lacked the ability to challenge or reinforce the inadequate evaluations prior to key decisions.

Current policy and role of services

Existing safeguarding policies highlight the importance of effective multi-disciplinary working, the timely sharing of information and child-centred decision making as key to protecting children.

Legislation such as the Children Act 1989, Children Act 2004, and Children and early years: working together to safeguard children' (2023) gives all sectors from health care to social care, education to the police, and legal services to a shared responsibility for identifying risks (Gov.uk, 2026).

It also helps in intervening early, and working together to help children to thrive in developing a sense of security and confidence in life.

In Theo's situation multiple agencies were involved but none sufficiently coordinated to meet the level of such directives as per the current safeguarding policy. Each had significant information to offer but there were issues of communication, risk assessment and professional challenge which did not fully maximise the effect of each of their actions. As a result, effort to improve protection and support for early intervention was not taken up. These weaknesses had a negative impact on Theo and Ruby, who continue to suffer domestic abuse, emotional harm and family issues as a result. This case illustrates how effective child safeguarding policies cannot prevent children being harmed unless strong partnership working, accountability, review and action within them are consistent and proactive in relation to the benefit of the child.

Recommendations

The process of multi and inter-disciplinary working needs to be open, transparent, timely and mutually agreed upon with the child best interests in mind.

Multi-agency safeguarding meetings should take place regularly between health and social care agencies to explore risks, tracking progress and coordinating work to address these.

All professionals are to be trained continually to enhance risk identification, awareness of domestic abuse and decision making (Millar *et al.*, 2022).

Organisations should also improve the supervision of management, foster professional challenge, keep a proper record and adopt evidence-based assessments to facilitate timely and adequate interventions.

Appropriate and clear accountability and responsibility for agencies can raise safeguarding outcomes and wellbeing of children and families.

In Theo's case, if social workers, health visitors, police officers, team managers and CAFCASS can work more closely together they should have got a better picture of the family's situation. There would have been more frequent information sharing and joint risk assessments which would have alerted professionals to escalating concerns and acted before it. A more critical approach would have been taken by team managers to question decisions where risks to safeguarding were high. Agencies should have ensured that they had ongoing communications with a coordinated plan of protection, with regular child protection reviews. If there had been earlier support offered in domestic abuse and extra support for their family it is likely that some of the risks Theo and Ruby faced would have been eliminated or reduced.

Conclusion

Conclusively, this analysis has shown that good partnership working, communication and child-centred intervention has been key in effective safeguarding.

Theo's case has analysed serious gaps in multi-agency working, risk assessment and sharing information.

It has shown that good practice, a culturally diverse workforce, an up-to-date policy framework and a consistent approach to their implementation has always been necessary, and is crucial, to protecting children, promoting wellbeing and enhancing outcomes for vulnerable families.

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