

Key Learning: Woody

What is a Rapid Review?

A Rapid Review must take place when a child has suffered a serious incident or death, and it is known or suspected that they may have been abused or neglected. The review helps us to identify learning and consider what went well and what needs to be improved. It seeks to understand what this means for practice and how multi-agency systems and practice can help children and keep them safe.

This Rapid Review was held in January 2025 in response to a young boy, who sadly died. The Rapid Review group were in full agreement that all relevant learning has been considered, and a Child Safeguarding Practice Review would not identify any further learning.

Understanding the young person and what happened

Woody was a happy, chatty, young White British boy who lived with his mum and older brothers and sisters, before he sadly died. There was a history of domestic abuse from dad to mum, and dad was reported to not be involved in family life. Mum was understandably struggling to meet the needs of 6 children by herself and there were periods where services were finding it difficult to contact or work with mum. Additional stressors included the family being at risk of eviction and mum struggling with her mental health.

Woody had long standing issues with impaction, where he needed medication to relieve constipation. There were worries about neglect and Woody not receiving the treatment he needed, and advice to take him to hospital wasn't acted on. In the weeks leading up to his death, Woody had not had a bowel movement for 8 weeks. Sadly, Woody died following a heart attack at his home. Woody was 6 years old when he passed away.

Key messages

Understanding and planning for a child's health needs

How we support victims of domestic abuse - impact on mums and children and holding mum's solely responsible for the safety and care of the children

Consider language - how generalisations and labels can lead to unhelpful assumptions about children and families

Strengthening professional curiosity and avoiding jumping to conclusions too quickly

Collaborating and sharing information between agencies and across boundaries

Strengthening child protection and child in need plans

What worked well

Woody's relationship with practitioners Records showed that Woody had a good relationship with practitioners who visited him. He talked openly with them, e.g. telling them he didn't like the taste of his medication. Woody shared that his stomach hurt sometimes. Practitioners often saw him as happy and smiling despite his discomfort.

Tenacity The school nurse was persistent in raising and escalating concerns and making referrals to the continence service for more specialist support for Woody. The school nurse carried out several visits to Woody at home and in school and tried to contact mum to support Woody's dis-impaction plan. This went over and above the usual offer.

Strong partnership working for example, between the school nurse and school, including how to support Woody in school and with his medication. The school nurse and family worker also visited together to try to provide more consistent support to the family.

Group Supervision focused on how to better involve and communicate with dad and how to identify a family network for mum and the children so that mum wasn't being held solely responsible for the plan. This was attended by the social worker, family worker,

the school nurse and supervisors in health. This could have been strengthened by school attending and the information being shared with the GP for discussion in their practice safeguarding meetings.

What did we learn?

Theme 1

Sharing information and professional collaboration

Missing information

Input from some key agencies, such as the GP, housing, Harbour and the Bladder and Bowel service was either missing, or **known but not shared** across all partners

None of the practitioners had a full picture of the situation and Woody's plan did not always reflect his or the family's needs

Not all practitioners involved with the child and family attended **core group meetings**

Opportunities were missed to share information in real time, between meetings

Opportunities to identify gaps in Woody's prescriptions for his medication were missed

Had the Bladder and Bowel nurse been fully aware of the family's history, **more help could have been offered by other practitioners** to support the dis-impaction plan

What does this mean for our practice?

Seeking and sharing information

All services supporting children and families need to **communicate clearly with each other in a timely way**. This includes:

Sharing information in real time with the key practitioners involved so worries can be triangulated, responded to quickly and plans created in partnership

Practitioners having access to key contact details and duty numbers for teams, so that information can be logged if practitioners are unable to speak to the named worker

Important information should not come as a surprise to practitioners, children and families during meetings

Being **clear and concise** about the nature of any worries or concerns:

what has happened

how long the worries have been happening and how often

the impact on the child/young person

how serious the worries are

Theme 2

Professional curiosity

Engagement

The family were seen by practitioners as being 'hard to reach' when there was some evidence that **services were 'hard to reach'** for the family, e.g. difficult to get to on public transport, letters going to the wrong address

Language

The language used reflected **assumptions rather than curiosity**

There were **missed opportunities to ask questions about behaviour** and reasons behind the behaviour rather than using labels such as 'non-compliant'

Multiple perspectives

There were **differences in how practitioners viewed certain situations** compared to what family were sharing, which practitioners could have been more curious about

What does this mean for our practice?

Staying Curious

Engagement

Where there are worries about non-engagement, all practitioners need to be **curious about the reasons for this and any barriers** that could be getting in the way, so these can be overcome.

When practitioners identify an issue with 'engagement', it may be helpful to consider:

'What do I need to do differently to be invited (back) into this family's home?'

'How might I change my approach so that this family would feel able to work with me?'

'What else could I offer this family that they would find most helpful?'

'Would the language I am using make this family want to work with me or would it make them feel judged?'

Theme 3

How practitioners and the family understood Woody's health needs

Not all practitioners understood the complexity of Woody's bowel problems and the possible consequences

Appointments were often weeks or months apart – this did not reinforce the seriousness for practitioners or mum

Woody had **several dis-impaction plans** during his childhood – this **may have normalised the issue**. Woody presented as happy, chatty and active rather than in pain

Since **specialist services were involved**, this would suggest that there **would be some impact from not treating the condition**

What does this mean for our practice?

Understanding complexity and risk

Specialist services should attend multi-agency meetings and ensure other practitioners understand the issue, the impact and seriousness of the risk

It can be helpful for practitioners to ask themselves **'How can I be sure that the information shared with the child/parents/carers has been understood?'**

Practitioners should consider using **words and pictures or social stories to explain health needs to children** in a way that they can best understand. (See Sneaky Poo for ideas that can be adapted - [Beating sneaky poo: Ideas for faecal soiling](#))

Theme 4

How we work with victims of domestic abuse

Mum was seen as the 'protective' parent and **all agencies placed responsibility on her** to keep herself and the children safe

She may not have been able to do this as **she was a victim herself**

The **children were not seen as victims** themselves, and opportunities were missed to link them in with support to help them to recover

What does this mean for our practice?

Seeing mum's and children as victims

All practitioners should **see children and young people as victims** when a parent/carer is being abused (Domestic Abuse Act 2021), listen to them and consider what help and support they need themselves

This could include **referrals to specialist services** such as Harbour and **involving children** in safety planning

To **avoid mother blaming** or placing all responsibility for the care and safety of the children on the victim/survivor, practitioners can:

Consider our language and keep away from victim blaming terms such as 'she made poor choices', 'she didn't prioritise the children'

Explore who else in the **family network** can provide help and support

Link with the specialist Practice Lead for Domestic Abuse for ideas about how to build relationships with those who cause harm

Use **group supervision** to provide a space to reflect and support engagement and planning

Theme 5

The robustness of child protection and child in need plans

There were other **additional needs** (complicating factors) that **were not addressed in the child's plan**, such as education, mam's mental health and housing

This meant **these issues weren't fully reviewed** during multi-agency meetings

Woody's health needs were added to the child protection plan however the action focused only on a referral to a specialist service

Actions could have been more holistic and include a focus on other approaches such as Woody's diet, which was thought to be linked to his constipation

What does this mean for our practice?

Strengthening child protection and child in need plans

All practitioners have a responsibility to input to the child's plan, so that this doesn't become the sole responsibility of the social worker.

Good child protection and child in need plans are clear about:

each issue/behaviour that is a worry

what specific tasks and actions need to happen to reduce the worry

who is responsible for the task/action (specific family members or practitioners)

the timescales for the actions to take place or be reviewed

Where specific needs are identified, such as health needs, then the relevant/expert practitioner in this field should have input to the plan

Holistic plans

Child protection plans focus on keeping children safe. Practitioners still need to pay attention **to wider needs and complicating factors, particularly as the plan changes to child in need**, so that the right support at the right time is in place.

Respectful challenge

All practitioners need to be able to respectfully challenge each other when they feel that the plan is not keeping a child safe and well.

What is the DSCP doing?

The DSCP will include learning from this Rapid Review in the 2025 Development Day

The DSCP will look at how guidance from 'How we Practice in Durham' (Children's Social Care) can be used for all partner agencies to highlight the importance of communicating with each other and co-creating plans

The DSCP will develop a briefing in line with 'How we Practice in Durham' that can be shared across the partnership to ensure a consistent approach

The DSCP will update and circulate the Cumulative Harm Guidance and continue to promote the use of multi-agency chronologies to support practitioners to identify risks and cumulative harm

The DSCP's 'Clarify, Verify and Reflect' briefing is available on the DSCP website to help practitioners stay curious in their approach

The DSCP updated the Information Sharing Agreement Guidance in 2024, and full training is available on the DSCP website

The DSCP will share findings from this review with the Domestic Abuse sub-group (DASVEG)

The DSCP's 'Voice of the child and lived experience' procedure is available to support partners to see the world through the eyes of a child

The DSCP has developed an action plan that covers all multi-agency and single agency actions. This will be monitored and reviewed in the Performance and Learning Group (PLG)

What can you do?

Discuss this key learning briefing in team meetings and supervision

Reflect on the importance of communicating and working with all partners involved with the family, including specialist practitioners.
Share information in real time when issues arise

Attend multi-agency meetings and contribute to plans when you are involved with a child and family

Access training on Domestic Abuse to improve your confidence and knowledge of domestic abuse and how to support victim/survivors

Always listen to and involve children and young people in conversations about their life and check out what they are telling you with others who know them well

Be clear about what has happened and the impact on the child/young person when sharing concerns

Describe what you see or hear (who, what, when, where, why, impact) and ask questions about the reasons behind behaviour rather than using labels or generalising

Use group supervision to provide a space to reflect and plan around a specific issue, for example 'engagement'

Useful links

[A Practitioner's Quick Guide to Cumulative Harm](#)

[Multi-agency Chronology Guidance](#)

[Managing Professional Differences and Mutual Challenge](#)

[Durham Harm/Worry Matrix](#)

[Other Training available for Partners](#). Please use this link to book onto the DSCP's domestic abuse training offer

[DSCP - Clarify, Verify and Reflect](#)

[DSCP Multi-agency Reflective Group Supervision Guidance](#)

[Voice of the Child and Lived Experience Guidance](#)

[Poo Go Home and Sneaky Poo](#) This site provides resources for children to help them understand bowel issues and what helps, in a child friendly way