



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

BMHP5021

Protecting and Supporting Families in Health and Care

Week 6

Multi and inter-disciplinary responses and partnerships with children, young people, and families

Trawsnewid Addysg; Trawsnewid Bywydau
Transforming Education; Transforming Lives

30/07/2026



www.uwtsd.ac.uk

Week beginning	Topic	Notes
1 8 th June	Introduction to Children Rights and Parenting	
2 15 th June	Factors influencing the experiences of children and families	
3 22 nd June	Safeguarding, assessment of needs and theories of child development	
4 29 th June	History of children Protection in the UK	
5 6 th July	Policy and Legislation related to Child Protection	
6 13 th July	Multi and inter disciplinary responses and partnership with children, young people and families	
7 20 th July	Factors which impact on the multi and inter disciplinary responses and partnership working with families' practice	Submission for the 24 th of July for C1 - reference list
8 27 th July	Impact of emerging digital technologies on the role of practitioner and service user	Assessment Presentations – round the table C1
9 3 rd August	Revision and Assignment Support	
10 10 th August	Assignment Support	C2 – 14th of August

Learning objectives

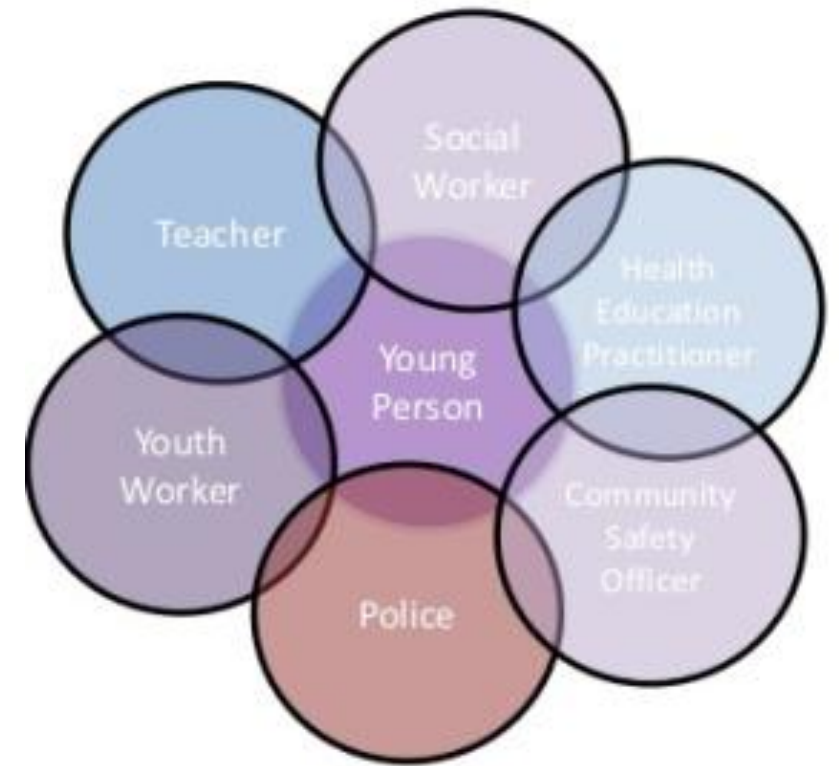
- Define multi-disciplinary work and its significance.
- Identify various disciplines involved in multi-disciplinary work.
- Discuss the benefits and challenges of multi-disciplinary collaboration.
- Apply strategies for effective multi-disciplinary teamwork.

What is multi-agency working?



What is multi-agency working?

Multi-agency partnership working is where practitioners from more than one agency work together jointly, sharing aims, information, tasks, and responsibilities to intervene early to prevent problems arising that may impact children's learning and achievement.



Multi-agency working

- Multi-agency working is key to effective safeguarding and child protection.
- Children and their families will access a range of services throughout a child's life.
- It's vital that practitioners work together to gain a full overview of a child's situation and have a co-ordinated approach to support.

Frontline practitioners

- Everyone who works with children has a responsibility to share any information that has a bearing on a child's welfare as early as possible.
- Practitioners working in adults' services should also share any information that has an impact on the wellbeing of a child - for example information about parents' capacity to provide safe and loving care.

Child Safeguarding Practice Reviews (CSPRs)

CSPRs emphasise the importance of information sharing and collaboration between agencies so that professionals can fully understand any risks a child may be exposed to and take appropriate action to keep them safe.



Victoria Adjo Climbié (2 November 1991 – 25 February 2000)

Key Learning Points for Current Practice:

Professional Curiosity: The inquiry highlighted how professionals accepted explanations without challenge and failed to speak directly with Victoria. Today, this remains crucial - we must maintain healthy scepticism, ask difficult questions, and always seek to understand the child's lived experience.



Information Sharing: Victoria was known to four local authorities, two hospitals, two police child protection teams, and the NSPCC, yet information was not effectively shared. Despite technological advances, recent reviews continue to identify communication breakdowns between agencies. We must prioritise timely and comprehensive information sharing.

The Child's Voice: Victoria was never spoken to alone with an interpreter. Today, this fundamental requirement remains paramount - we must ensure that every child has the opportunity to speak and be heard, with appropriate support for their individual needs.

Key Learning Points for Current Practice:

Record Keeping: Poor documentation featured prominently in Victoria's case. Accurate, timely record-keeping remains essential for effective safeguarding. Your records may be crucial for colleagues making decisions about a child's safety.

Management Oversight: The inquiry identified inadequate supervision and lack of challenge to poor practice. Regular, reflective supervision remains vital for safe practice, and we must create environments where challenge is welcomed and expected.

The recent [Child Safeguarding Practice Review Panel's](#) annual report reminds us that these fundamental issues remain relevant.

Child Safeguarding Practice Review Panel

Date published: 13 March 2025

NSPCC Learning has published a two-part podcast episode about the work of the Child Safeguarding Practice Review Panel.

Discussion points cover:

- the Panel's core roles;
- how learning is shared locally and nationally; and
- the national review into child sexual abuse within the family environment and the Panel's annual report.



Listen to the podcast on NSPCC Learning: [The work of the Child Safeguarding Practice Review Panel](#)

Watch part one on YouTube: [The work of the Child Safeguarding Practice Review Panel – part one](#)

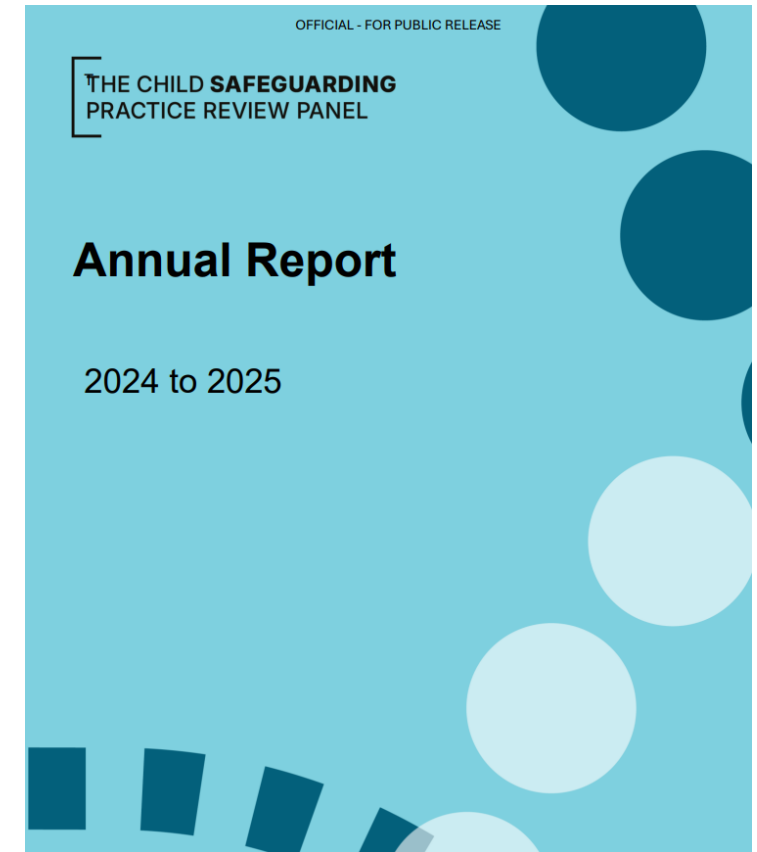
Watch part two on YouTube: [The work of the Child Safeguarding Practice Review Panel – part two](#)

Child Safeguarding Incidents

An overview and analysis of all serious child safeguarding incidents notified to the Panel between **1 April 2024 and 31 March 2025**, bringing together national learning to help strengthen safeguarding practice across England

Key themes

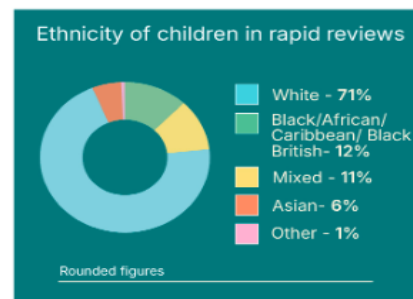
- **Babies under one were most affected**, accounting for 34% of rapid reviews and 60% of deaths
- **Harm rarely arose from a single issue**, with many children living in complex, overlapping circumstances
- **Neglect, domestic abuse, parental mental ill-health and substance use** frequently featured together
- **Strong multi-agency working is critical**, with reviews highlighting ongoing challenges around information sharing, coordination and risk assessment



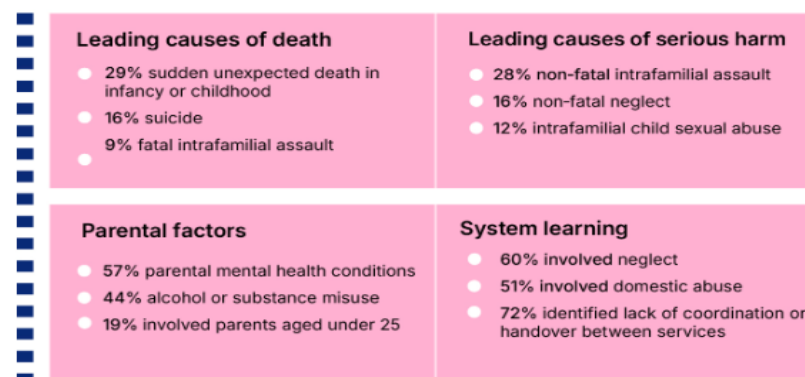
Annual Report 2024/25

At a glance

About the children



What we found this year (from 274 rapid reviews)



Percentages are based on reported incidents. Some incidents involved more than one child, and figures are rounded.

Read the full Annual Report and access learning resources at:
childsafeguarding.independent-panel.uk

Key figures

360+

CHILDREN AFFECTED

274 rapid reviews

Incident type



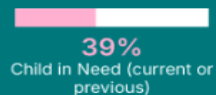
SERIOUS HARM



DEATHS

3% were classed as "other"

Children's social care involvement



THE CHILD SAFEGUARDING
PRACTICE REVIEW PANEL

[Infographic](#)

Examples of multi-agency working?

What is a Multi-Agency Risk Assessment Conference (MARAC)?

- A Marac is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist police, children's social services, health, and other relevant agencies all sit around the same table.
- Together, the meeting writes an action plan for each victim. They work best when everyone involved understands their roles and the right processes to follow.

What is a Multi-agency Risk Assessment Conference?



Here is the link to the online referral form for MARAC

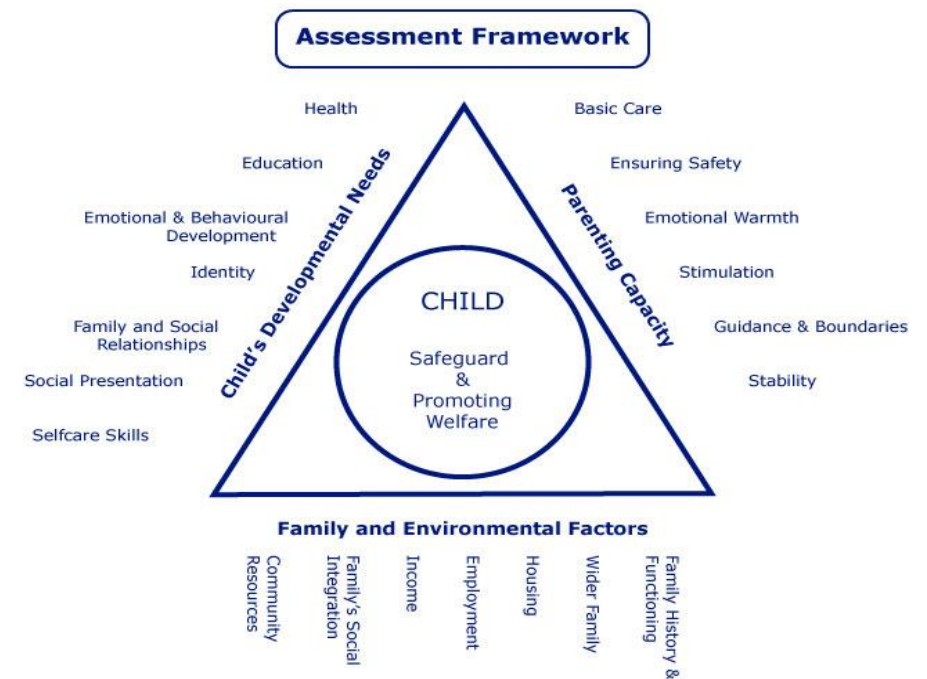
<https://eforms.redbridge.gov.uk/marac-risk-indicator-referral-form/>

Multi-agency Safeguarding Hub

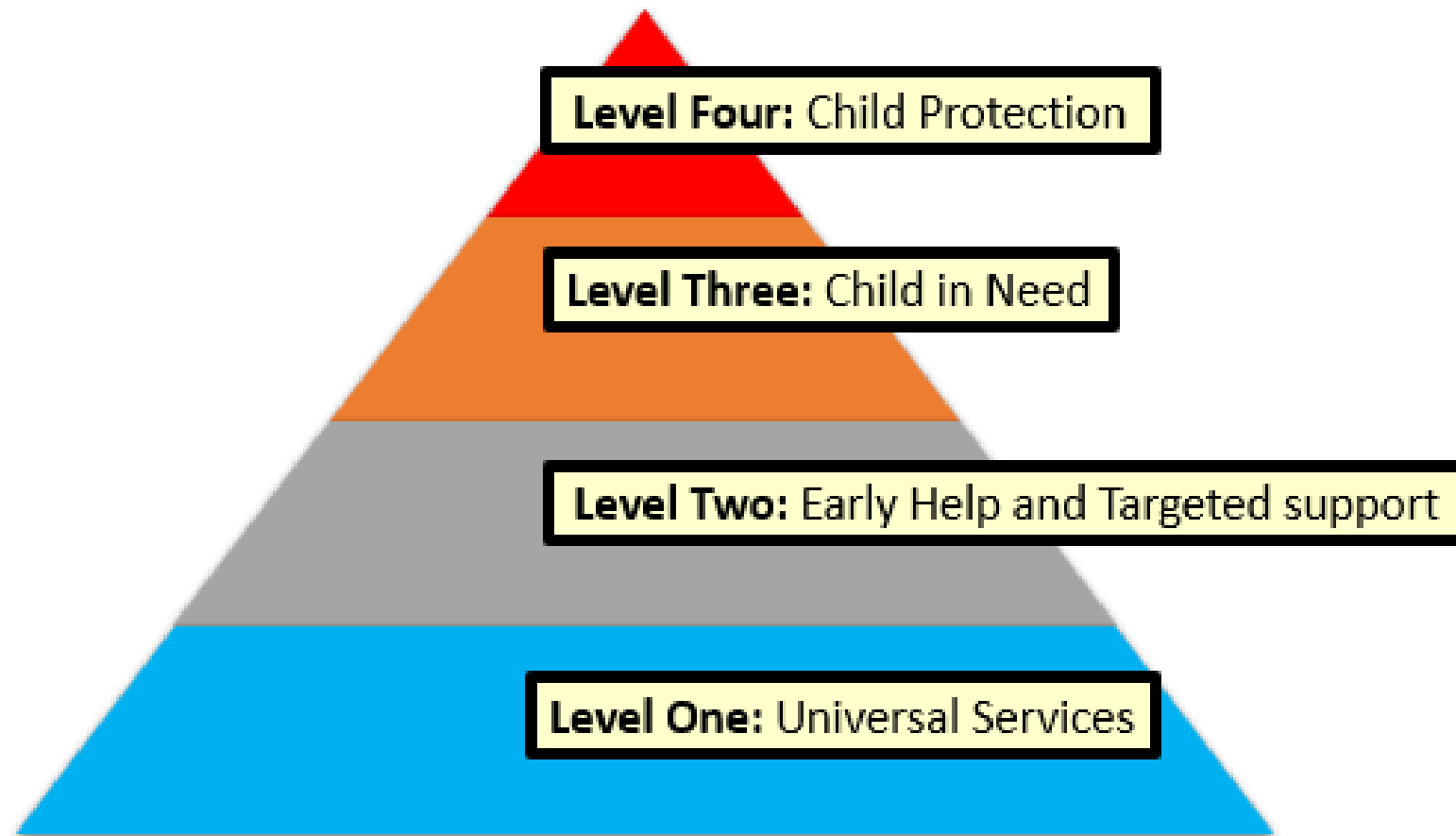


Framework for the Assessment of Children in Need and their Families

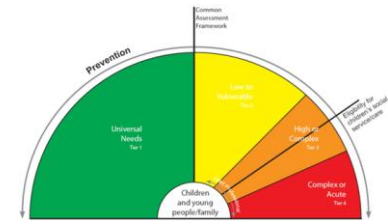
- All children/young people who receive Tier 3 Multi Agency support from Children and Young People's Services should have their plan tailored to meeting their own specific needs.
- All plans should be **SMART** (specific, measurable, achievable, relevant to the assessed needs of the child/young person and time related).



Threshold of Need



The four-tier model of services



Level 1 – Universal services such as schools, health visiting, GP and so on.

Level 2 – Targeted services for children and families beginning to experience – or at risk of – difficulties, for example school counselling, parenting programmes, support for teenage parents and so on.

Level 3 – Specialist services for children and families with multiple needs such as intensive family support, specialist child and adolescent mental health services, and services for children with disabilities.

Level 4 – Specialist services for children and families with severe and complex needs, including child protection services, and inpatient child and adolescent mental health services.

•Source: <https://www.scie.org.uk/publications/introductionto/childrensocialcare/furtherinformation.asp>

Family Help Front Door Family Resource Service

**Parenting
Programme Group
Work**

Freedom Programme

**Family Network
Support Packages**

**Family Help
Partnership
Coordinators**
[External partners only]

**Family Decision
Making and Family
Group Conferencing
Coordinators**

**Benefits and Debt
Officers**

**Specialist Housing
Officers**

**No Recourse to
Public Funds**

Specialist services

- Lower Level 3: As the complexity of a child's needs increases then reference should be made to Threshold Guidance and a **Common Assessment Framework (CAF)** completed.
- Upper Level 3: This level includes those children whose needs cannot be met without the involvement of Children's Social Care (**Children Act 1989**).
- Level 4: This includes children for whom adoption is the plan, those who are in the care system, children subject to Child Protection Plans and those who are in the criminal justice system as well as those with the highest level of complex and additional needs. At this level children's social care will be the lead agency and the threshold is met for statutory involvement of agencies.

•Source: <https://www.scie.org.uk/publications/introductionto/childrensocialcare/furtherinformation.asp>

Every Child Matters

- Whilst the roots of the multi-agency approach go way back to the 1980s, it was the release of the 2003 'Every Child Matters' report that made this way of working to improve children's lives and prevent future harm so popular.
- It is one of the most effective ways of tackling the risk factors that leave children and young people more vulnerable to abuse, neglect and poor outcomes later in life.

What makes multi-agency working effective?



A key worker

The idea is to have a dedicated person who acts as a link between the family and the range of services and agencies that they interact with, who makes the process seem simple and accessible to children and families.

Information sharing

- Information sharing allows workers in a multi-agency team to be aware and have input in the details of a child's care plan.
- Rather than have, for instance, a social worker, a teacher, and a psychologist who separately assess 'need' and match this to services, these actors can be included in each other's work and plan accordingly.

Joint training

Joint or interagency training is connected to bettering relationships among workers in a multi-agency team, preparing them for multiagency working, and enabling them to share the same processes and language.

Co-location

- Co-location often means a place where the multi-agency team works together on a day-to-day basis, although in certain situations it can mean regular face-to-face or virtual meetings.
- This possibility for interaction and shared space promotes 'relationship building, mutual professional understanding and the development of trust'. Co-location facilitates information sharing and developing of shared language and processes, while lessening the potential for power imbalances.

Joint funding/pooled budgets

- Joint funding or pooled budgets were seen to lead to better accountability and better services as agencies and workers share the same funder.
- Agencies working together also felt better supported in their work when they had joint funding.

Parental/carers empowerment

This includes involving the parents/carers and children (when possible) in discussions and planning about their care.



Effective team working

Clarity and accountability:

‘Clarity’ is commonly associated in the literature with successful multi-agency working, and is related to goals, actions, and individual responsibilities (i.e., clarity over ‘who is doing what’, including parents/carers).

Leadership/senior management and local governance

- Leadership and senior management and local governance affect how multi-agency working is set up and governed.
- Strong leadership is also supported by common frameworks throughout local government which are found to be key in ensuring good outcomes, regardless of the local authority the child lives in or the agency/programme they fall under.

Improving communication

- Good communication is central to effective multi-agency working. Put processes in place to make it as easy as possible for frontline practitioners to work together and build trusting relationships.
- **Provide clear pathways for inter-agency communication**
Different organisations have a range of structures so it's helpful to establish clear pathways for communication. Make sure everyone in your organisation is aware of them.
- **Build in flexibility for urgent child protection cases**
For example, when it's necessary to share concerns over the phone rather than making a written referral.

Improving communication

- **Include processes for sharing information at times of change**

For example, when a child returns home from care, comes off a child protection plan or register or makes the transition into adult care services.

- **Establish a clear language around risk and vulnerability factors**

Agencies often use slightly different terminology, and this can be confusing. In extreme circumstances it can result in levels of risk being misunderstood and action not being taken to protect a child. To avoid this, make sure you establish a clear language around risk and vulnerability factors.

Improving communication

- **Ensure child protection training covers the description of the risk**
Make sure child protection training teaches practitioners how to describe risk as well as recognising and responding to it.
- **Use proformas to make information clearer**
Consider using proformas to make the process of information sharing clearer and easier.

What are the benefits of multi-agency working?



Benefits of Multi-Agency Working

- A general benefit of multi-agency working is that it puts less strain on individual practitioners by sharing the workload and the responsibilities involved in protecting vulnerable individuals from abuse.
- This means that everyone can do their jobs better, leading to a more positive working environment and a higher quality of performance at work.

Multi-agency partnerships allow for best practices and experiences to be shared among different organisations, which can lead to improvements in the way that these services work.

This allows for a high standard of services across the board, increasing the quality of support given and consequently improving the lives of more people.

What are the challenges of multi-agency working?



What are the Challenges of Multi-Agency Working?

- Whilst the benefits of working in a multi-agency format outweigh any arguments, there are some challenges associated with this way of working that should be considered as well.
- The first of these is that it is much harder to coordinate a team of people who are all responsible for different tasks and often also answer to different managers. Initially, this can lead to hold-ups and disagreements, which can take some time to smooth over.

Cont.

- The working environments that practitioners come from can also differ quite a lot in a multi-agency approach to safeguarding, such as **healthcare workers** who are used to working seven days a week in comparison to educational staff who work shorter hours and have regular holidays.

Star Hobson Arthur & Labinjo-Hughes



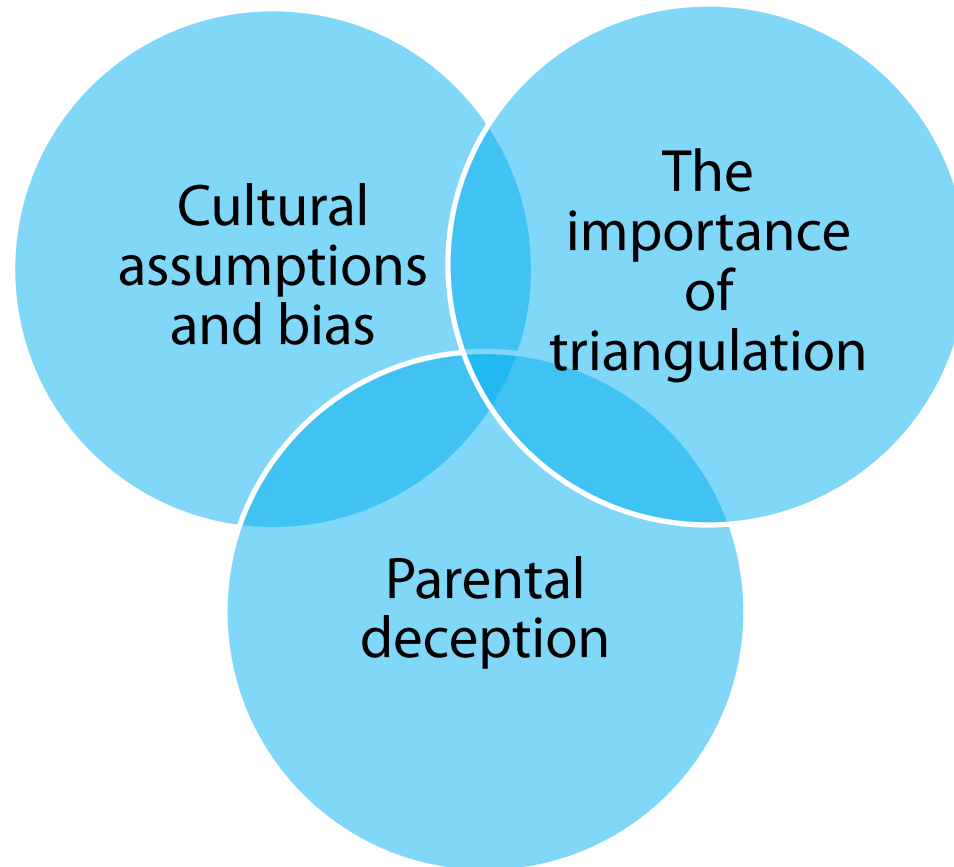
Background

A [review](#) of Child Protection in England, published by the Child Safeguarding Practice Review (CSPR) Panel this year, looks at the circumstances leading up to the murders of Arthur Labinjo-Hughes and Star Hobson in 2020 and explores why the public services and systems designed to protect them were not able to do so.

Different family members, in some cases on multiple occasions, raised concerns with police and social care professionals about the harm that they believed Arthur and Star were suffering. Throughout the review the 'Key Practice Episodes' relate to what is recorded in assessments as '**malicious referrals**' from family and friends, without a full and thorough multi-agency assessment.

'Their framing of the concerns raised by wider family members as 'malicious' was accepted without enough investigation or triangulation with other sources.' 12.29 p92

Questioning 'Malicious' Referrals



Parental deception

The parents/primary carers of Star and Arthur both described the concerns and referrals made by wider family and friends as 'malicious' and this was in part accepted by services assessing the safety and well-being of their children.

Multi-agency professionals identify important behaviour characteristics of parental deception:

- falsification
- omission
- evasion and
- distraction



However different professions working in child safeguarding can identify and respond differently to these features.

Health and social care professionals have reported that they were making a distinction between **benign deception** (where parents were reluctant to be open with professionals for various reasons) and **malicious deception**. Whereas parental deception was perceived by police practitioners as one of the strategies used by parents to hide abuse and subsequently avoid agency intervention.

The inference being that these professionals rationalise parental deception and this may affect how they might respond and what actions they may take.

Cultural assumptions and bias

Ideas about a child's situation and welfare can be heavily informed by intuition, which whilst based on experience, is often influenced by our biases.

Assumptions and biases relating to culture, ethnicity, gender and sexuality affected how practitioners understood Arthur and Star's daily experiences and risks to their safety.

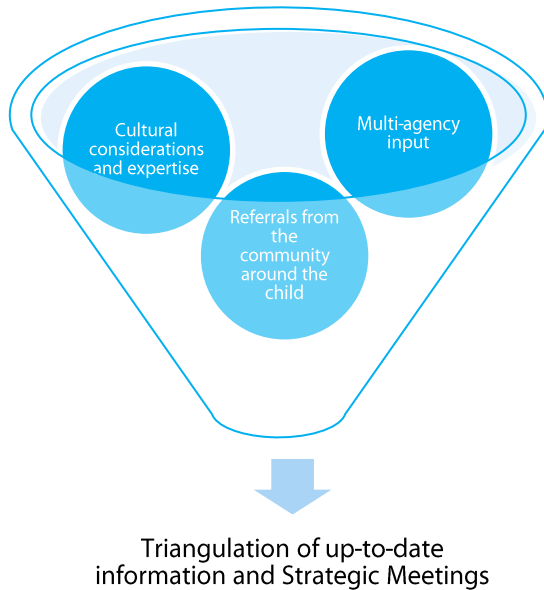
Arthur and Star's stories also highlight the **behavioural biases** that can impact upon information sharing within and between agencies



'The explanation that the referral might have been malicious and rooted in a dislike of Frankie and Savannah's same sex relationship was also too easily accepted'. 7:16 p75

- **Confirmatory bias** can impact judgement and action – it prevents practitioners from working in a child focussed way or effectively assessing the risks that a child faces as they naturally seek to find evidence that supports the fixed view they hold, and other information is avoided, ignored or disregarded.
- **Source bias** is the tendency to interpret information depending on its source not substance, for example, the view in Star's case that family members' referrals were malicious.
- **Diffusion of responsibility** - the tendency for people in groups to fail to act on the assumption that someone else is responsible, an issue identified as a frequent contributor to children's deaths or serious injuries (Brandon *et al.*, 2009). In Solihull, the police did not share photographs of Arthur with the MASH because they knew that children's social care had made a home visit and assumed that issues were 'in hand'.

Triangulation



Research and serious case reviews have highlighted the tendency of professionals to develop fixed ideas about a child's situation (positive or negative) and to stick to this notion, validating information which supports the existing hypotheses and rejecting any information which appears to contradict it.

There were missed opportunities for **Critical thinking and challenge** - within and between agencies and to consider information altogether e.g. Strategy Meetings were not held prior to the home visit to see Arthur and before Star's Child Protection Medical.

'a single agency assessment process – where decisions are being made by individual professionals in relative isolation – was not an appropriate way to fully interrogate and analyse all of the evidence available'

Risk assessments are always informed by multi agency information gathering which includes listening to family and friends.

'Star's wider family members were not listened to. The growing weight of concerned voices speaking on behalf of Star should have prompted professionals to reconsider the escalating risks to her. Framing family concerns as being 'malicious' was inappropriate and distracted professional attention from what might be happening to Star.'

Learning & key points for practice

Robust multi-agency strategy discussions are always being held whenever it is suspected a child may be at risk of suffering significant harm

Referrals should not be described as malicious in professional conclusions, due to the risks associated with this language.



National review into the murders of Arthur Labinjo-Hughes and Star Hobson

Other Findings:

- **Lack of timely and appropriate information sharing** and **limited information seeking**
- **Evidence was not pieced together and considered in the round**
- **Listening to the views of the wider family and those who know the child well** - in Arthur and Star's stories a significant gap was the failure to talk to and listen to wider family members.
- **Appropriate response to domestic abuse** - the impact of domestic abuse on Arthur and Star was not explored in depth; concerns about domestic abuse towards Star's mother were considered episodically and not investigated sufficiently; information about Emma Tustin's history of domestic abuse was not triangulated between agencies.
- **Working with diverse communities** – assumptions and biases relating to culture, ethnicity, gender and sexuality affected how practitioners understood Arthur and Star's daily experiences and risks to their safety.
- **Critical thinking and challenge** - there were missed opportunities for critical thinking and challenge within and between agencies and to consider information altogether

<https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson>

Task

In your group evaluate the effectiveness of multi-agency working and its impact on the child or children involved in your case study.



Reference List

NSPCC (2023) *Multi-agency working*. Available at: <https://learning.nspcc.org.uk/child-protection-system/multi-agency-working-child-protection/> (Accessed: 16 March 2024).

Child Safeguarding Practice Review Panel (2022). *National review into the murders of Arthur Labinjo-Hughes and Star Hobson*. [online] GOV.UK. Available at: <https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson>.