Learning Together from Serious 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.

Child A: Brighton & Hove Safeguarding Children Board have undertaken a Serious Case Review (SCR) regarding Child A. A was subject to a Care Order to Brighton & Hove City Council and had been in care since 2004. He was placed in a residential therapeutic unit in another local authority in 2010 and remained there until his death. In 2016 A's body was found on a railway track in West Sussex. A was 17 years of age. The review covered the period since A entered the residential unit.

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

History:

A had been exposed to significant levels of physical and emotional abuse and neglect in the context of chronic domestic violence in his early childhood. In 2011, A had made allegations of historical sexual abuse by a named family member. A had been placed in a number of foster homes, none of which could contain him, before being placed in a therapeutic unit at the age of 8. After further unsuccessful attempts to find a foster family that could manage his behaviour, he was placed in the another residential unit at the age of 12 and remained there until his death. There had been ongoing concerns about A's sometimes aggressive and denigrating behaviour, his fears and fantasies about his potential for committing sexual offences, and (largely historical) concerns about self-harming. A was also concerned about inheriting his mother's mental health difficulties.

The residential placement in another local authority was appropriate and A had made substantive developmental progress whilst there.

Plans had been formulated during 2015 to transfer A to a foster home, in preparation for independence. If A was in a family before his 18th birthday he would eligible for 'staying put' arrangements (post 18 support). In November 2015, introductions had begun and the proposed moving date was early January 2016. However these plans had created tension between the unit and Brighton & Hove City Council.

Amongst those who knew 'A' well and cared greatly about him, neither professionals nor family had identified that he was thinking about self harm around the time of his death.

Methodology: The Board commissioned the review to be undertaken by an independent consultant using a systems methodology. A Steering Group was formed of senior managers from agencies involved and they met six times with this lead reviewer. The reviewed looked at the quality and timeliness of care planning; the effectiveness of inter-agency co-operation; the extent to which A's voice was heard; his self-harming episodes; issues relating to family contact; his violent and aggressive outbursts and sexualised behaviour; the sufficiency and quality of psychiatric / psychological support; any formally notifiable incidents and any additional issues of relevance.

Front line staff who worked with A were invited to contribute to the review, and two consultation events were held to facilitate this as well as individual interviews. A's mother and A's maternal grandmother participated in the review, and the Lead Reviewer also spoke to the foster carer with whom it had been hoped A would live.

Findings and conclusions

Difference in professional approach:

The review highlighted that there was a significantly different perspective between the therapeutic approach of the unit (inner world) and Brighton & Hove City Council who were concerned with A's age and the need to prepare him for the realities of independence (outer world).

This was played out during 2015. The report notes that both these narratives were legitimate. The possibility of obtaining an expert opinion about the plans to move A on was not considered.

Strengths of Service Delivery

- The care, commitment and skill of staff at his therapeutic placement and the consequent stability those features offered A
- The level of continuity with only 2 allocated workers (SWRO and social worker) and 2 Unit 'link-workers' and 1 IRO across 5 years in placement. (The report noted however that notwithstanding the skills and commitment of the SWRO, such a complex case required a qualified social worker).
- Persistence in efforts by the Unit and BHCC staff to involve both A, his mother and siblings in maintaining contact with one another
- A's high level of involvement in an age appropriate manner in day to day and longer-term planning. A's voice was heard.

Areas for Development: Placements

- There were no pre-placement enquiries by BHCC to determine the availability of relevant local facilities e.g. CAMHS and educational provision. The education offering to A was limited.
- The agreed need for additional therapeutic support was not met for 3 years. The possibility of a multi-disciplinary assessment of risk to self or others was not discussed.

Transition toward greater independence

- A more extended introduction period and detailed review of how A was coping with the transition would have been beneficial.
- There should have been a contingency 'plan B' in case the foster placement did not work out.
- The prospective foster carers were not properly briefed and provided with a written summary of A's background. This meant issues of risk to other vulnerable children who A might come into contact with, and the risk to A himself, could not be properly addressed.
- A did not know what information the carers had been given about him which was a source of anxiety for him.
- Transitions over the Christmas period should be avoided as it is an emotionally charged time

Questions for Professionals:

How confident are you that all the education and health needs, including mental health & emotional wellbeing, of the children you work with are met?

How do you prevent drift?

If a child you are working with has a recognised need that is not being met by another agency how long do you wait and how do you escalate this?

What do you do if you have a difference of opinion with another professional working with a child?
Do you feel able and supported to challenge both colleagues and other agencies?

Do you give the same attention to transition planning and changes for adolescents as you do for younger children?

Do you always make sure there is a contingency plan?

Do you let children know what information is being shared about them, in an age-appropriate way, as a matter of routine?

Does the information you provides as a handover contain a coherent history of the risks the young person is vulnerable too as well as any potential risks they may pose?

How does your service maintain a level of continuity when working with children and their families?

Recommendations

Brighton & Hove City Council should assure itself that with respect to its looked after children:

- All relevant available information is being passed over, in accordance with Care Planning Regulations 2010, to foster carers as part of the matching process.
- The young person should be informed as to what information has been shared
- All Care and Placement Plans (as a priority those recognised to be high risk) include a clear contingency position (a 'plan B' as per para. 2.45 Volume 2 Care Planning, Placement & Case Review Regulations Guidance 2015)

Sussex Partnership NHS Foundation Trust

- In the context of 'Who Pays' Commissioning guidance, the Trust should continue to progress discussions with the relevant 3 authorities (West Sussex, East Sussex and Brighton & Hove) to facilitate access for 'looked after children' to specialist mental health services for those placed 'out of area' and still remaining within Sussex

Therapeutic Unit

- The management team should review the organisational capacity (knowledge and assertiveness) to challenge any Care Plan for a resident, about which the Unit has insufficient confidence

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 the following dates,

- Wednesday 19 July 2017, 1-4pm
- Monday 24 July 2017, 10am-1pm

To find out more and book your place please visit brightonandhovelscb.org.uk/event/child-a

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.