

# Learning Together from Case Reviews

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

This short briefing summarises what a serious case review has shown about the child protection system in Brighton & Hove.

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

### Liam's Story

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.

His Father was a care leaver from another area with history of volatile behaviours & substance misuse.

**Sharing learning** from reviews in order to improve safeguarding practice is vital. Brighton & Hove LSCB want to recognise and learn from good practice that is regularly commented upon in these reviews, as well as any weaknesses.

**If you work with children and families in Brighton and Hove, there may also be additional specific actions and recommendations for your agency and your role. Please ask your manager, or contact your representative on Brighton & Hove Local Safeguarding Children Board, to find out more. You can read the full report at [www.brightonandhovelscb.org.uk/scr-liam](http://www.brightonandhovelscb.org.uk/scr-liam)**

**Finding 1:** Care leavers who are, or who become **parents**, need to be supported and their **children's** safeguarding needs met.


Considerations to the safeguarding needs of Liam were not paramount. The sole focus was on his father as the client. Risk factors for Father - history of substance misuse, violent and volatile behaviour, and poor relationship with and disorganised attachment to his mother- were not recognised. Father's history and his experiences were known but no link was made to how his experiences of being parented may impact upon his ability to parent.



### How do you support your care leavers when they become parents?


**Finding 2:** A full & detailed **history** on fathers, partners (male and female) & other significant adults (male and female) in the family should be sought when **gathering information**. It is also important to share this information about **pregnant women** and their **partners** with **Midwifery** and **Health Visiting** teams so as to enable **effective risk assessment**.

This finding was directed at a local hospital whose local protocol and booking, which is based on a national proforma, did not require that both partners were asked about their social history or background. It follows that risk assessment and decision making will be compromised if a full and detailed history from both parents is not taken.

 **How do you share information about pregnant women and their partners with local Midwifery and Health Visiting teams?**

**Finding 4:** During **case transfers** there needs to be **easily accessible** case history information to **assess risk**

This finding was directed at the West Sussex Older Looked After Children Team. A case summary 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 not easily accessible to either the manager of the service or the duty social workers. This case summary did not require management sign off.

 **Remember case transfer is a time of increased risk and that safe transfers are an important part of a safe child protection process. How do you ensure safe transfer of your cases?**

**Finding 3:** Where cases are held on **duty**, responses to children may be limited / task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes.

This finding was directed at the West Sussex Older Looked After Children Team. When a social worker left it was not possible to immediately allocate all of her caseload meaning Liam's Father was unallocated. His Pathway Plan was reviewed during this period. It was completed as a paper exercise, following a single telephone conversation with him.



**The numbers of cases held on duty systems / unallocated vary across the country. What do you think about the numbers and management of unallocated cases in your team?**

**Finding 5:** **Data systems** need to support frontline managers in their daily management of tasks – including providing alerts for over due work

This finding was directed at Probation Provider Services whose data / performance management systems did not support frontline managers in their daily management tasks as there is no alert system for overdue work. The Review indicated that management oversight was lacking.



**LSCB to consider how data management systems in all partner agencies support managers to safeguard children.**

## **Finding 6:** Leaving Care Grants (LCGs) need oversight to ensure they enable **positive outcomes** for care leavers


This finding was directed at the West Sussex Older Looked After Children Team. Liam's father had requested money from his Leaving Care Grant and was given £600 over a two month period. This money was provided to him via the mechanism of a P card (a form of debit card). He 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. This concerned the Review Team given his history of drug use.

 **How do you make sure LCGs enable positive outcomes for care leavers and what auditable scrutiny of expenditure does your team have in place?**

**Finding 7:** Unplanned/ casual/ **corridor conversations** which impact on decision making need to be **recorded**

In this case 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) . This is a potential problem with any co-location of services, but particularly pertinent to us in Brighton & Hove due to our Multi Agency Safeguarding Hub.


Unplanned conversations which result in 'relevant information' being shared need to be routinely documented. For this purpose 'relevant information' means information that is either; **new, influences decision making or results in an action.**

 **Remember that all significant discussions that influence decision making need to be recorded.**

**Finding 8:** All possible non accidental injuries need to be referred to the police.

When Liam's parents brought him to the local hospital with his injuries the Emergency Duty Service (EDS) were contacted to see if they knew of the family, EDS told hospital staff about the previous domestic abuse incident in Brighton. Later that evening after further investigative interventions and NAI was deemed to be a concern. 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 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.

 **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.**

## **Finding 9:** Staff working in Accident & Emergency Departments in local hospitals need to follow the pan Sussex Procedures Section 8.36 **Pan Sussex Procedure - Unexplained Injuries to Young Children**

This finding 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.

Liam was left in a potential unsafe situation for a further 24 hours. Following a scheduled skeletal survey, further injuries to Liam were identified. 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 situation in such cases where possible non-accidental injury is suspected is problematic - it is precisely these cases which reinforce that it is everyone's responsibility to ensure that safeguarding is considered by all professionals involved.**

**Staff Briefing Sessions:** We will be holding some two hour long briefing sessions for staff from all agencies working in Brighton & Hove to come together and discuss the findings from this review and the implications for practice. These are free to attend, although space is limited, and will run on:

Friday 13<sup>th</sup> November 2015  
Monday 23<sup>rd</sup> November 2015

To find out more and book your place please visit  
[www.brightonandhovelscb.org.uk/event/learning-from-case-reviews](http://www.brightonandhovelscb.org.uk/event/learning-from-case-reviews)

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

We would like to hear your thoughts, feedback and comments on findings presented to you in this briefing and any feedback on the style of the briefing itself, please do contact us at [LSCB@Brighton-Hove.gov.uk](mailto:LSCB@Brighton-Hove.gov.uk) to ensure your voice is heard.