Learning Together from Case Reviews

How do we use recommendations from case reviews to improve our safeguarding of children & young people?

This short briefing summarises what a Learning Review has shown about the child protection system in Brighton & Hove.

It is important if Brighton & Hove is to become a safer place for children to live for everyone to embrace the learning from the review and take the necessary steps to help put right the issues identified.

Baby Alex – This Learning Review, looks at the circumstances surrounding the injury to a five-month-old child, while in the care of his parents. Prior to his injuries there were no safeguarding concerns about Alex or his sibling. They were not known to children's social care (CSC) or the police. The family was in receipt of enhanced health visiting support, initially due to financial issues and Father's insecure immigration status.

If you work with children and families in Brighton & Hove, there may also be additional specific actions & recommendations for your agency and your role. Please ask your manager, or contact your representative on the LSCB

Key Learning: The review identified four main areas that needed to be considered in relation to Safeguarding Practice in Brighton & Hove.

1. **"Think father/non-primary carer"**
2. **The impact on men of being a father**
3. **Professional persistence**
4. **Information sharing regarding domestic abuse**

History:

Mother came to the UK from Europe in 2012 and Father came from the Caribbean in 2014. Mother spoke good English and it is Father's first language. Mother came to the attention of the police in April 2015 as she was in possession of cannabis. Father was known to the Home Office for immigration matters. In December 2017 he was given limited leave to remain until 2022. There is no other known significant background information regarding either parent.

It was agreed that this review would consider in detail the period from the birth of Alex's sibling in September 2016 until 10 February 2018, when Alex was admitted to hospital with injuries. Relevant information prior to these dates was also considered as required, to allow the identification of any significant agency involvement with the parents. It was considered that there had been three "Key Episodes" and these were broken down as follows:

Support provided to the family | **Hospital admission 05.02.18** | **Night of 10.02.18**

The family were supported via a Universal Plus - Health Visiting Service, after it was identified during the pregnancy with sibling that Mother was stressed. This was largely due to Father's inability to work as his application to live and work in the UK was being considered by the Home Office. There was also a risk that he would be extradited. The related financial concerns and the lack of support from wider family were identified. The midwife and health visitors asked routine enquiry domestic abuse questions of Mother. No issues were disclosed until after Mother became pregnant with Alex.

Housing was a concern, partly due to a move to a bigger property when Mother was expecting Alex, and because the family were not eligible for housing benefit due to Father having no recourse to public funds. (NRPF) These issues were resolved when Father was legally able to work in the UK.

Mother told her midwife that Father was not happy about the pregnancy with Alex and had asked her to have a termination. She also stated that he could be verbally abusive. This information was shared with the health visitor, and Mother later shared her unhappiness in the relationship with a nursery nurse who became involved. The health visitor discussed the concerns with Mother who stated that Father would never physically harm her or Sibling.

The house move had led to the allocation of a new health visitor prior to the birth of Alex. There was a verbal handover which is good practice. Mother told the new health visitor that she was feeling anxious at the prospect of caring for two young children, and she was struggling with Sibling regarding his sleeping and feeding routines. The health visitor also noted a lack of age appropriate socialisation. Additional support was offered by the involvement of a nursery nurse who is part of the health visiting service. Initially Mother refused the support, but agreed to it following the birth of Alex, when she acknowledged that she was struggling to manage. Four home visits were undertaken by the nursery nurse, and her agreed involvement came to an end around three weeks before the hospital admission that led to this review. The health visitor was to remain involved.

Regarding the domestic abuse, the health visitor provided Mother with information on RISE. Mother did not contact them, minimising the relationship problems. Other support was also provided, with the health visitor making a charity application for a buggy to provide Mother with the means to get out more, attend her appointments, and hopefully attend the Children's Centre which was in walking distance of the family home.

The birth of Alex and post-natal contact was unremarkable. Shortly after his birth Father was given the right to work in the UK and found a job.

Following sessions of support from the nursery nurse Mother reported improvements in January 2018 and told the nursery nurse that she had secured a part time job in the evenings, with the plan for Father to work days and care for the children while she worked

Alex had been taken to his GP by Mother on 24 January 2018. He had reportedly been crying all night. This was thought to be due to constipation, and medication was prescribed.

They attended the GP again on 5 February 2018 and Alex was described as generally unwell. The GP was sufficiently concerned to refer Alex to the paediatricians at the hospital Children's Emergency Department (CED), suggesting that he may have gastroenteritis.

Mother took Alex to the hospital the same day. He was examined by an experienced paediatrician, observed, and then discharged.

Very late on 9 February 2018 Mother called 111 requesting an ambulance. She stated that she was on her way home from work and that Father was at home with the children. He had reported to her that Alex was having a seizure.

After midnight Mother tried to cancel the ambulance that was due to be sent. After seeking clinical advice, the operator agreed that the ambulance should still attend.

After some negotiation with Mother on the doorstep, and the attendance of a second ambulance crew, they were given access. They observed that Alex was looking visibly unwell with a bruise above his right eye and a 'hematoma' on the back of his head.

The police were called by the ambulance service as they transported Alex and Mother to the hospital. Officers arrived at the family home around an hour later and then ensured that Sibling was safeguarded.

Observations and a CT scan showed several injuries to Alex, including a subdural hematoma, a skull fracture, a fractured right clavicle, and multiple rib fractures. The injuries were later assessed to be between one week and one month old.

Both children were effectively safeguarded following the discovery of Alex's injuries.

Methodology:

The Chair of the Brighton and Hove Local Safeguarding Children Board (BHLSCB) agreed that the criteria for a Serious Case Review (SCR) was not met in this case. It was decided that this review should be undertaken to consider if learning could be identified about the way that agencies work together to safeguard children in Brighton and Hove.

The SILP methodology was subsequently chosen. This method engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time.

Agency reports are completed to provide the opportunity for consideration and analysis of agency practice and systems and identify the agency's learning from the case. Following this, practitioners, managers and agency safeguarding leads come together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued at the event. The same group then comes together again to study and debate the first draft of the review report. Later drafts are also commented on by all of those involved and they make an invaluable contribution to the learning and conclusions of the review.

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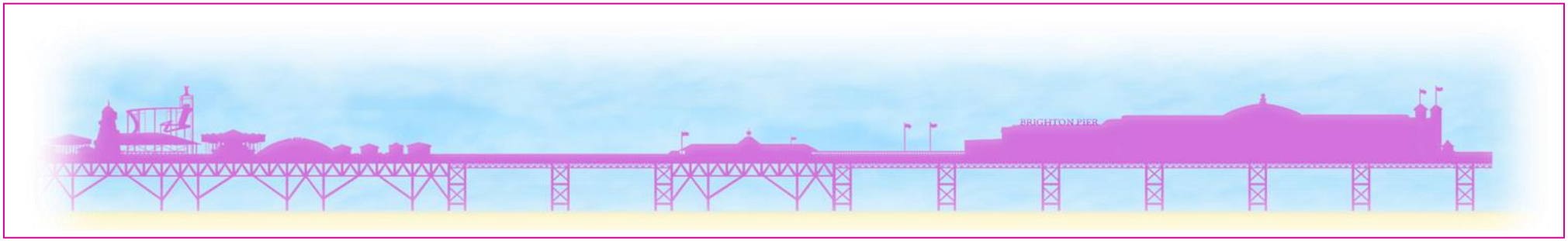
Recommendations

The review recognised that actions have already been taken in relation to some of the individual agencies identified learning, and that changes have been made. Some of the learning identified within this report will have been addressed by the single agency actions plans. For example, the Sussex Community Foundation NHS Trust are considering how they can improve their assessments of fathers following the birth of a child.

A recent SCR undertaken in Brighton and Hove, Child E, found that there may be a pattern of focusing only on the primary (usually female) carer for a child in foster care, and not giving enough attention to the role of the non-primary carer (usually male). All the professionals involved in this case took the view that this was widespread and 'normal' practice and could be explained largely in terms of the working life of the male carer and hence their 'unavailability'. The Board were asked to see if there is a local 'custom and practice' about this issue across the whole safeguarding system. Specifically, whether men are expected to take part in key processes, such as LAC reviews, New Birth Visits, Midwifery Booking appointments.



Learning Point 1: There is a need for the promotion of communication with GPs if there are concerns in a family regarding domestic abuse.

Are there methods of communication in place to allow the appropriate sharing of information about domestic abuse between agencies?

Is there a need to promote multi agency training within agency settings, to enhance knowledge around domestic abuse?

Learning Point 2: When predisposing vulnerabilities are evident, including financial stress due to NRPF, and domestic abuse, these should be considered, and the information shared appropriately.

Do staff have the required knowledge to understand what NRPF (No recourse to public funds) means, and how this can impact on families?

Are agencies discussing concerns about domestic abuse with partners, at an early enough stage of involvement?

Learning Point 3: It is known that domestic abuse is harmful to children emotionally, but they can also be physically harmed.

Are professional partners, appropriately aware of research and learning to understand the potential risks for young children living in households where domestic abuse occurs?

Learning Point 4: Professional persistence is essential to safeguard children.

Are staff within safeguarding partners, confident to challenge colleagues?

Do staff feel they can escalate their concerns, and ask for a professionals meeting to do this?

Learning Point 5: It is good practice to consider the impact of a new baby on fathers or secondary carers as well as mothers. This is particularly the case where concerns have been shared such as about the financial and practical impact of having a baby, or relationship issues. It is understood however that there are limited resources to promote this as standard practice in all cases but telling fathers that how they are feeling is important too is a start.

How can safeguarding agencies learn to interact better with male carers?

Do we need to develop our ability to empathise with fathers who are new to parenting and need their concerns discussed as much as those of their partners?

Learning Point 6: Changing practice to ensure that there is a professional focus on fathers/secondary carers, particularly when they are the alleged perpetrators of domestic abuse, would involve action on three levels as below;

1. Firstly, as a public health issue that considers why males are perpetrators and how to approach the issue.
2. Secondly in early help service provision, to provide services for preventative work with fathers/secondary carers.
3. And thirdly with individual practitioners to ensure that they 'think father/think man' when working with families.

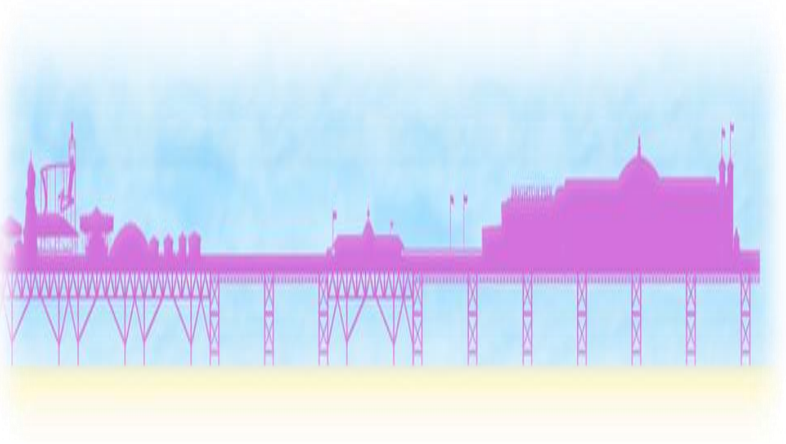
In our professional practice is there a way to capture the details of both primary and secondary carers involvement with the child /young person?

Do we need to make changes to our agency systems to encourage and incapsulate the details and involvement of secondary carers?

Learning Point 7: If a professional is referring a child for an assessment or opinion, it is acceptable to state that they do not know what the specific issue is?

We do not always know all the facts and circumstances relating to a child's condition. Should we still use our professional judgement to refer and seek another opinion?

Are staff confident enough to challenge other professionals, if they feel that different or more action, needs to be taken to safeguard a child or young person?



Staff Training available via the LSCB:

The LSCB would recommend that all staff consider how you may enhance your knowledge and learning by attending any of the available training sessions that are available.
In particular you may wish to consider courses on child neglect and domestic violence. See our upcoming training at brightonandhovelscb.org.uk/events or book on through the Brighton & Hove Learning Gateway

What next: The findings from this Learning Review will feed into the development of the LSCB's Neglect & Domestic Abuse strategies

To be kept up to date on the Board's safeguarding development please sign up to our newsletter

Brighton & Hove LSCB local safeguarding children board

Feedback: As staff and frontline managers you will know about the quality and impact of your own services, and those of the partner agencies you work with. The LSCB Learning & Improvement Framework highlights that it is important to the LSCB to have a constant feedback loop from the frontline to keep senior management and those with governance responsibilities 'reality-based'; not just in terms of what is or is not working, but to assist with ideas for improvement so that changes can be made systematically.

We would like to hear your thoughts, feedback and comments on findings presented to you in this briefing and any feedback on the style of the briefing itself.