Brighton & Hove
Local Safeguarding Children Board

Report of the
Serious Case Review:
Liam

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SCIE Lead Reviewers

Published 21 October 2015

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1 Introduction

1.1 Why this case was chosen to be reviewed

The Brighton & Hove Local Safeguarding Children Board determined to conduct a Serious Case Review (SCR) because the circumstances of this case met the following criteria:

(a) abuse or neglect of a child is known or suspected; and

(b) (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

(Working Together to Safeguard Children, 2013:68)[1]

1.2 Summary of case

1.2.1 This review concerns the services provided to Liam[2] who experienced head injuries, when seven weeks old, whilst in the care of his father. Both Liam's parents were young and prior to Liam's birth, his mother was not supported by any agency apart from core services such as GP. Liam's father had previously been 'looked after' by West Sussex County Council and was a 'care-leaver'[3] . He was known to have abused alcohol and drugs and was considered to have a volatile temper and had a criminal history of petty theft with some violence to peers.

1.2.2 At the time of Liam's birth his parents were living in a privately rented flat in Brighton and both midwifery and health visiting services were involved. His father was the subject of a probation order and he was also receiving support from the West Sussex County Council Care Leaving Service who provided financial assistance in furnishing the flat. The family were also supported by the maternal grandparents who lived in West Sussex. Soon after the birth of Liam the police were called to a domestic abuse incident involving the parents and this information was shared with children's social care who passed the information on to the health visitor.

1.2.3 During the first seven weeks of his life Liam was injured on at least two occasions and experienced fractured ribs, a fractured femur and bilateral skull fractures. Liam's father was found guilty of Section 18 Grievous Bodily Harm with intent and has been sentenced to 12 years and 6 months imprisonment. There were also civil care proceedings which concluded that on balance of probability the father caused the injuries. They also determined that the mother knew enough of the father's aggressive or volatile behaviour to have been able to make a reasonable judgement that he was not a safe, sole carer for her new baby, and hence, she did not act with levels of protection deemed reasonable for a mother.

1.2.4 Liam has recovered from his injuries and is currently living with his maternal grandparents and has regular contact with his mother.

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[1] Working Together 2013 https://www.gov.uk/government/publications/working-together-to-safeguard-children

[2] Liam is not the real name of the child but is a pseudonym given for the report to ensure that appropriate anonymity is maintained.

[3] A care–leaver is any adult who spent time in care as a child (i.e. under the age of 18). This care would have been approved by the state through a court order or on a voluntary basis. It can range from as little as a few months to as long as one's whole childhood (18 years). Such care could be in foster care, residential care or other arrangements outside the immediate or extended family.

1.3 Family composition

Family member	Age at 17th May 2013
Liam	Ten weeks old
Mother	19
Father	19
Maternal Grandmother	40
Paternal Grandmother	unknown
Maternal great grandmother	64

1.4 Timeframe

The review period is from May 2012 to 17th May 2013. This is from the probable date of conception of the child until the date of the Initial Child Protection Conference called because of the head injuries experienced by Liam.

1.5 Organisational learning and improvement

Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

'Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.' (*Working Together* 2013:65) and

'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.' (*Working Together* 2013:66)

Brighton & Hove Local Children Board (LSCB) identified that a review of this case held the potential to shed light on particular areas of practice including addressing the following questions:

- How effective are cross-border working relationships for vulnerable children and children in need?
- How do agencies work together when a child presents with a serious injury and a differential diagnosis is adopted?
- How effective are systems for assessment of young parents where there are vulnerabilities such as having previously been in care?
- How effective are assessments of fathers?

2. Methodology

2.1 Statutory guidance requires reviews to be conducted in such in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings. (2013: 67)

It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process (2013: 66-67)

In order to comply with these requirements the Brighton & Hove LSCB has used the SCIE Learning Together systems model (Fish, Munro & Bairstow 2010). Detail of what this has entailed is contained in the Appendix 1 of this report.

2.2 Reviewing expertise and independence

The review has been led by Fiona Johnson, an independent social work consultant accredited to carry out SCIE reviews with extensive experience in writing SCRs/IMRs under the previous 'Chapter 8' framework; and, Deb Austin, who is a Head of Service, in Children's Services, she has received training in the SCIE methodology and is working towards becoming an accredited reviewer. Both reviewers have had no significant previous direct involvement with the case under review[4].

The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

[4] Deb Austin was managing the Independent Reviewing Officers during the time period of this review and was consulted about changing the date of the Initial Child Protection Conference however her input was not sufficiently significant to prevent her undertaking the role of Lead Reviewer.

2.3 Acronyms used and terminology explained

Statutory guidance requires that SCR reports be written in plain English and in a way that can be easily understood by professionals and the public alike (2013: 70) Writing for multiple audiences is always challenging. Throughout the report footnotes are provided to explain relevant aspects of professional practice. In the Appendix 2 we provide a section on terminology which aims to support readers who are not familiar with the processes and language of the safeguarding and child protection work. Brighton & Hove LSCB and SCIE are both keen to improve the accessibility of SCR reports and welcome feedback and suggestions for how this might be improved.

2.4 Methodological comment and limitations

2.4.1 This review was undertaken using the SCIE methodology. It involved two LSCBs and staff from two children's social care departments, two GP practices, two midwifery teams as well as health visiting, police and probation staff. For more information regarding the methodology see appendix 1. This review was commissioned by Brighton & Hove LSCB given this was the area in which the injuries to Liam occurred. Due to cross border linkages and issues the West Sussex LSCB provided a representative to be part of the review team and facilitated front line professionals fully participating in the case group. The review has focussed on safeguarding systems within Brighton & Hove but has included findings about West Sussex systems where appropriate.

2.4.2 **Participation of professionals**

The lead reviewers and the review team have been impressed throughout by the professionalism, knowledge and experience that the case group (the professionals involved with the family, from all agencies) have contributed to the review; and their capacity to reflect on their own work so openly and thoughtfully in the review process. This has given the review team a deeper and richer understanding of what happened with this family and within the safeguarding network and why, and has allowed us to capture the learning that is presented in this report. The main limitation in terms of professional involvement in the review was that, at the time the review was completed, the hospital paediatrician was not able to contribute to the review because she was a witness in the criminal trial and the police felt her involvement in the review could prejudice the outcome of the trial. This may have limited the review team's understanding of her actions and any contributory factors influencing her practice however where possible attempts were made to get information from other sources. After the trial was over contact was made with her but she did not feel that she had anything further to add to the review report.

2.4.3 **Perspectives of the parents**

The lead reviewers wished to involve the family in the review process but as the father was the subject of a criminal investigation and the mother and maternal grandmother were possible witnesses in the criminal proceedings, the police advised against their involvement. This was a severe limitation on the review as they were the only people who could inform the review team about what happened to Liam during the first seven weeks of his life. After the criminal proceedings ended the lead reviewers approached the family again and, whilst the mother did not wish to meet with the lead reviewers, there were two very productive separate meetings with the maternal grandmother and the father which are summarised below.

2.4.4 The maternal grandmother was concerned that information held by West Sussex Care Leaving Service was not shared with professionals in Brighton and was keen to understand why this did not happen. This issue is considered in Finding 1. The

maternal grandmother confirmed that she knew that father had been a looked after child and that she knew he had used cannabis but understood that he was getting help from the GP in managing his drug-use. With hindsight maternal grandmother also identified that there had been a number of occasions when there was evidence of domestic abuse between the couple. She was clear however that at the time the parents gave adequate explanations and that she thought that they were just normal arguments between two young people. She said that if she had definite concerns she would have contacted agencies and knew how to do this. Finally maternal grandmother was concerned about the initial decision by social workers that she should supervise the contact between Liam and his father in their flat. Maternal grandmother considered that this placed too great a pressure on her and was not a reasonable expectation of family members in these circumstances. The lead reviewers concurred with this view and it was agreed that this learning would be shared within the social work service. This has been done.

2.4.5 The meeting with the father took place whilst he was in prison awaiting sentencing. Father continued to deny responsibility for the injuries to Liam but did acknowledge that his relationship with Liam's mother had been stormy and that caring for Liam had presented a challenge for both of them. The father also acknowledged that he had a significant drug problem prior to the birth of Liam and described using up to £50 worth of cannabis daily but said that he had reduced his use after Liam's birth. The father was surprised that there had not been an assessment of his capacity to parent Liam, given his previous history as a looked after child. He said that the only support he received from the Leaving Care Service during the review period was financial, and that there was no check made on how he had spent the money. Professional practice around support for care leavers is discussed in Findings 1 and 6. The father also said whilst he would have struggled to co-operate with an assessment process, he had been motivated to change as he wished to be a good parent. The father reported that he had good support from his probation officer and from the midwife involved after the birth of Liam however he did not consider that there was sufficient oversight of his capacity to be a good parent given his early childhood history. Despite this criticism of the services provided with regard to Liam he considered that generally social workers had acted in his interests and said that '…without the social I would have been completely f….ed'.

2.5 Structure of the report

Section 1 of the report provides background information and Section 2 describes the methodology used to undertake the review. Section 3 is an overview of 'what' happened in this case and 'why' - providing an appraisal of professional practice and including the review team's judgements about the timeliness and effectiveness of interventions. This leads on to Section 4 which is a presentation of the priority findings about what needs to happen in the multi-agency safeguarding system to reduce the risks of recurrence. Each finding concludes with some key questions for LSCB member agencies. It is the responsibility of the LSCB to decide how best to respond to the findings, with the aim of reducing the recurrence of poor practice. The questions are intended to support their considerations. Appendix 1 provides more detail about the methodology used in the review, Appendix 2 is a glossary of terms and abbreviations used in the report and Appendix 3 is a bibliography.

3. Professional practice appraisal

3.1. This section provides an overview of 'what' happened in this case and 'why'. The purpose of this section is to provide an appraisal of the practice that is specific to the case and it therefore includes the review team's judgements about the timeliness and effectiveness of practice including where practice was below expected standards. Such judgments are made in the light of what was known and was knowable at that point in time. For some aspects of the case the explanation for 'why' will be further examined in the findings in section 4 and a cross reference will be provided.

3.2. The time period for the review is from when professionals first became aware of the mother's pregnancy with Liam until the first conference when professionals agreed that a child protection plan was needed in order to ensure that he was safeguarded. Prior to the pregnancy there was no recent professional involvement with the mother apart from core services such as GP and school. The father was a care-leaver, and was being supported by a social worker from the West Sussex Older Looked After Children (OLAC) team, and was also known to the police and youth offending service as well as the GP and school.

3.3. This review has been undertaken because of the serious injuries experienced by Liam during the first seven weeks of his life. Although he survived and is now well, these injuries were life-threatening and he could have died. The vulnerable nature of small babies is well known and is a feature of many serious case reviews. It is therefore essential that all agencies working with parents consider what is known about their personal history and whether it includes anything relevant for their future care of children. Liam's parents were young and whilst little was known about the mother, there was information about the father which indicated that he could pose a risk to children. The father's childhood history was one of a poor attachment with his mother, with significant direct experience of domestic abuse and parental substance misuse. He had also been violent to peers and had misused alcohol and drugs. All of these factors present a significant risk indicator for him as a parent and were known to the OLAC team. This information was not shared with the key child care professionals responsible for Liam, meaning that the family were not offered any additional supports as parents and the potential risks to Liam were not assessed. This was not best practice. This issue is discussed in **finding 1**.

3.4. The GP was the first professional to be aware of the pregnancy as the mother attended the surgery in West Sussex within the first six weeks of the pregnancy. The GP sent a referral letter to the local midwifery service and provided the mother with a letter of support for her to make an application for re-housing and another for the Job Centre, explaining that she was unable to work because of vomiting as a result of her pregnancy. All of these actions were in accordance with accepted practice.

3.5. The mother and father attended their first midwifery booking appointment in Brighton & Hove when she was 17 weeks pregnant. The mother had decided she wished to have her baby outside the local area and therefore needed to complete her booking in Brighton & Hove. For reasons that are unknown there was a delay in the mother being booked into Brighton. This meant that her initial booking was late and the midwife was not provided with the referral letter from the GP and so did not have her past medical history. Despite these difficulties, the midwife undertook a comprehensive assessment of the mother's ante-natal needs and arranged for her scan and blood tests. The midwife also completed a full social history with the mother but, despite father being present at the appointment, did not ask him about

his background. This was because the focus of the interview was on the mother's medical ante-natal needs as is standard. The issue of how much information should be gathered about fathers during the ante-natal period is discussed further in **finding 2**. During the next six months the mother attended ante-natal appointments regularly, initially in West Sussex, and later in Brighton & Hove after the couple moved to live there. There was nothing remarkable about mother's ante-natal needs or the care that was provided during this time.

3.6. When the mother was four months pregnant the police were called to an address in West Sussex because they had a report from a neighbour that two people were arguing. The police attended and found the mother and father caring for the mother's cousin who was four years old. The police spoke to the mother and father separately and then completed a DASH risk assessment[5] and graded the risk as being standard (the lowest grading). A police report was completed which identified that, although the mother and father had been arguing in the presence of the child, he seemed to be well cared-for and was playing happily. This report was sent to the Police Child Protection Team (CPT) in West Sussex and forwarded to the local Children's Social Care (CSC) office who noted the information. The review team deemed that this was acceptable practice given the level and nature of the risk.

3.7. Soon after this, the father's mother (PGM) contacted his social worker and advised her that the father and the mother were living with her, that the father had re-offended and that the mother was pregnant. PGM told the social worker that the couple have been stealing from her and that their relationship was stormy. The social worker was due to move to a new job and was very busy. She considered that the father did not present a risk to women or children as his previous violence had been peer-related. It was reported that there was a strong ethos within the team that there should not be an assumption that care–leavers would be poor parents and that therefore there was not a need to be proactive in sharing information about their past. With hindsight the worker also felt that the father was hostile and therefore unlikely to engage positively with support systems available for young parents. This approach did not address whether father might need additional support to be a parent given his childhood history and also did not consider the possible risks to the unborn child. The issue of why workers had such a particular view of their responsibilities for safeguarding unborn babies is discussed further in **finding 1**.

3.8. As there was a gap before her post could be filled, some of the social worker's case-load, including the father, was to be held unallocated on duty, with urgent work being undertaken by a duty social worker. The social worker completed a case summary which detailed that father's partner was pregnant, that he was reported to be verbally abusive to her and his mother and that he could have volatile mood swings. This summary was recorded within the case records on the electronic system meaning that it was not easily accessible to either the manager of the service or the duty social workers. There are also other records (paper and electronic) which the social worker did not incorporate into the main records and which could not therefore be easily accessed. This was in part because the team was in the process of moving from one IT system to another and there was a reported lack of guidance about what records could/should be copied – this has now been resolved and there are clear protocols. The review team considered that the difficulties in accessing key information quickly and easily affected practice within the OLAC Team and this is discussed further in **finding 4.**

[5] Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment, this is a risk assessment tool consisting of a number of questions which the officers ask the victim. The answers given are used to make an informed professional judgement on the level of risk posed to the victim.

3.9. There was a lack of robust management oversight of cases that were held in the duty system and individual tasks were undertaken by different social workers on a daily basis. When the mother was six months pregnant a duty social worker contacted the father in order to complete the review of his Pathway Plan.[6] Usual practice would be that a pathway plan review would be completed with a young person and would include a discussion of all aspects of their life and consultation with those people involved in supporting a young person. In this case the review was completed over the telephone with no consultation with any other agency. The social worker did not read the father's history and accepted fathers' self-report that he was more settled and was looking forward to becoming a father in the new year. The social worker reported that he did not feel any responsibility for the work with father as it was 'an unallocated case' and considered that the requirement was that he completed the review in order to meet timescales. This was a missed opportunity for the significance of father's history to his forthcoming parent role to surface and be addressed by professionals. How work is managed and undertaken on duty is considered further in **finding 3**.

3.10. During this contact with the duty worker, father requested money from his Leaving Care Grant (LCG) as he was moving into a new home. The duty worker subsequently visited father in his new flat in Brighton & Hove and gave him £350 from his LCG. The duty worker did not talk to father about what he intended to buy with the money and there were no checks made as to how he in fact spent it. This was not best practice. The social worker noted that the flat was very sparse with little furniture but did not discuss with mother or father their plans for the arrival of the baby. After completing the pathway plan review, the social worker updated the team manager but despite being advised of the pregnancy, the team manager did not review the decision to hold the case on duty. At no point was there a discussion about father's capacity to parent and none of the workers in the OLAC team considered whether there was a need for a pre-birth assessment of father's abilities as a parent given his history. This was not best practice. Consideration of the culture operating within the team and how aware workers were about their responsibilities regarding safeguarding is discussed in **finding 1**.

3.11. In early January the father was sentenced for an offence of burglary to an 18-month Community Order with a supervision requirement (for 18 months) and mandatory attendance at a Thinking Skills Programme.[7] The Offender Manager met the father within one week and he told her that his partner was pregnant and that he was a care-leaver and had a social worker in West Sussex. The Offender Manager started a risk assessment and as part of this contacted the West Sussex OLAC Team for background information, which was good practice. A different OLAC duty worker confirmed that they knew the father and were aware of his partner's pregnancy. The OLAC duty worker said that they had no particular concerns and did not disclose the father's previous substance misuse or past violence. This is in part because the Offender Manager did not ask about these issues but also reflects a lack of awareness by the West Sussex OLAC team of their responsibility for safeguarding that has been reflected in earlier paragraphs and is discussed in **finding 1**. Soon

[6] The Children (Leaving Care) Act 2000 requires that a Pathway Plan is developed for all care –leavers. The Pathway Plan fulfils the requirements both for assessing the young person's needs and planning services and must be reviewed every six months.

[7] TSP (Thinking Skills Programme) is a general offending behaviour programme designed to strengthen and develop thinking skills that have been linked to the risk of offending. It is an accredited programme that applies cognitive behavioural techniques to address poor problem solving, poor perspective taking, inadequate emotional management and impulsive decision making.

after this the father met with a facilitator for the Thinking Skills Programme and she agreed, in consultation with the Offender Manager, that he could defer starting the Thinking Skills Programme until after the birth of the baby.

3.12. In early February the father was arrested for shoplifting and told the Offender Manager that he was stealing to raise money to buy things for the baby. The Offender Manager reassessed the father and he appeared in court and received an additional concurrent sentence. The Offender Manager considered that the father showed appropriate remorse about this offence and did not identify any safeguarding risks to the unborn child that were sufficiently significant to warrant any action. The Offender Manager did not identify that the father might need further assistance from other agencies in preparing for the baby. The Offender Manager did not discuss the matter in supervision as her caseload was about sixty and the reflective supervision model that was being used required that the worker identify the most risky cases for discussion. The father was a significantly lower risk than most other cases on her caseload. The Offender Manager should have completed an Initial Service Plan (including the risk assessment) by mid-February but this was not fully completed until May. This was because of her heavy workload and competing work pressures. There was no management oversight of this process as Probation Service management systems do not include an alert system for overdue work; this is discussed further in **finding 5**.

3.13 In mid-February the father contacted the OLAC Team and spoke with the duty social worker who completed his pathway plan review and who had provided him with LCG monies previously. Father asked for further money from his LCG in order to buy equipment for the baby. He was told that the LCG could not be used for this but when five days later he asked for money for a washing machine and bed slats this was given to him following consultation with the manager and was recorded as being money given to buy items for the baby. The manager did not consider whether this was appropriate use of the LCG which is a limited one-off budget intended to enable care-leavers to prepare for living independently. There was also no check made on what the money was spent on and no thought given to whether there could be other ways in which the father could be assisted to prepare for the baby, as would have been expected. The review team was concerned that the OLAC team did not give consideration as to whether there was adequate preparation for the baby. This lack of focus on potential safeguarding issues is dealt with in **finding 1.** The OLAC team's commitment to enabling young people to have independence in choosing how to spend their LCG meant that there was inadequate scrutiny over expenditure of money and insufficient guidance was provided to the care-leaver about how to manage a very limited resource. This is considered further in **finding 6.**

3.14. Liam was born in March, the father was present at the birth and both maternal and paternal grandmothers visited the family at the hospital. The birth was unremarkable apart from the mother being found to be severely anaemic which meant that she was extremely tired in the weeks following the birth. A specialist teenage pregnancy midwife provided the post-natal care to the mother and Liam and the family were visited four times during the two weeks after Liam's birth. The Offender Manager met with the father at this time and he told her he was tired helping care for the baby. The health visitor also made her first visit at this time and started the Initial Child Assessment. At this stage no professional identified any issues about the family's presentation as there was nothing of concern evident. The level of contact by all professionals at this time was of a high level and there was a good overlap of contact by midwifery and health-visiting. Soon after this the father started on the Thinking Skills Programme where he presented as a calm, softly spoken man who

was excited about becoming a father. The father attended meetings twice weekly and contributed very well to the group work discussions.

3.15. The day after the health visitor visited, a Friday, there was a verbal argument between the parents and a neighbour called the police. The police visited the parents who told them that they had been arguing in front of Liam because they were tired and stressed following his birth. The attending police officer noted that Liam seemed to be clean and well-cared for. The police graded the DASH incident risk as being standard (the lowest grading) and a report (MOGP1) was sent through to the Advice Contact & Assessment Service (ACAS) duty service in Brighton & Hove. This action met required standards. A duty social worker reviewed this form on the Monday and contacted the health visitor and provided her with the detail on the form and asked her to monitor the situation. The GP and midwife were not contacted. In accordance with local protocols that only allowed information to be shared with health visitors and school nurses, without parental consent. The health visitor told the Brighton & Hove duty social worker that the father was a care-leaver with a social worker in West Sussex and noted that ACAS would be taking no further action. The duty social worker was not aware of the previous domestic abuse incident as the police record system at that point was partial and did not cross-reference police child protection reports where they took place in different geographical areas. Since then a new system has enabled information from different areas to be cross-referenced and the links identified. On balance, the review team considered the duty social worker's actions were sufficient, given that the domestic abuse incident was a verbal argument between new young parents; however, it was thought that best practice would have involved contacting the GP and midwife in order to gather fuller information. The issue of information sharing between agencies at the point of contact with CSC has since been addressed by the development of a Multi-Agency Safeguarding Hub within Brighton & Hove. For this reason this issue is not included as a finding but is addressed later in the report under the heading Additional Learning from the Review.

3.16. The health visitor was intending to visit the family again within nine days and did not change that plan despite the information about the domestic abuse incident. Knowing that the social worker was not taking any further action an earlier visit would have been more appropriate. The next day the health visitor met the midwife by chance when they were both present at a children's centre and shared the information regarding the domestic abuse incident. The midwife visited the same day and discussed this with the parents, who reported that it was a one-off incident resulting from being tired because of night feeds for the baby. This was good practice by the midwife. Unfortunately neither the midwife nor the health visitor recorded either their conversation or the visit. The midwife was also unaware that the father was a care leaver and that ACAS were not taking any further action. The reasons for the lack of recording by the health visitor and midwife are because their conversation was informal and resulted from their co-location, this issue is discussed further in **finding 7.**

3.17. The health visitor then visited as planned and completed the Initial Child Assessment. Both parents were at home and were welcoming and co-operative. The health visitor noted that the glass in the door to the property was broken and she asked the parents if this was caused during the domestic abuse incident. This was denied by the parents who said a workman put a ladder through it. The parents acknowledged that they had been shouting but that there had been no physical violence and they both agreed that arguing in front of Liam was harmful to him. The health visitor spoke to the mother alone and asked her whether the father was

violent to her which she denied. The health visitor provided mother with a card that included details of support services for victims of domestic abuse. The health visitor then gave the parents an appointment for a fortnight later for Liam to be seen at the clinic for his six-week health visiting check. The actions by the health visitor were in accordance with best practice regarding working with victims of domestic abuse. It is now known, however, that the broken glass was caused during a domestic incident and that the mother had been the victim of sustained domestic abuse prior to that date. A significant challenge for all agencies is enabling victims of domestic abuse to trust professionals sufficiently so as to be honest with them about their experiences.

3.18. The Offender Manager visited the family two days later and saw both parents. She observed that the parents interacted well together and that the flat was clean and well-furnished with lots of toys; she felt the parents were coping well. This visit was not a requirement of the father's Community Order as he was not high risk but the Offender Manager was aware that the father was a young parent and wanted to see how he was coping. The review team considered that this was therefore good practice.

3.19. A fortnight later the father cancelled the planned health visitor clinic appointment saying that they had to unexpectedly visit mother's family. The health visitor then made an unplanned visit four days later and weighed and measured Liam. This was good practice. The health visitor did not record anything unusual about this visit and has no recollection that Liam was unsettled or was possibly teething. Later that day the parents took Liam to the GP and told him that the health visitor had recommended they take the baby to the GP because he was possibly teething. Liam was seen at an emergency appointment at the end of the evening surgery. The GP examined Liam for signs of an infection and checked his ears and chest but did not undertake a full physical examination as he was aware that Liam was due to have his six-week medical check, which would have involved a full physical examination, at the surgery the next day. This was an acceptable decision. The GP did not identify any evidence of infection and advised the parents to give Liam some Paracetamol. The GP did not note anything in the parents' presentation that caused him concern. The next day the parents did not bring Liam in for his six-week check and the surgery sent them a replacement appointment the following week.

3.20 Six days later, on a Sunday morning, Liam was brought to the hospital by his parents with injuries to his head and bruising to the left side of his face and left ear. The parents told the health professionals that the injuries occurred whilst the mother was out with the maternal grandmother and Liam was in the sole care of his father. The father told the nurse that Liam had fallen off his lap and hit his head on a table whilst falling to the floor. The duty paediatrician identified that there were a number of causes for the injuries and established a differential diagnosis[8] that included possible non-accidental injury (NAI). A nurse undertook a 'Carefirst check' to see if Liam was known, by contacting the Emergency Duty Service (EDS) and was told about the previous domestic abuse incident. The nurse did not provide the EDS worker with any information about Liam's injuries at this point. A CT scan was done which confirmed bilateral skull fractures and a bleed to the brain. The hospital staff treated Liam for the head injuries and he was admitted as an inpatient to the hospital. Later that evening, at 9pm, the nurse contacted EDS again and, in accordance with local safeguarding procedures, told them that Liam's injuries might be non-accidental. EDS staff noted the information but did not contact the police as they considered that Liam was safe in hospital. It is known that responsibilities for

[8] Differential diagnosis is the process of weighing up the probability of one cause versus that of other causes possibly accounting for a patient's illness/injuries

contacting the police when possible non-accidental injuries are identified out of hours are confusing as this matter has been identified in a previous review and this matter is considered further in **finding 8**.

3.21. The next day the hospital social work practice manager received the EDS referral regarding Liam's skull fracture. She immediately telephoned the police and a strategy meeting[9] was held that agreed a joint investigation[10]. A hospital social worker and CPT police officer visited the flat and saw bags of shopping dropped by the mother and grandmother which seemed to confirm their story that when they saw the injuries to Liam on their return to the flat, they took him to the hospital immediately. Later that day the paediatrician met with the father and he changed his explanation for the injuries saying that he had fallen asleep with Liam lying on his stomach and that when he awoke Liam was lying on the floor crying. The paediatrician considered that this explanation could match the injuries, unlike the father's earlier story, but still pursued a differential diagnosis that included non-accidental injury (NAI). The next day a skeletal survey of Liam was completed and a possible abnormality to his right fibula was noted. There was a need for a further skeletal survey to be completed two weeks later before the full extent of the injuries to Liam could be confirmed (some fractures will not be identifiable at this stage).

3.22. Liam responded well to treatment and was fit for discharge within four days. On the Thursday, the practice manager agreed an initial care plan with the family whereby the mother would care for Liam at the maternal grandmother's home; this is detailed in a written agreement with the parents and maternal grandmother. The practice manager visited Liam at the maternal grandparents' home the next day and considered that the family were coping well. Initially contact with father was supervised by maternal grandmother but this was quickly re-arranged to a contact centre as the maternal grandmother was not comfortable with the responsibility. The contact supervisor reported to the social worker that Liam was not comfortable in the care of his father but that he responded well to his mother and maternal grandparents. The decision to place Liam in the care of his mother at the maternal grandparents was correct as it enabled continuity of care for a small baby and there was limited evidence that the mother posed any risk to the child. All explanations of the injury to Liam pointed to the father as the possible perpetrator as he had acknowledged that Liam was in his sole care when the injuries occurred.

3.23. Two weeks later Liam had further scheduled x-rays which showed multiple rib fractures probably caused at an earlier date than the skull fractures. This information was shared with the practice manager at 5pm when Liam had already returned with the mother to maternal grandmother's home. The practice manager immediately contacted the police and it was agreed that no action would be taken that night but that a strategy meeting would be held the following day. The strategy meeting was held and it was noted that the additional injuries meant that a number of people, including mother and maternal grandmother, could have caused them. The paediatrician provided a report to the strategy meeting outlining the differential diagnosis but saying that the injuries were probably caused non-accidentally. After some discussion the police requested an updated written medical report which clearly detailed the injuries could not have been caused accidentally. Furthermore the police indicated that they would not arrest the parents before this report was

[9] A strategy meeting is a multiagency meeting held under child protection procedures that agrees whether a child protection investigation under S.47 of the Children Act 1989 is required. The strategy meeting is a forum for sharing information and agreeing actions.

[10] A joint investigation is a formal child protection investigation undertaken by police and children's social care where there is concern that a child is at risk of or has been subject to significant harm.

received and asked that no-one spoke to the parents about the medical report until after their arrest in order to maintain the integrity of the police investigation. It was agreed by the ACAS Team Manager that the parents would not be arrested until the police had received an amended report and that in the meantime Liam would remain in the mother's care at the maternal grandparents. In the event this report was not received until the following day and the parents were then arrested. At this stage it was negotiated with the maternal grandmother that her mother would live with them enabling Liam to remain in the care of his maternal grandmother but supervised by someone who could not have caused the injuries. The police representative on the Review Team was clear that the police should have progressed their criminal investigation on the basis of the report received at the strategy discussion and did not need to wait for an updated report. Social work representatives on the panel also felt that the chair of the Strategy Discussion should have challenged the police and been more assertive in requiring that they be enabled to take action to safeguard Liam immediately. The review team were concerned that Liam remained in the care of mother and maternal grandmother for a significant period after the possibility that they were perpetrators was identified and this issue is considered in **finding 9**.

4 The findings

4.1 Introduction

Statutory guidance requires that serious case review reports provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence. Section 3 provides the analysis of what happened and why, whilst section 4 provides the findings about what needs to happen in the multi-agency safeguarding systems to reduce the risks of recurrence. The SCIE Learning Together systems approach uses the learning from an individual case to provide a 'window on the system' into how well the local multi-agency safeguarding systems are operating.

4.2 What light has this case review shed on the reliability of our systems to keep children safe?

4.2.1 This case has highlighted the difficulties in working with young parents and identified the importance of effective assessment processes that identify additional supports that may be needed where there are specific vulnerabilities such as having been previously 'looked after'. This is especially true when assessing fathers as many agency procedures are insufficiently robust in their approach to men. It has also identified some areas for improvement around multi-agency working out of hours particularly when responding to complex medical conditions that may have differential diagnoses.

4.2.2 In order to help with identification and prioritisation, the systems model that SCIE has developed includes 6 broad categories of these underlying patterns. The ordering of these in any analysis is not set in stone and will shift according to which is felt to be most fundamental for systemic change:-

- Innate human biases (cognitive and emotional)
- Family-professional interaction
- Responses to incidents
- Longer term work
- Tools
- Management systems

There is, of course, overlap between categories. The precise nature of each Finding, expressed in its headline, forms a sub-category within each pattern.

4.2.3 The task in developing each finding is to present a clear example of how the issue manifests itself in the case, and then to:

- identify in what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case;
- highlight any information gleaned about how general a problem this is perceived to be locally, or data about its prevalence more widely;
- be clear about why it matters; and
- state how the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems.

4.3 Summary of findings

4.3.1 This section contains 9 priority findings that have emerged from the learning review. The findings explain how professional practice could be improved. It does this by considering patterns that are supportive of good quality work and patterns that introduce or increase risk to the reliability with which we can expect professionals to achieve good quality work.

4.3.2 Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues. Evidence is provided to show how each finding is indicative of potential risks to other children and families in future cases, because they undermine the reliability with which professionals can do their jobs. Findings for which there is only initial or emerging evidence of prevalence outside this case have been presented as questions.

4.3.3 The review team have prioritised 9 findings for the LSCB to consider listed below: -

	Finding	**Category**
1	Does the primarily advocacy role adopted by the West Sussex OLAC Team and the lack of understanding of the correlation between maltreatment in childhood and the impact upon them as a parent, mean social workers do not adequately identify the risk that care leavers might pose to their own or other children, meaning that they are left without the support they need as parents, and children can go unprotected?	(communication and collaboration in response to incidents)
2	The booking form used by midwives in Brighton & Hove means that social information is mainly sought from the expectant mother rather than both parents, meaning that important information relating to the assessment of risk may not be obtained.	(tools)
3	Is there a pattern in Brighton and Hove and West Sussex that where social work cases are held on a duty system the work becomes task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes?	(management systems)
4	The Framework 'i' IT system in West Sussex does not include the provision for stand alone case transfer summaries leaving workers and managers without easily accessible case history information on which to assess risk.	(tools)
5	Data management systems within Probation providers across Sussex and Surrey produce data reports that give an overview of performance against indicators but do not provide managers with information about overdue tasks.	(tools)
6	Is there a pattern in West Sussex OLAC Service of a lack of consistently robust oversight of how Leaving Care Grants are spent, leading to potential risks to and from care leavers not being recognised?	(management systems)
7	The benefits of the casual sharing of information between health professionals in Brighton & Hove about joint cases brings the associated risk that they do not share all the relevant information nor regularly record the information in the appropriate case records.	(communication and collaboration in longer term work)
8	The current response by the Children Social Care's Emergency Duty Service to notification from a hospital of a possible non-accidental injury to a child who is admitted to hospital, results in a delay to the police being informed compared with the in-hours response, potentially jeopardising the child protection investigation and police inquiries.	(communication and collaboration in response to incidents)
9	IIs there a pattern in Brighton & Hove that the current approach of the police in cases of possible non-accidental injury does not accommodate the process of differential diagnosis by health professionals, and hinders timely social work action to address immediate risks to a child?	(communication and collaboration in response to incidents)

4.4 Findings in detail

4.4.1 Finding 1:

Does the primarily advocacy role adopted by the West Sussex OLAC Team and the lack of understanding of the correlation between maltreatment in childhood and the impact upon them as a parent, mean social workers do not adequately identify the risk that care leavers (male and female) might pose to their own or other children, meaning that they are left without the support they need as parents, and children can go unprotected? (communication and collaboration in response to incidents)

The OLAC team adopted an advocacy approach to their work with care leavers and operated from a value base that being a "care leaver did not make you a bad parent". Care leavers were viewed as being the same as any other young people, as opposed to being individuals with probable additional needs given their care history. Referring a care leaver for a pre-birth assessment was viewed as punitive rather than a supportive response and the understanding of the effect of an abusive childhood on the care-leaver's capacity to parent was limited.

4.4.2 How did the issue feature in this particular case?

When father's mother contacted the OLAC social worker to express her concerns that her son and his pregnant partner were living with her, there was no recognition of father's support needs as a new parent or that his background and volatility may indicate a risk to his child. There was no consideration to the safeguarding needs of the baby and despite the social worker having a full awareness of father's history and experiences; no link was made with how these experiences may impact upon his ability to parent. The correlation between experiencing maltreatment during adolescence and possibly inflicting maltreatment as a parent was not made [11] and as such the link between father's experiences of being parented and his ability to parent was not recognised. In this case, clear risk factors were not recognised, namely father's extensive history of substance misuse, violent and volatile behaviour, and poor relationship with and disorganised attachment to his mother.

4.4.3 How do we know it is an underlying issue and not something unique to this case?

Information from case group members identified a culture within the West Sussex OLAC Service which championed and advocated on behalf of care leavers. The starting position that "being a care leaver didn't make someone a bad parent" led to a lack of recognition that care leavers do have additional support needs by virtue of their care history. West Sussex Children's Services have now set up a range of measures to re-dress the perspective of OLAC staff away from just advocacy to a risk informed perspective. These include setting up a procedure that all care leavers who are to become parents will now be subject to a pre-birth assessment. Extensive work has taken place to ensure that young people who fall into this cohort are identified early and Team Managers in the Service are tasked with overviewing the care-plans for these specific young people. Managers have also received training on safeguarding and child-protection case management. Training for staff is planned.

What is needed is clarity about whether these measures will change the culture and influence practice more generally with regard to how West Sussex OLAC team members view their responsibilities towards safeguarding children.

[11] Thornberry TP, Henry KL. (2013). "Intergenerational continuity in maltreatment.". *J Abnorm Child Psychol*. 41(4): 555–569. Crittenden, P (2008) "Raising Parents: Attachment, Parenting & Child Safety", Willian.

4.4.4 How common and widespread is the pattern?

On 30/06/14 there were 587 children allocated to the West Sussex OLAC Teams; of these 220 were Children in Care and 324 were Care Leavers. Discussions with case group and review team members indicated that the culture of social workers seeing themselves as advocates for care leavers and not necessarily aware of wider safeguarding responsibilities, applied across the OLAC service. There are 27.5 social workers and support staff working within these teams. The review team did not feel that the social workers working with care-leavers in Brighton & Hove shared this value base and had evidence that they had therefore operated in a different way when considering risks posed by care-leavers to young children.

4.4.5 What are the implications for the reliability of the multi-agency child protection system?

All Children's social workers, regardless of where in the system they are based, should be skilled in recognising risk and responding appropriately. If there is no challenge to the culture and value base, workers will not actually think differently and will not have the confidence to have conversations with care leavers about the impact of their experiences upon their ability to parent. The range of measures introduced to re-dress the perspective of staff to a more risk informed one should help workers understand what support care-leavers need to become better parents. This will necessitate a cultural shift in how pre-birth assessment is viewed thereby avoiding risk going unrecognised, new parents not being appropriately supported and babies being placed at risk of significant harm.

Finding 1:
Does the primarily advocacy role adopted by West Sussex OLAC Team and the lack of understanding of the correlation between maltreatment in childhood and the impact upon them as a parent, mean social workers do not adequately identify the risk that care leavers might pose to their own or other children, meaning that they are left without the support they need as parents, and children can go unprotected? (communication and collaboration in response to incidents)

The empowering and advocacy approached embedded within the OLAC Team is a respectful and person centred approach which provides this vulnerable group of young people with appropriate support. However a cultural premise that "being a care leaver doesn't make you a bad parent" fails to recognise that care leavers will have additional needs as parents by virtue of their own (poor) experiences of being parented, and fails to recognise that risks to children are often caused by omission as well as commission. Viewing a referral for pre-birth assessment as a punitive measure rather than a supportive process that could help and assist care leavers in becoming new parents, can fail the people the service is attempting to empower and can also mean that risk factors are not addressed and children are left at risk of significant harm.

Considerations for the Board and partner agencies

- How does the Board know that care leavers in Brighton & Hove who become parents are getting sufficient support and their children's safeguarding needs are sufficiently addressed?
- How will Brighton & Hove LSCB engage with West Sussex LSCB about the findings that related to West Sussex social work practice?
- What has West Sussex done to in order to address the cultural underpinning within the OLAC service to address the problem identified in this review?

4.5.1 Finding 2:

The booking form used by midwives in Brighton & Hove means that social information is mainly sought from the expectant mother rather than both parents, meaning that important information relating to the assessment of risk may not be obtained. (Tools)

At the booking appointment a booking questionnaire is completed by the midwife with the woman (demographics, medical, social, psychological, obstetric history). It is an opportunity to establish a relationship with woman through effective, sensitive and open communication. The first antenatal contact or 'booking' visit is the most important and detailed of all visits and gives an opportunity to assess general health and to start making forward-looking plans for pregnancy, birth and parenthood. It is considered to be part of the clinical risk assessment process.

4.5.2 How did the issue feature in this particular case?

A significant problem in this case was that most of the professionals working with Liam and his parents did not know of the father's difficult history and the troubled and volatile relationship he continued to have with his mother. The midwifery booking appointment was an opportunity to gather such information particularly because the father was present and both parents co-operated fully with the process. The local protocol and booking form, which the midwife followed, did not require that partners were asked about their social history or background. As a consequence no information was documented about father.

4.5.3 How do we know it is an underlying issue and not something unique to this case?

The maternity booking form is standardised across the Hospital Trust and details maternal social issues such as previous child protection issues; domestic abuse; mental health issues; substance misuse. The booking form has minimal information relating to the father.

4.5.4 How common and widespread is the pattern?

The maternity booking form is used for all pregnant women at BSUH (approx. 6000 number of deliveries per annum). The maternity forms have recently been updated using examples from other Trusts locally and around the country.

4.5.5 What are the implications for the reliability of the multi-agency child protection system?

The booking information is a vital part of the risk assessment and care planning for families and their unborn babies. If a full and detailed history is not taken from both parents the risk assessment and decision making will be compromised.

Finding 2: **The booking form used by midwives in Brighton & Hove means that social information is mainly sought from the expectant mother rather than both parents, meaning that important information relating to the assessment of risk may not be obtained.** (tools)
This review has identified that the booking form used in Brighton & Hove concentrates mainly on information from and about the mother rather than from both parents. This means that, even if the partner is present, important information may not be gathered which could inform the risk assessment on the unborn child.

Considerations for the Board and partner agencies

- Is the Board aware that the midwifery booking assessment is mainly aimed at obtaining maternal information?
- Is the Board confident that the maternity booking process at present provides a sufficiently detailed social history of both parents?
- Is the Board confident that there are effective multi-agency information sharing systems to ensure that all agencies share relevant information about pregnant women & their partners with the midwifery team?
- Is the Board of the view that it is cost effective to include questions about father's history on the midwifery booking form?

4.6.1 Finding 3:

Is there a pattern in Brighton & Hove and West Sussex that where social work cases are held on a duty system the work becomes task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes? (management systems).

When it is not possible to allocate work immediately it is common practice across social work teams to hold the work unallocated in a 'duty system' where specific, essential and urgent tasks are completed by different workers, who cover the system on a rota basis.

4.6.2 How did the issue feature in this particular case?

When the social worker in the OLAC team left it was not possible to immediately allocate all of her caseload and so the manager prioritised allocation of current looked after children meaning some of the workload was held unallocated, with urgent tasks being picked up by duty workers. Father's Pathway Plan was reviewed during the period his case was held on the duty system. This was completed, as a paper exercise, following a single telephone conversation with father, in order to meet statutory timescales. There was no consideration given to his support needs or the need to refer for a pre-birth assessment.

The rationale behind the decision to place father's case on duty was that he was a care leaver and was reluctant to engage with social workers. Furthermore the manager was not aware that father's girlfriend was pregnant at the point this decision was made. The impact of holding the case on duty was that the response given by social workers to the father when he contacted the service was very limited. The workers with whom father had contact did not have a knowledge and understanding of his history or the significance of this in respect of him becoming a new parent. Responses to father were task orientated and lacked consideration of his current situation, support needs or potential risk to the unborn child. There was no management oversight of father's case and no consideration given to allocating the case when his impending fatherhood came to management attention.

4.6.3 How do we know it is an underlying issue and not something unique to this case?

Information from case group members indicated that cases held on duty within the West Sussex OLAC Service were dealt with on a task by task basis, with no ownership of the case, limited reference to previous history, and no consideration given to outcomes. Management oversight was limited with no structured management systems in place. The West Sussex OLAC service's experience with

regard to work on duty cases is not unique. Members of the Review Team reported that within services they have responsibility for, it was not unusual for cases held on a duty system to at times be worked on a task orientated basis, with a lack of consistency and accountability.

4.6.4 How common and widespread is the pattern?

Cases are held unallocated in duty systems across all social work services. A recent Department for Education report[12] identified that of 64 Local Authorities contributing to the research '… the percentage of responding local authorities reporting 0-10 unallocated cases has remained largely consistent. However, at each of the four visits five local authorities have reported over 50 unallocated cases.'

In Brighton & Hove on 30th June 2014 there were 28 out of 2257 open cases that did not have an allocated social worker or were allocated to a manager. These included 2 care leavers out of a cohort 165 and 2 looked after children out of a cohort of 466. 9 children with no allocated social worker were open to Children's Disability Service; 10 to the Child in Need service and 4 to the Hospital social work team. In West Sussex on 30th June 2014, there was one unallocated looked after child and 21 unallocated care leavers out of 4273 open cases.

4.6.5 What are the implications for the reliability of the multi-agency child protection system?

There will be occasions when some cases will be unallocated and will need to be worked on a duty basis. It is important that such cases are not worked in a reactive, task orientated way but within the context of ensuring that workers take the time to scan the records in order to examine previous behaviour, actions and requests. If this doesn't happen, then assessments are likely to be flawed resulting in safeguarding needs going unmet and child protection risks not being recognised and acted upon.

Finding 3:
Is there a pattern in Brighton and Hove and West Sussex that where social work cases are held on a duty system the work becomes task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes? (management systems)

In the context of unlimited demand and finite resources, there will always be some work that is not immediately allocated to a named social worker creating risks that needs to be managed and moderated on a duty basis. If duty systems which hold unallocated work are not adequately resourced and do not have a system in place that provides a level of management oversight and understanding of the cases, cases will be reactively rather than proactively worked. This can result in children not being adequately protected and safeguarded.

Considerations for the Board and partner agencies

- Does the Board know how many social work cases are held on duty systems in Brighton & Hove?
- Is the Board confident that effective management systems are in place which will ensure appropriate oversight of cases held on a duty system in Brighton & Hove?
- Does the Board know how unallocated work is prioritised in Brighton & Hove? e.g. prioritising LAC over care leavers as in West Sussex
- Is the Board aware of the arrangements in place for the management of

[12] DFE, (2012) "The Social Work Improvement Fund – summary report on activity 2010-12"

individual cases, including the sharing of information between agencies where there is no allocated worker? • How will Brighton & Hove LSCB engage with West Sussex LSCB about the issues concerning managing unallocated work held on duty?

4.7.1 Finding 4:

The Framework 'i' IT system in West Sussex does not include the provision for stand alone case transfer summaries, leaving workers and managers without easily accessible case history information on which to assess risk (tools).

Case transfers are completed when there is a change of allocated social worker for a child or young person. A case transfer summary is the tool by which the social worker can effectively handover key and relevant information about the case history, current status of the case, current risk / protective factors, incomplete actions, key family members and professionals and reference key documents. In this case the case summary was completed but it was embedded within case records.

4.7.2 How did the issue feature in this particular case?

The review team were concerned that information regarding father's history and impending fatherhood had not been taken into consideration when the decision was made by the OLAC manager for his case to become unallocated and be responded to on a duty basis. Further investigations revealed that unlike most other reports, the case summary did not require management sign off due to the way it was created – as a case record sheet entry.

4.7.3 How do we know it is an underlying issue and not something unique to this case?

Case notes within the Framework 'i' system do not allow for management sign off, so this does not promote managers quality assuring the content and does not leave an audit trail to show that the manager was aware of the content and had ensured it had contained the information required. Other social work reports within the Framework 'i' IT system are 'episodes' and these are electronically signed off by the manager. If a transfer summary was established to be an episode in the same way, the manager would be able to ensure the quality and demonstrate oversight in the same way.

4.7.4 How common and widespread is the pattern?

Framework 'i' is the recording system used across all social work teams within West Sussex (up to 30 teams), and therefore the absence of a transfer episode would apply to all children receiving a social work service within West Sussex. There are set transfer points where there is transfer within teams (for example at an Initial Child Protection Conference or 1st Looked After Child Review); however re-allocation also occurs within teams. This is often when workers leave, but can also be for other practice related reasons. Therefore case transfer would be a frequent occurrence within the service. This issue therefore relates to general practice of all social workers within West Sussex. Within Brighton & Hove, the CareFirst IT system has a specific, stand-alone case transfer record that requires management sign-off.

4.7.5 What are the implications for the reliability of the multi-agency child protection system?

A key responsibility of a team manager is to provide management oversight on the cases open within the team, and to ensure safe and appropriate intervention. If any cases are unallocated within the team and are responded to on a duty basis, the role

of the manager is even more important. In addition the point of transfer of cases is a time of increased risk as key information can be lost if it is not handed over correctly, A robust case transfer process is an important part of a safe child protection process.

Finding 4:
The Framework 'I' IT system in West Sussex does not include the provision for stand alone case transfer summaries leaving workers and managers without easily accessible case history information on which to assess risk (tools)

The point of case transfer is a time of increased risk as key information can be lost, resulting in assessments being based on incomplete or inaccurate information and risk factors not being effectively identified. The transfer summary is the tool by which the social worker can effectively handover the key and relevant information. Safe case transfers and effective management oversight are an important part of a safe child protection process.

Considerations for the Board and partner agencies

- How will Brighton & Hove LSCB engage with West Sussex LSCB about the issues concerning the Framework 'i' IT system?
- Is the West Sussex Board aware that the Framework 'i' IT system does not have a separate transfer summary episode record?

4.8.1 Finding 5:
Data management systems within Probation providers across Sussex and Surrey produce data reports that give an overview of performance against indicators but do not provide managers with information about overdue tasks (management systems).
An area of Probation practice in this case was the delay in completing a risk assessment of father. Exploring what lay behind this revealed that there was a gap in the performance management process.

4.8.2 How did the issue feature in this particular case?
The Offender Manager should have completed an Initial Sentence Plan (including the risk assessment) by mid-February but this was not finalised until May. This was because of her heavy workload and competing work pressures. The Offender Manager did not discuss the issue in supervision as her caseload was about sixty and the reflective supervision model that was being used required that the worker identify the most risky cases for discussion. The father was a significantly lower risk than most other cases on her caseload. The Probation Service Manager who supervised the Offender Manager was not aware that she had not completed the Initial Sentence Plan. The Service Manager directly supervised between 10 and 14 staff with comparative caseloads to the Offender Manager and so had a supervisory responsibility for over 600 cases. She was clear that in such circumstances she relied on Offender Managers to bring to supervision the work that needed to be discussed.

4.8.3 How do we know it is an underlying issue and not something unique to this case?
In most organisations data management systems are capable of performing a number of functions, providing corporate higher level data about performance

against key target indicators whilst also supporting more junior managers in their daily management tasks. It is not uncommon for the higher level functions to be more fully developed and often the needs of operational managers are less well met by data systems reports.

When discussed within the review team it became apparent that the data management system in place within the Probation Service was not developed in a way that could assist individual managers with their management tasks.
The Probation Service Manager was aware of team performance regarding completion of service plans and knew that this information was considered by more senior managers. There were no systems in place that alerted her to individual workers who were not meeting deadlines and she was not aware of any systems that had been established elsewhere that could provide this information. As a result there was no automatic management oversight of the Initial Sentence Plan process as Probation Service management systems did not include an alert system for overdue work. Individual managers would be required to check each case manually or rely on the report of the Offender Managers.

4.8.4 How common and widespread is the pattern?

The data management system in use is used by all Probation Providers in Kent, Surrey and Sussex. Kent had developed an alert system but during this period Surrey and Sussex had not, so potentially all managers in those areas were operating without additional systems that would enable them to manage the performance of their staff. The database system in use is based on a national system and the limitations on the data reports to managers are a known problem that is being examined across Kent, Surrey and Sussex . A solution is now being rolled out based on the Kent approach. Whilst exception reporting was delayed and the data reports were not provided very frequently, this is now being established on a weekly basis.

4.8.5 What are the implications for the reliability of the multi-agency child protection system?

Performance management systems often serve a number of audiences and within Probation, senior managers are more effectively served than operational managers. Managing performance of staff can be a key factor in ensuring that the multi-agency child protection system is working effectively.

Finding 5: **Data management systems within Probation providers across Sussex and Surrey produce data reports that given an overview of performance against indicators but do not provide managers with information about overdue tasks** (management systems).
IT data management systems ideally are configured to perform to a range of tasks both delivering higher level performance data and also supporting managers in the day-to-day management of staff and their work tasks. The systems used by Probation providers did not support front-line managers in their daily management tasks as they did not provide them with routine performance management data regarding overdue assessments. This is particularly important given the size of the caseloads and the adoption of a reflective supervision methodology which means it is not feasible for operational managers to manually keep abreast of progress on all cases they oversee. Frontline Probation managers now receive information detailing which Initial

Sentence Plans are overdue to support them in overseeing the work of their teams.

Considerations for the Board and partner agencies

- Is the Board confident that data management systems in Probation Provider Services support front line managers in their daily management tasks?
- Is the Board aware of whether other member agency data management systems support managers in safeguarding children?

4.9.1 Finding 6:

Is there a pattern in the West Sussex OLAC Service of a lack of consistently robust oversight of how Leaving Care Grants are spent, leading to potential risks to and from care leavers not being recognised? (management systems)

Care leavers in West Sussex are entitled to a Leaving Care Grant (LCG) of £2,000.00. These monies are to support the care leaver in moving into independent accommodation and are provided in acknowledgement of the fact that most care leavers will not have the financial support of families that many other young people may have when moving onto independent living. The LCG is provided to purchase essentials such as a bed, fridge and cooker as well as deposits and rent in advance for privately rented accommodation or insurance and TV licence payments**.** The Review team found that in this case it was used by the father to buy things in preparation for the baby. Exploring this further revealed a concern that there was insufficient management oversight of the allocation of LCG monies to young people, specifically those young people who were managed via duty arrangements.

4.9.2 How did the issue feature in this particular case?

The father requested monies from his LCG and was given £600 over a 2 month period in payments of £250 and £350. This money was provided to the father loaded onto a "P" card (a form of debit card that can be used to withdraw cash up to the agreed limit). Although father reported it was to purchase essential items for his flat, there was no checking mechanism to ensure that this was what the monies had been spent on. The Review team were concerned that father, given his history of substance misuse, could have spent the money on alcohol and/or drugs, resulting in risk to self or others.

4.9.3 How do we know it is an underlying issue and not something unique to this case?

Information from case group members indicated LCG monies were on occasions provided to care leavers loaded onto "P" cards and that there was an insufficiently robust process for managers to check what the monies were spent on. Case group members felt that the practice in this case was concerning because there was very little known about the father by the people making the decisions to give him the money. The Review team were advised that workers would generally assign smaller sums to young people whom they were the allocated worker for and then judge how it had been spent before giving more money, or would ask for receipts. The issue of how workers respond when working with a client 'on duty' as opposed to being allocated is discussed in finding 3. A further influence on practice in the OLAC team identified was that the West Sussex Children in Care Council have made a challenge that care leavers be allowed to spend their LCG without what is perceived as, unnecessary oversight and scrutiny from social workers. This seems to have resulted (as in this case) in some LCG monies being provided to care leavers without sufficient oversight on how it is being spent. This practice is not thought to

apply in Brighton & Hove where different arrangements are in place that involve care leavers never being given cash or access to cash.

4.9.4 How common and widespread is the pattern?

On 30/06/14 there were 587 children allocated to the West Sussex OLAC Teams, of these 220 were Children in Care and 324 were care leavers. This is a process that is specific to West Sussex. Brighton & Hove operate a different system for release of LCG monies which involves the need for large purchases to be made via a corporate debit card and requires receipts from care leavers to account for expenditure of smaller sums of money.

4.9.5 What are the implications for the reliability of the multi-agency child protection system?

Parenting, whether corporate or not, involves tensions around how to give enough freedom to encourage independence but not too much to avoid a risk to health and well-being. Corporate parenting has the additional bind of having to also be accountable for the appropriate use of public money. This case review suggests that West Sussex is on the permissive end of the parenting spectrum in terms of the process for LCG monies.

Finding 6:
Is there a pattern in West Sussex OLAC Service of a lack of consistently robust oversight of how Leaving Care Grants are spent, leading to potential risks to and from care leavers not being recognised? (management systems)

The practice in West Sussex of providing LCG monies with limited oversight on what it is being spent on, can result in a lack of accountability for monies spent and potential risks to and from care leavers not being recognised. This practice has arisen from a challenge from the Children in Care Council for care leavers to be able to spend their LCG without unnecessary scrutiny from social workers. Whilst it is important to listen to the views of children and young people, there is also a need to act as a responsible corporate parent. The question of "what would a good parent do?" when faced with a request to release significant sums of money should be foremost in workers minds.

Considerations for the Board and partner agencies

- What does the Board know about the administration of the Leaving Care Grants in Brighton & Hove?
- How does the Board know that the use of the LCG in Brighton & Hove is enabling positive outcomes for care leavers?
- How will Brighton & Hove LSCB engage with West Sussex LSCB about the findings that related to West Sussex social work practice?
- How does West Sussex LSCB know that there is appropriate scrutiny of the LCG?
- How does West Sussex LSCB know that the use of the LCG in West Sussex is enabling positive outcomes for care leavers?

4.10.1 FINDING 7:

The benefits of the casual sharing of information between health professionals in Brighton & Hove about joint cases brings the associated risk that they do not share all the relevant information nor regularly record the information in the appropriate case records. (communication & collaboration)**.**

Co-location is often thought of as conducive for information sharing and inter-professional working. Health staff who are co- located or who have a close working relationship can share information about joint cases on a casual basis, but the risk is in doing so that they do not share all the relevant information nor regularly record the information in the appropriate case records

4.10.2 How did the issue manifest in this case?

The Health Visitor fortuitously came across the midwife for Liam's mother in the Children Centre and informed her that ACAS had phoned and told her that they had been notified of a domestic abuse incident by the Police. The midwife agreed that as she already had a visit planned to the family she would enquire about the domestic abuse incident. The midwife was not aware that father was a care leaver or that ACAS was taking no further action and there was no agreement between the health visitor and midwife about what follow up there will be after the midwife's visit. The Health Visitor did not record the fact that she had shared the information with the midwife in the Child's Records and the midwife did not record her contact with the Health Visitor in the midwifery notes.

4.10.3 How do we know it is an underlying issue and not something unique to this case?

Discussions with the case group and review team would indicate that this is not just an issue pertinent to this case but is common in other cases where staff members are either based in the same building and have frequent casual contact or when professionals have close working relationships which mean they talk more informally to each other on a regular basis and do not formally request a meeting to discuss a case or always record each conversation.

4.10.4 How common and widespread is this pattern?

The case group thought that "corridor conversations" within Brighton & Hove co-located health services were a common occurrence but there are no formal records and an audit would need to be undertaken to establish the prevalence more definitively.

In a supervision audit undertaken in Children Centre's in October 2013 only 25% of respondents stated that Informal/adhoc supervision was always recorded in case files. This issue is particularly significant within health services as families can often have more than one health professional involved with their family.

4.10.5 What are the implications for the reliability of the multi-agency child protection system?

All information which impacts upon the care plan for children and families should be recorded in the appropriate health records so it is explicit to any professional who picks up the notes how decisions were made and what action was taken. Co-location and ad hoc "corridor conversations" could result in information shared on a casual basis not being viewed in the same way as information gained through formal meetings and/or referrals. This could lead to incomplete records, a known feature of Serious Case Reviews.

Finding 7:
Health staff in Brighton & Hove who are co- located or who have a close professional working relationship may share some information about joint cases on a casual basis but the risk is that they may not share all the relevant information nor always record the information in the appropriate case records. (communication & collaboration)

Collaborative multi-agency working may be improved by co-location and close working however there are also risks that professionals will not always record conversations that may happen informally and that information may not be transferred in as complete a fashion as when a more formal approach is made.

QUESTIONS FOR THE BOARD TO CONSIDER

- Is the Board aware of this issue?
- How does the Board know if professionals are recording informal conversations?
- Does the Board think that this is an issue for all agencies where there are instances of planned or unplanned conversations and information not being documented?

4.11.1 FINDING 8.

The current response by the Children Social Care's Emergency Duty Service to notification from a hospital of a possible non-accidental injury to a child who is admitted to hospital, results in a delay to the police being informed compared with the in-hours response, potentially jeopardising the child protection investigation and police inquiries. (response to incidents).

The Emergency Duty Service (EDS) operates outside of normal office hours and covers East Sussex and Brighton & Hove. They respond to serious child care issues that cannot wait until the following working day. The service that is provided is effectively a 'life and limb' cover where immediate risks to children are prioritised and anything that is not extremely urgent is deferred to staff on duty the following day, or after the weekend.

4.11.2 How did the issue manifest in this case

When the parents brought Liam to the hospital on the Sunday morning a nurse undertook a 'Carefirst check' to see if Liam was known, by contacting the EDS and were told about the previous domestic abuse incident in Brighton. The nurse did not provide the EDS worker with any information about Liam's injuries at this point. The hospital staff treated Liam for the head injuries and he was admitted as an inpatient to the hospital. Later that evening after further investigative interventions, at 9pm, the nurse contacted EDS again and, in accordance with local safeguarding procedures, told them that Liam's injuries might be non-accidental. EDS staff noted the information but took no further action as they considered that Liam was safe in hospital**.**

4.11.3 How do we know it is an underlying issue and not something unique to this case?

Discussion within the case group and review team confirmed that the responsibility for contacting the police when possible non-accidental injuries are identified out of hours is confusing. This matter has also been identified in a recent learning review

within Brighton & Hove. The hospital procedures clearly state that the expectation is that staff should inform social workers when non-accidental injuries are suspected. During normal working hours social workers then take responsibility for contacting the police and initiating strategy discussions. Out of hours the hospital staff assume that the EDS workers would take the same actions. In reality the staffing ratios for EDS mean that unless there is an immediate risk to the child EDS will probably defer this to the day staff, leading to delay in the police being informed.

4.11.4 How common and widespread is this pattern?

The review team has identified that the Royal Alexandra Children's Hospital Emergency Department sees on average 70 - 100 patients per day, with seasonal variation in the attendances. For example, more children attend hospital with respiratory illnesses and ailments between October to March and more attend with injuries during the summer. Although no specific data is available which identifies how many patients sustain head injuries, data is available that indicates that nearly half of the children who attended, did so because they had sustained an injury of some sort.

The EDS service covers all of Brighton & Hove and East Sussex and operates between 5pm and 8.30 am during weekdays and all day over the weekend. The service is staffed by 1 social worker, and a caseworker (in the evening), with the support of an on-call manager. EDS report regular contact from hospital staff out of hours. The numbers of children admitted to hospital with non-accidental injuries are comparatively low. A recent learning review in Brighton & Hove identified similar confusions regarding responsibilities for alerting the police to a possible non-accidental injury which also resulted in delays in the police investigation.

4.11.5 What are the implications for the reliability of the multi-agency child protection system?

Child abuse and its identification does not only occur in office hours, therefore a safe system must respond effectively regardless of the day or time. Child protection investigations of possible non-accidental injury need to be initiated speedily so as to maximise the gathering of relevant evidence. Any delays in advising the police of a possible inquiry increases the likelihood that key information is lost, potentially. detrimentally affecting the child protection investigation. This case has shown a pattern whereby, in cases where the child is in a safe place such as a hospital, there can be delay in advising the police meaning that police investigations that start out of hours do not run optimally. Multi-agency child protection depends on effective speedy close working between health, social work and police colleagues.

FINDING 8.
The current response by the CSC's Emergency Duty Service to notification from a hospital of a possible non-accidental injury to a child who is admitted to hospital, results in a delay to the police being informed compared with the in-hours response, potentially jeopardising the child protection investigation and police inquiries. (response to incidents)

The current arrangements for informing the police about possible non-accidental injuries to children out of hours are insufficiently robust and increases the likelihood of delays in the criminal investigation being initiated, with the possible loss of important evidence to the inquiries.

QUESTIONS FOR THE BOARD TO CONSIDER

- Were the Board aware of this problem?
- Is the current multi-agency out of hours safeguarding system fit for

purpose? Is the current staffing cost-effective?
- Are there other ways that the police could be advised on non-accidental injuries to children?
- Do the current procedures work out of hours?
- Are there any other factors that affect the police being informed about possible injuries to children – are there any other factors that prevent direct communication between police and health staff?

4.12.1 FINDING 9.

Is there a pattern in Brighton & Hove that the current approach of the police in cases of possible non-accidental injury does not accommodate the process of differential diagnosis by health professionals, and hinders timely social work action to address immediate risks to a child?(communication and collaboration in response to incidents).

The process of multi-agency working during a child protection investigation is always a complex process. The needs of the child should always take priority but are often affected by the police need to gather evidence for a criminal prosecution. Social work interventions may be limited by the need to avoid compromising a criminal investigation. In this case the care plan for Liam was not amended despite the social worker knowing of possible risks to him because she felt prevented from securing his safety by the police embargo on her talking to the parents. The police had imposed this embargo as they wanted more a more definitive report from the hospital regarding the cause of Liam's injuries.

4.12.2 How did the issue manifest in this case

Following a scheduled skeletal survey, further injuries to Liam were identified – namely healing rib fractures. A further Strategy Meeting was held where the paediatrician reported a number of possible causes for the injuries but said that they were probably non-accidental. After some discussion the police requested an updated written medical report which clearly detailed the injuries could not have been caused accidentally. The police indicated that they would not arrest the parents before this report was received and asked that no-one spoke to the parents about the medical report until after their arrest in order to maintain the integrity of the police investigation. The timescales attributed to the newly identified healing injuries covered a period when Liam had been in his father's, his mother's and his maternal grandmother's sole care, thereby identifying them all as possible perpetrators. The social worker was asked not to share this information with the family which prevented her from changing the care arrangements for Liam. The police request resulted in Liam being left in a potential unsafe situation (in his mother's care at the home of the maternal grandmother) for a further 24 hours as the social worker could not discuss with the family new care arrangements for Liam and why they were needed, until after the parents had been arrested by the police.

4.12.3 How do we know it is an underlying issue and not something unique to this case?

The police representatives in the case group clearly stated that their approach in insisting on a written report detailing the cause of the healing injuries had been strongly influenced by a case the previous week when health professionals had verbally indicated non accidental injury as part of their differential diagnosis. This

subsequently changed in a written report received after they had arrested the possible perpetrators.

The social workers in the case group also reported that the progress of a police investigation influences their planning on cases. The expectation as laid out in Working Together 2013 is that there should be close working between health, social care and police professionals which accommodates both the needs of the criminal investigation and the requirement to ensure the safety of the child.

The degree to which this is an issue outside of Brighton & Hove is not fully known however a published serious case review in Lambeth has identified similar difficulties. Within their report a Review Team member from Health summed up the clash neatly saying:

> *"In my experience, this is quite a common pitfall in strategy meetings and is a generalisable finding. It arises because doctors don't fully understand that social workers and police are listening for a clear opinion on which to plan the rest of the investigation (and if they don't hear it they may feel unable to proceed) and because social workers and police don't appreciate they may be listening to a discussion of ideas rather than a finished opinion. In practice, getting to an opinion is an iterative process – that involves some people checking out the history, others requesting more specialist help or further investigations. It's about tolerating (and planning for) uncertainty to allow this process to happen"*[13]

4.12.4 How common and widespread is this pattern?

Considering a differential diagnosis is a core role for medical staff when trying to identify all possible causes for medical signs and symptoms, including injuries to children. Head injuries in children can present subtly and can be difficult to diagnose as there are a number of potential causes, including non-accidental injury. The combination of head injuries and rib fractures made it more probable that the injuries were non-accidental but did not rule out categorically other explanations. The case group and review team considered that the complexity of the judgements and decisions in this case are very common and the challenges faced by the front-line professionals identified in this case are regularly experienced. A paediatrician may not always be able to give an exact cause for an injury/injuries despite non-accidental injury being possible and will be considering, based on a number of factors and medical investigations, whether a non-accidental injury is 'more likely than not' a possibility.

4.12.5 What are the implications for the reliability of the multi-agency child protection system?

A safe multi-agency child protection system is one which has to balance protecting children whilst successfully pursuing criminal prosecutions in respect of perpetrators. There is an inherent challenge in fulfilling both without jeopardising either, where the needs of the child are not overlooked in the process of trying to pursue a successful criminal prosecution. If this balance is not achieved, prioritisation of a police investigation may mean that there is a delay in safeguarding children.

[13] Lambeth Safeguarding Children Board Serious Case Review Child H
http://www.lambethscb.org.uk/Serious_Case_Review_professional_section

FINDING 9.
Is there a pattern in Brighton & Hove that the current approach of the police in cases of possible non-accidental injury does not accommodate the process of differential diagnosis by health professionals, and hinders timely social work action to address immediate risks to a child? (communication and collaboration in response to incidents)

Currently, police are requesting a definitive view from health professionals regarding whether an injury has been caused non-accidentally in order to progress their criminal investigations. This conflicts with the process of differential diagnosis by health professionals and can lead to children being left in unsafe situations whilst these issues are resolved.

QUESTIONS FOR THE BOARD TO CONSIDER

- Was the Board aware of this issue before this review?
- Does the Board have any systems for identifying where there are similar delays because of misunderstandings about differential diagnoses between health and police professionals?
- Are there ways in which greater mutual understanding could be developed between relevant health and police professionals?
- What does the Board think of the consequences if this situation remains unchanged?
- What are the options available to the Board to make similar situations less likely in the future?

5 Additional learning

5.1 Alongside the Findings, there was one significant issues which emerged from this review which the Brighton & Hove LSCB needs to be aware of, and about which the board may wish to consider taking further action:

This relates to the issue of information sharing between the duty social worker and the GP and midwife about the domestic violence incident. The review team considered that the practice of the duty team was good enough but that best practice would have been to contact the GP and midwife to gather fuller information. When this was discussed with the review team and the case group it was felt that the arrangements for information sharing between agencies were now significantly different because of the development of the Multi-Agency Safeguarding Hub (MASH) within Brighton & Hove and that therefore practice was now significantly different which was why this matter was not included as a finding. There is the possibility that professionals are being over-optimistic about the positive influence of the development of the MASH and the LSCB may wish to consider at a future date reviewing information-sharing within the MASH.

6 Conclusion

6.1 This was a case review undertaken because a very young child experienced significant injuries and criminal proceedings are ongoing. A significant feature of the review was understanding why agencies were unaware of the potential risk that father posed to this child. Most of the agencies working with the family were unaware that father had a significant history of violence and substance misuse whilst he was an adolescent. Those agencies who were aware of father's background did not make any links between these behaviours, his abusive experiences as a child and the possible impact of these upon his ability to provide safe and effective parenting. Information sharing was limited because key professionals did not identify the potential risk he posed. This was exacerbated by the limited assessments that are done of fathers during the antenatal period and was affected by the family moving out of area.

6.2 The second significant area of learning was with regard to the inter-agency child protection assessment and intervention processes. The review identified that there are some aspects of joint working, out of hours, which need improvement and that mutual professional understanding of the nature of differential diagnosis needs to be strengthened. The review also highlighted the importance of balancing the safeguarding of a child with a criminal investigation.

6.3 This review has identified a number of factors which affected the work of the professional safeguarding children network with Liam. It has analysed the judgments and actions of those involved in the case, and the reasons for these. It has also explored what this case has told us about weaknesses and vulnerabilities in the multi-agency child protection system. In a 'systems' case review, the individual case acts as a window on the local systems, so that broader learning can emerge. Through this case, nine priority findings have been identified, relating to:

- Professional understanding of their safeguarding responsibilities with regard to all children even if their primary responsibilities are to a different client group;
- Midwifery assessment processes which should record social information on both parents;
- The organisation of duty systems which need to be managed to enable the service to meet the same minimum standards as for allocated work;
- The IT system in West Sussex which needs to be adapted to enable effective case transfer summaries that are signed down by managers and easily accessed by workers;
- The Probation data management systems which need to be configured so as to provide managers with useful data to assist them in managing individual workers caseloads;
- Effective use of the leaving care grant which requires that social workers provide sufficient oversight of public money whilst still enabling care-leavers a degree of independence;
- The need for staff within co-located settings to ensure that good working practices do not result in relaxation of professional responsibilities regarding recording information and data sharing;
- The nature of out of hours social work intervention where there are child protection concerns relating to children in hospital;
- How agencies work together when there is medical uncertainty because of differential diagnoses.

Appendix 1 – Methodology

1. This SCR has used the SCIE Learning Together model for case reviews. This is a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance in the 2013 revision of *Working Together to Safeguard Children* (2013) now requires all SCRs to adopt a systems methodology.

2 The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3 Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4 The basic principles – the 'methodological heart' – of the Learning Together model are described in summary form below:

- **a.** **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?
- **b.** **Provide adequate explanations** – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
- **c.** **Move from individual instance to the general significance** – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.
- **d.** **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.
- **e.** **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

5 Typology of underlying patterns

5.1 To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection systems are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

They are presented in six broad categories of underlying issues:

1. Multi-agency working in response to incidents and crises
2. Multi-agency working in longer term work
3. Human reasoning: cognitive and emotional biases

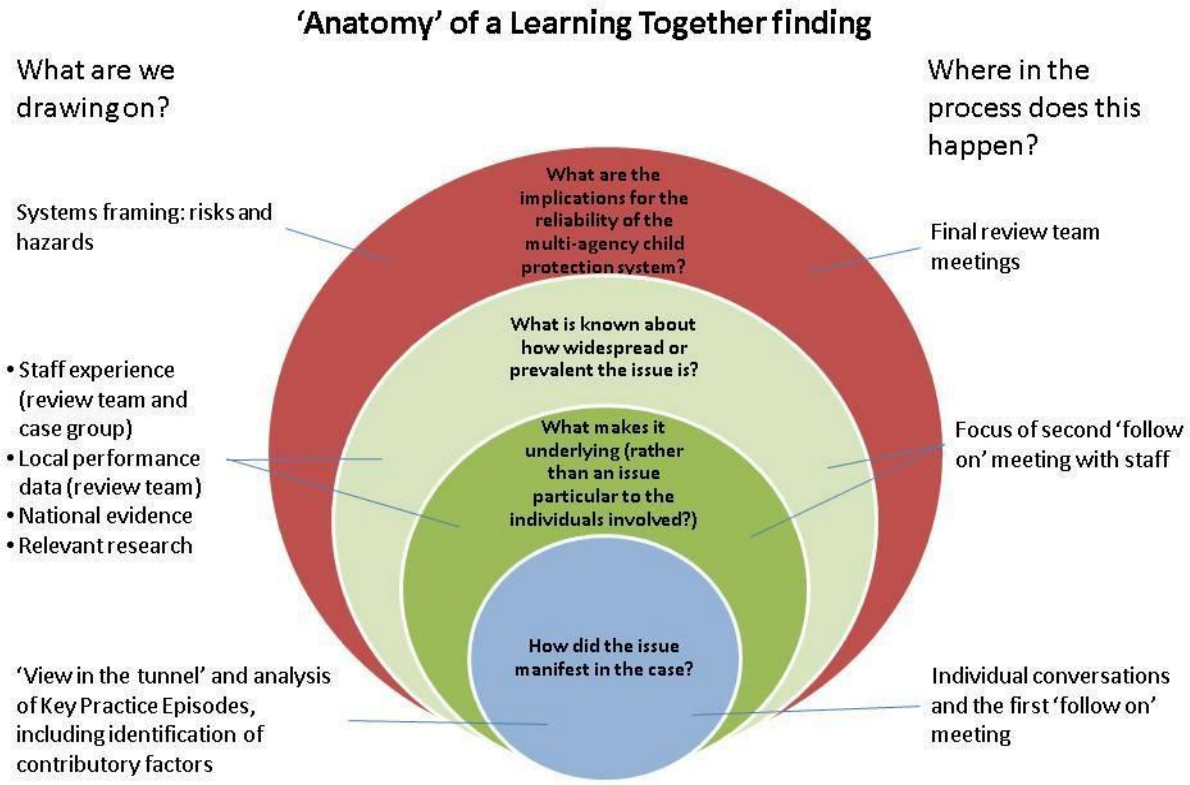
4. Family – Professional interaction
5. Tools
6. Management systems

Each finding is listed under the appropriate category, although some could potentially fit under more than one category.

6 Anatomy of a finding

For each finding, the report is structured to present a clear account of: -

- How the issue manifests itself in the particular case
- In what way it is an underlying issue – not a quirk of the particular individuals involved this time and in the particular constellation of the case?
- What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
- How the issue is usefully framed for the LSCB to consider relative to their aims and responsibilities, the risk and reliability of multi-agency systems. This is illustrated in the Anatomy of a Learning Together Finding (below).



7 Review Team and Case Group

7.1 The review team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by two independent lead reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about

general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints and changes in structure. The review team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

Review Team Members
Fiona Johnson, SCIE Independent Lead reviewer
Deb Austin, Head of Safeguarding Brighton & Hove City Council & Lead Reviewer
Debi Fillery, Named Nurse, Brighton & Sussex University Hospitals NHS Trust
Caroline Reid, Quality Assurance Programme Manager, Brighton & Hove City Council
Eddie Hick, Child Protection & Safeguarding Manager Sussex Police
Jamie Carter, Designated Doctor Brighton & Hove CCG
Kerrin Page, Director of Offender Management (Brighton & West Sussex) Kent Surry & Sussex Community Rehabilitation Company
Sam Bushby, Head of Safeguarding West Sussex County Council
Yvette Queffurus, Named Nurse Sussex Community Trust

7.2 The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.

In this case review, the Review Team carried out individual conversations with 17 case group professionals, and up to 19 professionals were invited to attend the case group meetings which discussed the practice in this case and agreed the findings.

7.3 Structure of the review process

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

The review team form the 'engine' of the process, working in collaboration with case group members who are involved singly in conversations, and then in multi-agency 'Follow-on' meetings. The sequence of events in this review is shown below:

Date	**Event**
28.03.14	Introductory meeting for the Review Team
09.05.14	Introductory meeting for the Case Group – to explain the Learning Together model/method, and the case review process which they will be part of.

12.05.14 13.05.14 15.05.14	Three days' conversations with members of the Case Group (individual sessions of about 1.5 hours with each member of the Case Group; normally conducted by two members of the Review Team)
05.06.14	First Review Team analysis meeting
16.06.14	Second Review Team analysis meeting
30.06.14	First Follow-on meeting (Review Team and Case Group) In this meeting, the group works together on • identifying Key Practice Episodes (KPEs) in the case which affected how the case was handled and/or the outcome of the case • appraising the practice in these KPEs • considering what was affecting the work/workers at the time (the 'view from the tunnel')
07.07.14	Third Review Team analysis meeting
14.07.14	Fourth Review Team analysis meeting
31.07.14	Second Follow-on meeting (Review Team and Case Group) At this meeting, the group were provided with a draft report which sets out the emerging underlying patterns and findings, and were asked to consider whether these are specific to this individual case or pertain more widely and form a pattern.
15.08.14	Fifth Review Team meeting – to consider the draft final report
18.11.14	SCR Sub-Group meeting – to consider the draft final report
24.11.14	LSCB meeting – to consider the draft final report
21.10.15	Final report, fit for publication, to be submitted to Department for Education (DfE)

7.4 Scope and terms of reference

Taking a systems approach encourages reviewers to begin with an open enquiry rather
than a pre-determined set of questions from terms of reference, such as in a traditional
SCR. This enables the data to lead to the key issues to be explored.

7.5 Sources of data

7.5.1 Data from practitioners

- Conversations, as described above, with members of the Case Group; these were recorded and discussed by the whole Review Team.
- Members of the Case Group have also helpfully responded to follow-up queries and requests from the Lead Reviewers and the Review Team for clarification or further information, where this has been needed.

7.5.2 View from the Tunnel and Contributory Factors

The data from the conversations with the Case Group translates into their 'view from the tunnel' which enabled us as reviewers to capture the optimum learning from the case. Case Group members are also an invaluable source of information about the why questions – an exploration of the Contributory Factors which were affecting their practice and decisions at the time.

7.5.3 Participation

The Lead Reviewers and the Review Team are grateful for the willingness of the professionals to reflect on their own work, and to engage so openly and thoughtfully in this SCR. Everyone has contributed very fully in the process. Individual practitioners all have participated responsively in conversations, which have recalled their role in this story, and in group discussions which have at times been very difficult and challenging. All this has given the Review Team a deeper and richer understanding of what happened with this family and within the safeguarding network, and has allowed us to capture the learning which is presented in this report.

7.5.4 Data from documentation

The Lead Reviewers and members of the Review Team reviewed the following documentation:

Brighton & Hove Children's Services records
West Sussex Children's Services records
Midwifery notes
Hospital records
Probation records
Police records

7.5.5 Data from family, friends and community

As in traditional SCRs, the Learning Together model aims to include the views and

perspectives of family members as a valuable element in understanding the case and the work of agencies. Whilst it is regrettable that this was not possible to approach family members to be involved in this review due to the criminal process, the father and maternal grandmother shared their views following the conclusion of the criminal proceedings.

Appendix 2 – Glossary of Terms & Abbreviations

ACAS	Advice Contact & Assessment Service – Brighton & Hove Children's Services social work access point.
Carefirst	IT data base used by children's social work in Brighton & Hove – hospital staff refer to making a Carefirst check to see if a child is known to CSC
CPT	Child Protection Team (Police)
CSC	Children's Social Care
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment
EDS	Emergency Duty Service providing emergency out of hours social work service to Brighton & Hove and East Sussex
Framework i	IT data base used by West Sussex Children's Social Care
LCG	Leaving Care Grant
LSCB	Local Safeguarding Children Board
NOMS	National Offender Management Service
OM	Offender Manager
OLAC	Older Looked After Children
Pathway Plan	The Children (Leaving Care) Act 2000 requires that a Pathway Plan is developed for all care –leavers. The Pathway Plan fulfils the requirements both for assessing the young person's needs and planning services and must be reviewed every six months.
s.47 enquiry / Section 47 enquiry /child protection enquiry	s.47 enquiry refers to section 47 of the Children Act 1989 which gives local authorities the duty to 'make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare' when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm
SCR	Serious case review

TSP	TSP (Thinking Skills Programme) is a general offending behaviour programme designed to strengthen and develop thinking skills that have been linked to the risk of offending. It is an accredited programme that applies cognitive behavioural techniques to address poor problem solving, poor perspective taking, inadequate emotional management and impulsive decision making. The programme consists of 19 sessions in total, divided into 3 modules: Self Control, Problem Solving and Positive Relationships. Each module consists of five group work sessions followed by an individual one-to-one session with a facilitator. TSP is suitable for men and women aged 18 and over, assessed as having a medium or high risk of reconviction. NOMS current commissioning strategy is not to commission TSP for those convicted of robbery and other acquisitive
TM	Team manager

Appendix 3 - Bibliography

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Brighton & Hove Local Safeguarding Children Board

Learning & Improvement Report

Brighton & Hove Safeguarding Children Board Response to 'Baby Liam' Serious Case Review

Agreed by the LSCB on 17 March 2015
Signed off by the Case Review Subcommittee on 8 September 2015
and by the Board on 22 September 2015

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Preface

During the first seven weeks of his life Liam[14] was injured on at least two occasions and experienced fractured ribs, a fractured femur and bilateral skull fractures. Liam has since recovered from his injuries and is currently living with family members and has regular contact with his mother.

As a result of Liam's injuries I requested the Board undertake a Serious Case Review to ascertain lessons from the ways in which agencies had worked singly and together to support Liam and his family. Liam's injuries provided a poignant opportunity to look more closely at our multi-agency child protection arrangements in Brighton & Hove, and afforded West Sussex Local Safeguarding Board a likewise opportunity.

The Review was conducted using the Social Care Institute for Excellence (SCIE) Learning Together systems methodology; a model we have had experience of in Brighton & Hove and is a process which triggers as much change to local practice and culture as the actual findings within the report.

The solutions to the problems the findings identified were not necessarily easy to find. Nonetheless, we have been committed to looking at how best to strengthen our procedure and guidance, knowledge, training and skillset so as Brighton & Hove can become a safer place for children to live and thrive.

Board Members, including colleagues from West Sussex, attended an Extraordinary Meeting of the LSCB on 24th November 2014 to consider the questions the Review raised for both the Board and its partner agencies with implications for commissioners, managers and frontline staff. An action plan was created from this energetic discussion the progress of which is closely monitored by the Case Review Subcommittee.

What is set out within this document is the product of these discussions. What you read here is a concise account of critical points in the management of the case, the Reviews' findings, the Board's response and our planned actions. It has been written to be meaningful and manageable to all professionals across different sectors, professions and agencies and to dispel any perception held that 'this couldn't happen to us'. It is hoped it will also assist policy makers and the public to better understand the complexity of keeping children safe from harm.

Graham Bartlett
Independent Chairperson

[14] Liam is not the real name of the child but is a pseudonym given for the report to ensure that appropriate anonymity is maintained.

Evidence from the Trial
The Review Team was mindful of the parallel process of criminal proceedings, but also keen to involve key family members in the Review. Maternal Grandparents met with Independent Reviewers early into the process so as the process could be explained to them. As Father was awaiting criminal trial Lead Reviewers were counselled to await the conclusion of the trial for direct consultation. Father has since been sentenced having pleaded guilty to causing grievous bodily harm.

After the criminal proceedings ended the Independent Reviewers approached the family again and, whilst Mother did not wish to meet with the lead reviewers, there were two very productive separate meetings with Maternal Grandmother and Father. The family views reinforce what the Review process found. The family's views and experiences are recorded in sections 2.4.3 - 2.4.5 of the report.

Background
Liam was born in 2013. His parents were young and whilst little was known about his mother, there was information about his father which indicated that he could pose a risk to children. Liam's father had previously been looked after by West Sussex County Council and was a care-leaver. Father's childhood history was one of a poor attachment with his mother, with significant direct experience of domestic abuse and parental substance misuse. He had also been violent to peers and had misused alcohol and drugs.

Findings
All findings will be shared with front line staff working with children and families in Brighton & Hove via a Special Bulletin circulated post SCR publication. Findings will be reiterated during *Brighton & Hove LSCB SCR – Learning from Practice* seminars.

Finding	Category
Finding 1 Does the primarily advocacy role adopted by the West Sussex OLAC Team and the lack of understanding of the correlation between maltreatment in childhood and the impact upon them as a parent, mean social workers do not adequately identify the risk that care leavers (male and female) might pose to their own or other children, meaning that they are left without the support they need as parents, and children can go unprotected?	Communication & collaboration in response to incidents
Finding 2 The booking form used by midwives in Brighton & Hove means that social information is mainly sought from the expectant mother rather than both parents, meaning that important information relating to the assessment of risk may not be obtained.	Tools
Finding 3 Is there a pattern in Brighton and Hove and West Sussex that where social work cases are held on a duty system the work becomes task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes?	Management systems
Finding 4 The Framework 'i' IT system in West Sussex does not include the provision for stand–alone case transfer summaries leaving workers and managers without easily accessible case history information on which to assess risk.	Tools

Finding 5 Data management systems within Probation providers across Sussex and Surrey produce data reports that give an overview of performance against indicators but do not provide managers with information about overdue tasks.	Tools
Finding 6 Is there a pattern in West Sussex OLAC Service of a lack of consistently robust oversight of how Leaving Care Grants are spent, leading to potential risks to and from care leavers not being recognised.	Management systems
Finding 7 The benefits of the casual sharing of information between health professionals in Brighton & Hove about joint cases brings the associated risk that they do not share all the relevant information nor regularly record the information in the appropriate case records.	Communication & collaboration in longer term work
Finding 8 The current response by the Children Social Care's Emergency Duty Service to notification from a hospital of a possible non-accidental injury to a child who is admitted to hospital, results in a delay to the police being informed compared with the in-hours response, potentially jeopardising the child protection investigation and police inquiries.	Communication & collaboration in response to incidents
Finding 9 Is there a pattern in Brighton & Hove that the current approach of the police in cases of possible non-accidental injury does not accommodate the process of differential diagnosis by health professionals, and hinders timely social work action to address immediate risks to a child?	Communication & collaboration in response to incidents

Finding 1

Does the primarily advocacy role adopted by the West Sussex OLAC (Older Looked After Children) Team and the lack of understanding of the correlation between maltreatment in childhood and as a parent, mean social workers do not adequately identify the risk that care leavers (male and female) might pose to their own or other children, meaning that they are left without the support they need as parents, and children can go unprotected? (communication & collaboration in response to incidents)

Board Response

As a result of this Review the Board recognised that it did not have sufficient knowledge of the care leaving process or know enough about the support provided to care leavers who are going to become parents in Brighton & Hove.

We learnt from the Review into this case that considerations to the safeguarding needs of Liam were not paramount. The sole focus was on his father as the client. Whilst the West Sussex social worker had a full awareness of father's history and his experiences of maltreatment during adolescence, no link was made to how these experiences of being parented may impact upon his ability to parent. In this case clear risk factors were not recognised, namely father's extensive history of substance misuse, violent and volatile behaviour, and poor relationship with and disorganised attachment to his mother. Whilst this finding is directed towards the West Sussex OLAC team, the Board fully embraced the opportunity to make sure this wasn't an underlying issue in Brighton & Hove as well. Board Responses and action plans are in place in both areas, overseen by respective Case Review Subcommittees.

The Independent Chairperson, Brighton & Hove LSCB has formally shared findings relating to West Sussex social work practice with the Independent Chairperson, West Sussex SCB.

Outcomes

As a result of the actions below the Board has been assured that care leavers in Brighton & Hove who are, or who become parents, are supported and that their children's safeguarding needs are met.

West Sussex SCB are addressing the finding in relation to practice in West Sussex. This is evidenced in the West Sussex Safeguarding Children Board response to this serious case review.

Agreed Actions

1a) Board has commissioned Monitoring & Evaluation Subcommittee to undertake a multi-agency audit on young parents who are care leavers. This should include input and feedback from care leavers in Brighton & Hove, with involvement from the Care Council, and be supplemented by quantitative and qualitative data, as far as is practicable.

The outcome from this audit will be shared with the Corporate Parenting Board.

Learning at Brighton & Hove LSCB is supported by Quality Assurance activity.

Timescale: Quarter 2 2015/16 LSCB Multi-Agency Quality Assurance Programme
Lead: Chair, Monitoring & Evaluation Subcommittee

1b) Brighton & Hove LSCB Independent Chairperson has written to West Sussex SCB Independent Chairperson to share this finding related to West Sussex social work practice. **Timescale:** December 2014 **Completed** **Lead:** Brighton & Hove LSCB Independent Chairperson
1c) Heads of Safeguarding, Chairs and Business Managers of Brighton & Hove and West Sussex LSCBs have met to discuss finding more fully. **Timescale**: January 2015 **Completed** **Lead(s):** Heads of Safeguarding /ADs Brighton & Hove and West Sussex, Chairs & Business Managers Brighton & Hove LSCB and West Sussex SCB

Finding 2

The booking form used by midwives in Brighton & Hove means that social information is mainly sought from the expectant mother rather than both parents, meaning that important information relating to the assessment of risk may not be obtained. (tools)

Board Response

The Board was already aware, from initial findings from an ongoing SCIE Themed Review on young parents and domestic violence [which looked at the quality and timeliness of pre-birth assessments], that maternity booking forms are based on national models and ask general demographic information in relation to both parents. However, as this case highlighted, the local protocol and booking form did not require that partners were asked about their social history or background. Board asked for assurance from the local hospital that this finding has been taken into consideration when reviewing their booking form and processes.

We know that booking information is a vital part of risk assessment and care planning for families and their unborn babies. If a full and detailed history is not taken from both parents then it follows that the risk assessment and decision making will be compromised.

Maternity services in Brighton & Hove have updated their documentation to reflect this recommendation to improve the amount of information available to the maternity service. Board are assured that Information is sought about the identity and address of fathers of children who attend the children's hospital. Since this Review the antenatal booking form has been enhanced to include more basic information about parents. Handheld notes now include booking social information which also increases the amount of information known about both parents. The name and demographic details of the father are documented in a separate section additional to this new information.

As Midwives need other professionals to share information with them if they know their client is pregnant or has a pregnant partner, the Board asked for assurance that effective multi-agency information sharing systems are in place across *all* agencies to share this information. At its meeting in March 2015 statutory Board agencies were tasked with advising on how they are assured that their agency is considering

fathers, partners (male and female) and other significant adults (male and female) in the family when gathering family information as well as in all assessments addressing the needs and welfare of children and young people. The Case Review Subcommittee has received assurances that practitioners in partner agencies have been reminded of the importance of sharing information about pregnant women and their partners with Midwifery and Health Visiting teams so as to enable effective risk assessment.

Outcomes
As a result of the actions below children will be better safeguarded because social information about both parents is obtained, and shared, to inform assessments of risk.

Agreed Actions
2a) Brighton & Sussex University Hospitals (BSUH) Trust to reassure Board that midwifery booking assessments are robust and include specific social information regarding both parents and significant others. **Timescale:** March 2015 **Completed** **Lead**: Chief Nurse, BSUH
b) LSCB, in its next request to statutory agencies for an update on Red and Ambers areas of the Section 11, to ask an additional question of all statutory partners: *What specific guidance does your organisation have for practitioners to consider fathers, partners (male and female) and other significant adults (male and female) in the family when **gathering family information** as well as **in all assessments** addressing the needs and welfare of children and young people.* **Timescale:** March 2015 **Completed** **Lead:** Brighton & Hove LSCB Independent Chairperson & Business Manager
c) Specific question about gathering family information to be added to the next Pan Sussex Section 11 Audit. **Timescale:** April 2016 **Lead:** Brighton & Hove LSCB Independent Chairperson & Business Manager
d) Reminder of Practice All members of the SCR Subcommittee have remind practitioners in their agencies to share information about pregnant women and their partners with Midwifery and Health Visiting teams to enable effective risk assessment. Reminder for practice has been included in LSCB Safeguarding Newsletter. **Timescale:** February 2015 **Completed** **Lead:** Statuary Agencies via SCR Subcommittee

Finding 3

Is there a pattern in Brighton & Hove and West Sussex that where social work cases are held on a duty system the work becomes task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes? (management systems).

Board Response

The Board is not confident that effective management systems are in place which ensures appropriate oversight of cases held on a duty system in Brighton & Hove. This is because the number of cases held on duty, how unallocated work is prioritised and how long cases have been held on duty has not been routinely reported to the Board.

The Board also need to be confident that information sharing between agencies, where there is no allocated worker, is robust.

The Board has commissioned Monitoring & Evaluation Subcommittee to audit cases on duty. This will be a multi-agency audit.

When the west Sussex social worker in the OLAC team left it was not possible to immediately allocate all of her caseload and so the manager prioritised allocation of current looked after children meaning some of the workload was held unallocated, with urgent tasks being picked up by duty workers. Liam's father's Pathway Plan was reviewed during the period his case was held on the duty system. It was completed as a paper exercise, following a single telephone conversation with father, in order to meet statutory timescales. The impact of holding the case on duty meant that the response given by social workers to Liam's father when he contacted the service was limited, task orientated and lacked consideration of his current situation, support needs or potential risk to the unborn child.

The Independent Chairperson, Brighton & Hove LSCB has formally shared this Finding regarding managing unallocated work held on duty with the Independent Chairperson, West Sussex SCB.

Outcomes

As a result of the actions below children and young people held on duty systems will be more effectively safeguarded.

West Sussex SCB are addressing the finding in relation to practice in West Sussex. This is evidenced in the West Sussex Safeguarding Children Board response to this serious case review.

Agreed Actions

3a) Children's Social Work to provide Board with a report that:

- Details of how many cases are held on duty systems. Detailed by type of case (CIN, CP, LAC, Care Leaver)
- Gives and overview of duty management oversight and how unallocated work is prioritised and how long cases have been held on duty.
- Describes the management of individual cases and sharing of information between agencies

Timescales: June 2015 Board **Completed**
Lead: Head of Safeguarding

b) Board has commissioned Monitoring & Evaluation Subcommittee to audit cases on duty. This will be a multi-agency audit. Learning at Brighton & Hove LSCB is supported by Quality Assurance activity. **Timescale**: Quarter 3 15/16 LSCB Multi-Agency Quality Assurance Programme **Lead**: Chair, Monitoring & Evaluation Subcommittee
c) Position statement, commentary and action regarding cases that don't have an allocated social worker to be included in the Brighton & Hove LSCB Management Information Report presented quarterly to Monitoring & Evaluation Subcommittee and Board. **Timescale:** December 2015 Board **Completed** **Lead**: Performance Analyst - Social Care Children's Services
d) Brighton & Hove Independent Chairperson to write formally to West Sussex SCB Chair to notify him of this finding concerning management of unallocated work held on duty **Timescale:** December 2014 **Completed** **Lead:** Brighton & Hove LSCB Independent Chairperson

Finding 4

The Framework 'I' IT system in West Sussex does not include the provision for stand-alone case transfer summaries leaving workers and managers without easily accessible case history information on which to assess risk (tools)

Board Response

The Board acknowledge that the point of case transfer is a time of increased risk and that safe transfers are an important part of a safe child protection process and that in this did not happen in this case.

The Board is assured this Finding is not a problem within Brighton & Hove because the CareFirst IT system has a specific, standalone case transfer record that requires management sign-off.

The Review highlights there was a gap before the West Sussex social worker post could be filled, some of her case-load, including Liam's father, was held unallocated, with urgent work being undertaken by a duty social worker. The social worker had completed a case summary which detailed that Liam's mother was pregnant, that Liam's father was reported to be verbally abusive to her and his mother and that he could have volatile mood swings. This summary was recorded within the case records on the electronic system meaning that it was not easily accessible to either the manager of the service or the duty social workers. Further investigations revealed that unlike most other reports, the case summary did not require management sign off due to the way it was created – as a case record sheet entry. This does not promote managers quality assuring the content and does not leave an audit trail to show that the manager was aware of the content and had ensured it had contained the information required.

The Independent Chairperson, Brighton & Hove LSCB has formally shared this Finding about issues concerning the Framework 'i' IT system with the Independent Chairperson, West Sussex SCB.

Outcomes
West Sussex SCB are addressing the finding in relation to practice in West Sussex. This is evidenced in the West Sussex Safeguarding Children Board response to this serious case review

Agreed Action
4a) Brighton & Hove Independent Chairperson to write formally to West Sussex Chair to notify him of this finding concerning issues related to Framework 'I' IT System. **Timescale:** December 2014 **Completed** **Lead:** Brighton & Hove LSCB Independent Chairperson

Finding 5

Data management systems within Probation providers across Sussex and Surrey produce data reports that give an overview of performance against indicators but do not provide managers with information about overdue tasks (management systems).[15]

Board Response

The Board recognise that the data management systems in Probation Provider Services did not support frontline managers in their daily management tasks as there is no alert system for overdue work. The Review indicates that management oversight was lacking.

Probation Provider Services have since confirmed that officer diaries within the case management system are personalised to each individual offender manager and details incoming work, overdue tasks and appointments for each offender manager. In addition to this, the Business Intelligence Team now routinely monitor data quality, incoming and overdue work and provide managers with this information on a weekly and monthly basis. Examples of the reports that are provided include due terminations, initial sentence plans, expected release from custody dates and pending transfers, all of which will be provided at team level and identify the relevant offender managers. These reports act as a check and balance and enable managers to proactively manage their staff who may not be effectively managing their own work to ensure timely completion of the tasks required. From the National Probation Services point of view they have retained the ability to obtain reports on outstanding pieces of work so as offender managers can be held to account.

The Board was urged to consider whether other partner agencies' data management systems support managers in safeguarding children and we were not able to confidently answer this question. We accept we have not been as curious about this as we could have been. Agencies were not able to provide the necessary assurances about data management systems and subsequent management oversight during table discussion at the March LSCB meeting. Further consideration has been forward planned to the LSCB Board Meeting in December 2015.

[15] In June 2014 the 35 probation trusts in England and Wales were replaced by 21 community rehabilitation companies (CRCs).

Outcomes
The Board is aware of how agencies use data to better improve safeguarding outcomes for children accessing their services and Managers are better supported to provide effective oversight.

Agreed Actions
5a) Probation have provided a report to the Board that assures that data management systems are now in place in support front line managers to have oversight of overdue tasks. **Timescale:** February 2015 **Completed** **Lead:** Director of Operations, Kent Surrey & Sussex Community Rehabilitation Company
b) LSCB, in its next request to statutory agencies for an update on Red and Ambers areas of the Section 11, to ask an additional question of all statutory partners about how their data management systems support managers in safeguarding children. **Timescale:** March 2015 **Completed** **Lead:** Brighton & Hove LSCB Independent Chairperson & Business Manager
c) Additional question about how agencies data management systems support managers to safeguard children to be added to next full Section 11 audit. **Timescale:** April 2016 **Lead:** Brighton & Hove LSCB Independent Chairperson & Business Manager / All Statutory Agencies to complete

Finding 6

Is there a pattern in West Sussex of a lack of consistently robust oversight of how Leaving Care Grants are spent, leading to potential risks to and from care leavers not being recognised (management systems)

Board Response

The Board were initially unable to identify the connection with this Finding and safeguarding, as on the surface it seems to be around the management of the leaving care grant. On reflection it was felt that this issue was more about the young person's experience, and the degree to which they feel supported by the assistance offered when leaving care.

Liam's father, who we know was a care leaver, had requested monies from his Leaving Care Grant and was given £600 over a two month period in payments of £250 and £350. This money was provided to the father via the mechanism of a P card (a form of debit card, where specified amounts of money to agreed limits are placed on the card specific to each client and replaced the 'petty cash' system. The father reported it was to purchase essential items for his flat, however there was no checking mechanism to ensure oversight that this was what the monies had been spent on. The review team were concerned that given his history of substance misuse, he could have spent the money on alcohol and/or drugs, resulting in risk to himself or others.

Whilst this Finding is more directed towards West Sussex the Board required clarification about the administration of the Leaving Care Grants in Brighton & Hove and more importantly assurance that their use enables positive outcomes for care leavers. Head of Service has confirmed BHCC provide a Setting Up Allowance for young people leaving care which is currently up to a maximum of £2100 (2014-15 level) and is increased annually in line with the Consumer Price Index. In order to access funds, the young person and their Social Worker or Personal Adviser will identify and cost what items they will need for their own accommodation. These will then be purchased by either the Social Worker /Personal Advisor, foster or supported lodgings carer or supported housing keyworker together with the young person. Funds will never be made available directly to the young person for them to spend. Some items, particularly furniture and white goods are often ordered online by the Admin Team to be delivered directly to the young person's address. Receipts are obtained for every item purchased both for audit purposes and the reclaim of VAT. The Admin Team also maintain a spreadsheet which details the expenditure on each young person's Setting Up Allowance. This provides up to date information on current spend and what amount is still available.

Outcomes
As a result of the action below Brighton & Hove LSCB is aware and can therefore better challenge if necessary how care leavers in Brighton & Hove are supported to transition into independent living.

West Sussex SCB are addressing the finding in relation to practice in West Sussex. This is evidenced in the West Sussex Safeguarding Children Board response to this serious case review

Agreed Actions
6a) Board has written to Head of Service – Support Through Care, who has clarified administration of LCGs, particularly how they enable positive outcomes for care leavers and confirmed that robust and auditable scrutiny of expenditure is in place. **Timescale**: January 2015 - **Completed**. **Lead**: Brighton & Hove LSCB Independent Chairperson & Head of Service – Support Through Care
b) Brighton & Hove LSCB Independent Chairperson to write formally to West Sussex SCB Independent Chairperson to share findings from this review related to West Sussex social work practice. **Timescale:** December 2014 **Completed** **Lead:** Brighton & Hove LSCB Independent Chairperson

Finding 7

Health staff in Brighton & Hove who are co-located or who have a close professional working relationship may share some information about joint cases on a casual basis but the risk is that they may not share all the relevant information nor always record the information in the appropriate case records. (communication & collaboration)

Board Response

The Board want to make clear its view that unplanned conversations are good practice and aid effective and timely safeguarding. It is our view that collaborative multi-agency working is improved by co-location and close working.

That said, we acknowledge that sharing information on a casual basis that is then not appropriately recorded could be a risk across all agencies and not just for our Health colleagues as highlighted within this Review. We therefore want assurance across the partnership that unplanned conversations which result in 'relevant information' being shared are routinely documented. For this purpose 'relevant information' means information that is either; new, influences decision making or results in an action. The Board expects clear messages from Senior Management, and for questions to be asked in supervision or management oversight sessions, that reinforce that all significant discussions that influence decision making are recorded.

The issue that the Review raises, where the Health Visitor fortuitously came across information about a domestic abuse incident from the Midwife during an unplanned conversation (which was then not documented by either professional) because they are co-located, is a potential problem with any co-location of services, but particularly pertinent to us in Brighton & Hove due to the recent development of our Multi Agency Safeguarding Hub.

The Board will want to ensure that multi-agency audit activity tracks how information comes into an agency and how this information is shared and recorded. The Board will want to be further assured that all statutory agencies have a clear and robust recording policy in place which supports staff to maintain an accurate and clear record of their involvement with a child and family – including any relevant information obtained from unplanned conversations.

Outcome
As a result of the below actions children will be more effectively safeguarded because agencies will make sure there is a full, up-to-date record and audit trail of why interventions have taken place; the purpose of each step taken; the decisions made and the resulting action.

Agreed Actions
7a) LSCB multi-agency training Developing a Core Understanding to make explicit expectations about record keeping as a result of this Review. **Timescale**: December 2014 **Completed** **Lead**: Brighton & Hove LSCB Business Manager
b) Reminder of Practice Board and all statuary agencies have reminded staff that it is good practice to have unplanned conversations and that accurate record keeping, is an integral and important part of safeguarding practice. All members of the SCR Subcommittee have highlighted this finding within their own agencies. Reminder for practice has been included in LSCB Safeguarding Newsletter. **Timescale**: February 2015 **Completed** **Lead:** Statuary Agencies via SCR Subcommittee

c) Managers across the Partnership to reinforce via supervision / management processes that all conversations that impact on decision making are appropriately recorded.

All members of the SCR Subcommittee have highlighted this finding within their own agencies.

Reminder for practice has been included in LSCB Safeguarding Newsletter.

Timescale: February 2015 **Completed**
Lead: Statuary Agencies via SCR Subcommittee

Finding 8

The current response by the Children Social Care's Emergency Duty Service (EDS) to notification from a hospital of a possible non-accidental injury to a child who is admitted to hospital, results in a delay to the police being informed compared with the in-hours response, potentially jeopardising the child protection investigation and police inquiries. (response to incidents).

Board Response

The Board are aware of the problems highlighted by this Finding as it reiterates a similar Finding from a recent Brighton & Hove Learning Review. We acknowledge that this Review reiterates that the current EDS does not function as well as we want it to.

When Liam's parents bought him to the local hospital with his injuries a 'Carefirst check' was carried out to see if Liam was known, by contacting the EDS and were told about the previous domestic abuse incident in Brighton. The nurse did not provide the EDS worker with any information about Liam's injuries at this point. The hospital staff treated Liam for the head injuries and he was admitted as an inpatient to the hospital. Later that evening after further investigative interventions, EDS were again contacted and, in accordance with local safeguarding procedures, told that Liam's injuries might be non-accidental. EDS staff noted the information but took no further action as they considered that Liam was safe in hospital**.**

The Review tells us that during normal working hours social workers take responsibility for contacting the police and initiating strategy discussions. Out of hours the hospital staff assume that the EDS workers would take the same actions. What we learn from the Review is that in reality the staffing ratios for EDS mean that unless there is an immediate risk to the child EDS will probably defer this to the day staff, leading to delay in the police being informed.

As a result of this Finding we requested Children's Services commission a comprehensive review of the EDS system. From this review the EDS Manager now ensures that all possible non accidental injuries are referred to the police. This provides clarity and consistency with the requirements of the Pan Sussex procedures.

The difficulty around balancing uncertainty (from a health perspective) and the need for definites (from a police perspective) when there is a differential diagnosis is explored more fully in Finding 9.

Outcomes
As a result of the below actions child protection investigations and police inquiries are timely in and out of Children's Social Work hours.

Agreed Actions
8a) Executive Director of Children's Services to commission a formal review of EDS provision. **Timescale:** March 2015 **Completed** **Lead:** Executive Director, Children's Services, Brighton & Hove City Council
b) Reminder of Practice All Health staff to be reminded to follow the Pan Sussex Procedures in cases where Non Accidental Injury is suspected. **Timescale**: February 2015 **Completed** **Leads**: Designated Doctor and Designated Nurse Brighton & Hove Clinical Commissioning Group, via Health Advisory Group.

Finding 9

Is there a pattern in Brighton & Hove that the current approach of the police in cases of possible non-accidental injury does not accommodate the process of differential diagnosis by health professionals, and hinders timely social work action to address immediate risks to a child? (communication & collaboration in response to incidents).

Board Response

The Board's resounding view is that safeguarding needs to be at the top of the agenda and that we must look closely at our systems and ensure that the pathway for cases like Liam's, where the diagnosis was very differential, are managed in a consistent way, with a clear relationship between Health, Police and Children's Services.

This was a clear failing in this case, resulting in Liam being left in a potential unsafe situation for a further 24 hours. The Review shows us how this came about, when following the scheduled skeletal survey, further injuries to Liam were identified – namely healing rib fractures. The paediatrician reported a number of possible causes for the injuries but said that they were probably non-accidental. This led to the police requesting an updated written medical report which clearly detailed the injuries could not have been caused accidentally. The police indicated that they would not arrest the parents before this report was received and asked that no-one liaise with the parents about the medical report until after their arrest in order to maintain the integrity of the police investigation. The timescales attributed to the newly identified healing injuries covered a period when Liam had been in his father's, his mother's and his maternal grandmother's sole care, thereby identifying them all as possible perpetrators. The social worker was asked not to share this information with the family which prevented her from changing the care arrangements for Liam.

Whilst the situation in such cases where possible non-accidental injury is suspected is problematic, the Board agree that it is precisely these cases which reinforce that it is everyone's responsibility to ensure that safeguarding is considered by all professionals involved.

The Board requested a joint agency meeting (Paediatrician, Children's Services, Police and Legal Services) to discuss the interface of differential diagnosis, child protection investigations and criminal proceedings. At the conclusion of this meeting all were in agreement that the current pathway as set out under the pan Sussex Child Protection & Safeguarding procedures is clear and fit for purpose. Finding 9 exemplified a specific set of circumstances when procedures weren't followed (the need for a written report from medics) rather than be indicative that procedures weren't clear. Staff working in Accident & Emergency Departments in local hospitals have been reminded of expectations to follow the pan Sussex Procedures *Section 8.36* Pan Sussex Procedure - Unexplained Injuries to Young Children

Outcomes
As a result of the below actions children are more effectively safeguarded because social work action is enabled to be timely so as to address immediate risk when a possible non-accidental injury of a child is suspected.

Agreed Actions

9a) Joint agency meeting (Paediatrician, Children's Services, Police and Legal Services) to discuss the interface of differential diagnosis, child protection investigations and criminal proceedings.

Timescale: February 2015 **Completed**
Leads: Designated Doctor, Brighton & Hove Clinical Commissioning Group, Managing Principal Lawyer, Brighton & Hove City Council, Head of Safeguarding, Brighton & Hove City Council and Detective Superintendent, Public Protection Branch, Sussex Police.

Sharing learning from learning reviews and serious case reviews in order to improve safeguarding practice is vital. The Brighton & Hove Safeguarding Children Board is committed to ensuring that learning from reviews is disseminated as widely as possible to professionals across the Partnership.

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West Sussex Safeguarding Children Board

Board Response to Brighton & Hove Serious Case Review - Liam

April 2015

1. Introduction

1.1 This review concerns the services provided to Liam who experienced head injuries, when seven weeks old, whilst in the care of his father. Liam is not the real name of the child but is a pseudonym to ensure anonymity is maintained.

1.2 Both Liam's parents were young and prior to Liam's birth, his mother was not supported by any agency apart from core services such as GP. Liam's father had previously been 'looked after' by West Sussex County Council Care Leaving Service and was a 'care leaver'. He was known to have abused alcohol and drugs and was considered to have a volatile temper and had a criminal history of petty theft with some violence to peers.

1.3 This serious case review was commissioned by Brighton & Hove Safeguarding Children Board because of the serious injuries experienced by Liam during the first seven weeks of his life and Brighton and Hove was the area in which the injuries to Liam occurred. Although Liam survived and is now well, these injuries were life threatening and he could have died. The review involved two local safeguarding children boards and staff from two children's social care departments, two GP practices, two midwifery teams as well as health visiting, police and probation staff. As per guidance when a serious case review is undertaken, one LSCB needs to lead on this and be responsible for the review. West Sussex Safeguarding Children Board fully participated in the review and assisted with the process. The review focussed on safeguarding systems within Brighton & Hove but there are findings which are relevant to West Sussex

1.4 At the time of Liam's birth his parents were living in a privately rented flat in Brighton and both midwifery and health visiting services were involved. His father was the subject of a probation order and he was also receiving support from the West Sussex County Council Care Leaving Service who provided financial assistance in furnishing the flat. The family were also supported by the maternal grandparents who lived in West Sussex. Soon after the birth of Liam the police were called to a domestic abuse incident involving the parents and this information was shared with children's social care who passed the information on to the health visitor.

1.5 During the first seven weeks of his life Liam was injured on at least two occasions and experienced fractured ribs, a fractured femur and bilateral skull fractures. It is thought that Liam's father caused the injuries and a criminal prosecution has resulted in a custodial sentence. There have also been civil care proceedings which concluded that on balance of probability the father caused the injuries. In addition, they concluded that the mother did know enough of the father's aggressive or volatile behaviour to have been able to make a reasonable judgement that he was not a safe sole carer for her new baby and hence did not act with levels of protection deemed reasonable for a mother.

1.6 Liam has recovered from his injuries and is currently living with his maternal grandparents and has regular contact with his mother.

1.7 This case has highlighted the challenges in working with young parents and identified the importance of effective assessment processes that highlight additional supports that may be needed where there are specific vulnerabilities such as having been previously 'looked after'. This is especially true when assessing fathers, as many agency procedures are insufficiently robust in their approach to men. It has also identified some areas for improvement around multi-agency working out of hours particularly when responding to complex medical conditions that may have differential diagnoses.

1.8 The case was additionally perceived to shed light and address the following questions:

- How effective cross border working relationships are for vulnerable children and children in need?
- How do agencies work together when a child presents with a serious injury and a different diagnosis is adopted?
- How effective are systems for assessment of young parents where there are vulnerabilities such as having been previously in care?
- How effective are assessments of fathers?

1.9 Statutory guidance[16] requires SCRs to be conducted in such in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings

1.10 In order to comply with these requirements Brighton & Hove Safeguarding Children Board has used the SCIE Learning Together systems model[17]. This approach endeavours to understand professional practice in context, identifying the factors in the system that influence the nature and quality of work with families and make it more or less likely that the quality of practice will be good or poor.

1.11 West Sussex Safeguarding Children Board met in April 2015 to review the full report from Brighton & Hove when it fully accepted the findings outlined in Chapter 4 of the Report. The Report was formally signed off in conjunction with Brighton & Hove following the conclusion of the criminal trial and consultation with the family completed.

1.12 West Sussex Safeguarding Children Board has implemented an action plan based on the serious case review findings relating to West Sussex. The plan incorporates actions already taken as a result of the learning and identifies actions required to strengthen practice by all agencies in West Sussex. This action plan and updates have been shared with Brighton & Hove Safeguarding Children Board.

[16] Working Together to Safeguard Children, 2013 Chapter 4
[17] Learning Together, Fish, Munro & Bairstow SCIE 2008

Findings

2. Finding 1

2.1 Does the primarily advocacy role adopted by the West Sussex OLAC team and the lack of understanding of the correlation between maltreatment in childhood and the impact upon them as a parent, mean social workers do not adequately identify the risk that care leavers might pose to their own or other children, meaning that they are left without the support they need as parents, and children can go unprotected?

2.2 WSSCB View:

2.21 WSSCB is in the process of ensuring that there is a culture of continuing learning in order to strengthen a consistent safeguarding perspective within the Children Looked After Service. All staff are completing basic safeguarding training as a required standard**.** The impact on practice will be monitored through supervision and audit.

2.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:

2.31 WSSCB is aware that a range of interventions have already taken place to strengthen the safeguarding perspective within the Children Looked After and Young People's Service. All staff and managers are completing refresher safeguarding training and specific training is being commissioned on the potential impact of care experience on parenting capacity. Briefings by the responsible Principal Manager have taken place with all managers and staff within the Children Looked After Service and a similar exercise has taken place in the Young People's Service. The briefings have focused on the findings and learning from this SCR and have reiterated expectations of all staff in relation to safeguarding practice with care leavers. The Young People's Service now have responsibility for delivering a service to Care Leavers.

2.32 Relevant safe-guarding training is now a requirement for all staff and managers.

2.33 Work has been undertaken to establish the safeguarding training requirements for the Young People's Service

2.34 The service has identified all young people who are Looked After and/or care leavers about to become parents and are ensuring each has a pre-birth assessment with good management oversight of each case.

3. Finding 3

3.1 Is there a pattern in Brighton & Hove *and West Sussex that where social work cases are held on a duty system the work becomes task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes? (Management Systems)*

3.2 WSSCB View:

3.21 The Board recognises that within the period examined by the review, the Older Children Looked After Service (OCLA) had a small number of care leavers who were unallocated and managed on duty. Whilst it is recognised within the review that there are always a small number of cases at any one time unallocated and managed

through a duty system the issue in this case was the poor quality of practice when working with cases on duty and the lack of robust management oversight. A review of the duty system has been carried out and improvements instigated. All care leavers have an allocated worker .

3.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:

3.31 An evaluation of the current duty system has been completed to determine any risks.

3.32 Steps have been taken to ensure that pathway plans are not completed on duty. If the rare occasion does occur when this is required then expectations will be clearly specified by the relevant manager including a thorough assessment to be completed involving the young person.

3.33 Instructions have been reinforced to ensure IROs are consistently compliant with the IRO handbook in relation to care leavers eligibility and their expectations of Social Workers. Practice will reflect this.

4. Finding 4

4.1 The Frameworki IT system in West Sussex does not include the provision for stand alone case transfer summaries, leaving workers and managers without easily accessible case history information on which to assess risk.

4.2 WSSCB View:

4.21 The Board recognises that the IT system does not have a separate transfer summary episode record.

4.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:

4.31 A Case summary/case transfer episode has been created in Framework 'I'. This episode has a requirement of 'management sign off'.

5. Finding 6

5.1 *Is there a pattern in West Sussex OLAC Service a lack of consistently robust oversight of how Leaving Care Grants are spent, leading to potential risks to and from care leavers not being recognised? (Management Systems)*

5.2 WSSCB view

5.21 The Board recognises that there was a lack of consistent management oversight in relation to Leaving Care Grants for Care Leavers who were unallocated and managed through the duty system.

5.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:

5.31 Guidance on spending principles for Children Looked After and Care Leavers has been re-written. The revised guidance has been distributed to all managers and staff with clear expectations regarding compliance with this guidance.

5.32 An Audit was undertaken based on a sample of recent spend on Independent Living Grants (ILGs). The findings of the audit concluded that ILG spend on the cases examined was appropriate.