Cumberland Safeguarding Children Partnership

Local Learning Review CB

Cumberland Council

CUMBRIA CONSTABULARY

NHS North East & North Cumbria

What is a Local Learning Review?

A Local Learning Review (LLR) is undertaken when a child or child has suffered abuse or harm, but the circumstances do not meet the full criteria for a Rapid Review or Local Child Safeguarding Practice Review. However, the three safeguarding partners believe there is learning about the way in which local professionals/agencies work together to safeguard children, that could strengthen safeguarding practice locally and improve multi-agency working to better safeguard and promote the welfare of children.

Background

This briefing summarises the findings of a Local Learning Review concerning a young person (referred to as CB) and her family. The review was undertaken following a Rapid Review initiated in London in April 2025, after concerns about abuse were reported.

The purpose of the review was to:

- Understand agency involvement when the family lived in Cumbria (until 2022).
- Identify what worked well and where improvements were needed.
- Inform future safeguarding practice across partner agencies.

This review has provided valuable insight into how services can better protect children. While good practice was evident, there are clear lessons to strengthen how agencies:

- Assess risk.
- Work together.
- Support children to be heard.

Safeguarding partners are committed to acting on this learning to improve outcomes for children and young people.

CB lived in Cumbria with her family before relocating to London. During her time in Cumbria, the family had involvement with police, social care and other services.

In 2020 while living in Cumbria, serious concerns were raised about harm within the family. Safeguarding processes were initiated, including:

- Police protection measures.
- A child protection plan.
- Multi-agency involvement.

CB later disclosed further abuse after the family moved out of the area, which prompted a wider review of earlier interventions.

Learning from the Review

Good Practice

The review identified several examples of good practice:

- When concerns were first identified there was swift protective action with immediate steps being taken to ensure the child's safety when concerns were first raised.
- There was a multi-agency response where agencies worked together quickly to share information and assess risk.
- Concerns relating to family members' wellbeing were appropriately shared during safeguarding processes.

However, the review highlighted important areas for improvement:

Thorough Investigation

- Opportunities were missed to fully explore concerns at the earliest stage.
- Decisions to close investigations were made too quickly, without fully exploring the allegations and subsequent retractions.

Child Protection and Safety Planning

- Safety plans were not always robust or consistently implemented.
- Greater consideration should have been given to limiting contact that could influence or pressure the child, including unsupervised access to electronic devices.

Understanding Risk Within the Family

- Assessments did not sufficiently explore family dynamics, including:
    - The ability of parents to protect.
    - The impact of domestic abuse.
    - Individual family members' roles and behaviours.
    - Engaging with, and assessing the alleged perpetrator.

Listening to the Child

- More time and support should have been given to help the child share their experiences safely.
- Practice highlighted the need for increased confidence and skill when working with children at risk of sexual abuse.

Joined-Up Working

- There was a lack of coordinated decision-making between agencies at key points.
- More consistent multi-agency planning and oversight was needed.

Cultural Awareness

- Insufficient attention was given to understanding the family's cultural context and how this may influence safeguarding.

Use of Child Protection Categories

- The category used did not fully reflect the nature of the risks, which may have reduced clarity in planning and decision-making.

Improvements Since 2020

It needs to be noticed that since the initial concerns in 2020 agencies have already taken steps to strengthen safeguarding practice, including:

- Enhanced training and supervision for professionals.
- Stronger oversight of investigations and decision-making.
- Improved safety planning guidance.
- Greater management oversight of decisions about children returning home.
- Regular multi-agency audits and quality assurance processes.

Taking Learning into practice

The partnership has agreed to a series of actions to further improve practice:

- Provide specialist training to improve confidence in working with child sexual abuse.
- Undertake targeted audits to ensure current practice is robust.
- Strengthen multi-agency collaboration and learning.
- Improve cultural competence across services.
- Ensure effective information sharing, particularly when families move between areas.
- Provide assurance that the category of risk for child protection planning reflects the key risks and concerns.

It is important as a practitioner to take the issues identified into your supervision, team meetings and group supervision.

- How as practitioners can we increase our confidence and competence in working with child sexual abuse?
- Am I using a range of appropriate tools and techniques in my direct work with children to understand their lived experience and to facilitate disclosure?
- Do I fully understand a family's race and culture, and do I ensure I am using an intersectional approach to understand their lived experience?
- How do I ensure that when assessing a family's ability to protect that my assessments are robust, evidence based and focused on the likely risks and harms?

- Am I aware of my unconscious bias when assessing risk and ensure I remain professionally curious in all my work with families?
- Do I ensure timely and effective information sharing particularly where families move between areas, to support continuity of safeguarding.