Learning & Improvement Report

Brighton & Hove Local Safeguarding Children Board Response to Child E Serious Case Review

E was a looked after child, living long-term with his maternal aunt and her partner (Family & Friends carers) and their son. In his mid-teens, E became unsettled and at times distressed, and the placement came under increasing pressure, related to his angry defiance at home and risk-taking behaviour elsewhere. At school he continued to achieve well as a compliant and popular pupil.

When E's placement broke down in early autumn 2014 he went into foster care with Brighton & Hove carers in another village. It seemed that E 'engineered' a return home after a few weeks, and at this time was involved in an attack on a friend whom he suspected, with associates, of being involved in a burglary at his family home. E then became very frightened about the danger of reprisals, and insisted that he must be moved out of Brighton immediately.

E was determined to go to stay with his birth father, who at this point was only known to him via social media (though the local authority had met him). The local authority was called upon to approve an emergency, unregulated placement, which involved E going to stay with a close friend and neighbour of his birth father over a week-end, while a foster placement in that area could be found. It was at this person's home, four days later, that he was found to have hanged himself.

As a result of E's death I requested the Board undertake a Serious Case Review (SCR) to ascertain lessons from the ways in which agencies had worked singly and together with E and his family. Throughout this review professionals who had worked with E and his family spoke of a 'cheeky cheerful chappie' and a 'lovely boy'. It was clear that E was much cared for by his family and those supporting him.

Working Together 2015 allows LSCBs to use any learning model consistent with the principles in the guidance. This review was conducted using the Social Care Institute for Excellence (SCIE) Learning Together systems methodology. Sally Trench, an independent person with experience in conducting reviews arising from safeguarding concerns, was commissioned as the lead reviewer. She was supported by a consultant and former member of the Brighton & Hove LSCB, Leighe Rogers. Both have considerable safeguarding experience.

To support the process, a review team consisting of senior managers from involved agencies met 10 times with lead reviewers and were a sounding board, providing necessary context on organisational policies and practice. Frontline staff who worked with E and his family were heavily involved in the review, talking about their experiences and safeguarding practices. Some family members also contributed to the review, sharing their experiences of receiving services during the period focused on in this review. A full evaluation of the process will be undertaken to learn from the experiences of all those involved with this methodology.

The review found that there was learning for agencies involved but that the tragic incident was neither predictable nor preventable.

The Brighton & Hove LSCB has reflected on the lessons arising from this tragedy and will use its' authority and statutory role to make sure these are shared throughout all agencies working with children and young people in the city. This work has already started through a series of learning events and the extensive circulation of a briefing for professionals working with children and families. Actions necessitated from this review will be monitored by the Brighton & Hove LSCB's Case Review Subcommittee with progress reported to the Board.

Graham Bartlett
Independent Chair
Brighton & Hove Local Safeguarding Children Board

Finding 1. There is an inherent tension regarding the respective roles of the local authority as Corporate Parent, and Family and Friends Carers who may be seen as 'parents' or 'family'. This can result in unhelpfully blurred boundaries and a difficulty in asserting the LA's statutory responsibility for a child or young person when this is required

Board Response

The Board would like to make clear that it understands that Family & Friends (F&F) Carers are rightly regarded differently to other foster carers. We acknowledge that in this case there appears to have been some blurring of boundaries between the responsibilities of the Corporate Parent and Family & Friends Carers. This ambiguity may have compromised the Corporate Parent's ability to assert its authority to ensure the wellbeing and safety of E. The Board accept that it is difficult to remove all ambiguity and tension about respective roles, rights and responsibilities in Family & Friends care. This is because regulations governing the approval process require fitting family members into a legal framework and allocating them a professional role. This doesn't reflect their familial relationship, the nature of that relationship and the inevitable emotional context of the care being provided.

This finding shows us the nature of the partnership required between the local authority, as the Corporate Parent, and Family & Friends Carers, and potential difficulties in this, as already outlined, are not included either in national or Brighton & Hove local guidance and policy documents. It is our view that such placements as these may benefit from more specific guidance addressing the extra complexity and stresses of such arrangements.

This finding also suggests that where longstanding Family & Friends Carers have virtually all authority delegated to them, the local authority may then find it difficult to intervene when needed to ensure a child's needs are being met[1]. We know that when a placement starts a Placement Planning Meeting takes place and delegated authority agreements are agreed which set out the roles/ responsibilities of carers, parents, social worker. An issue may be that for longstanding placements the delegated authority agreement is not routinely updated, although it is subject to review by the Independent Reviewing Officer, as appropriate. The Board would recommend a more formalised arrangement to strengthen this system. We must also be mindful that young people, particularly those aged 16 plus who are legally Gillick competent to make some decisions, should be consulted in decisions made about their care.

In support of compiling this Board response, Brighton & Hove City Council's Families, Children & Learning Directorate, have clarified that if a child is placed under Fostering Regulations with Family & Friends carers a qualified social worker is allocated to supervise the placement in accordance with Fostering Regulations. It has been confirmed that the Family & Friends Team run a monthly Support Group for Family & Friends Carers, and special guardians, and that Family & Friends Carers access the same training programme as unrelated foster carers. In addition to this they can also access, and are actively encouraged to do so, a rolling program of Friends & Family workshops. The expectation is that all foster carers should attend. Ofsted, as noted in its 2015 inspection, commented, '*Foster carers receive good quality preparation and are well supported'.* The Board have been assured that there is an appropriate level of training and support for Family & Friends Carers, but at this stage it is not clear what engagement with these offers look like and how non-engagement is monitored and scrutinised to ensure the best outcome for the child. This will require further exploration in order for the Board to be satisfied that Family & Friends carers receive specialist support groups and training, for their particular needs.

Since this serious case review there has been an Ofsted inspection of services for children in need of help and protection, children looked after and care leavers (14 April – 8 May 2015). This inspection rated services for Children Looked After & achieving permanence as Good. Whilst this is re-assuring the Board needs to now be further satisfied that the Families, Children & Learning Directorate retain the

[1] Delegated authority is the process that enables foster carers to make common sense, everyday decisions about the children and young people they care for, such as allowing them to go to friends' houses for sleepovers, signing consent forms for school trips and even arranging hair cuts.Holders of parental responsibility can delegate authority to foster carers to undertake such tasks and decisions. Foster carers never have parental responsibility for a fostered child, so they can only take decisions about the fostered child where that authority has been delegated to them by the local authority and/or the parents.

necessary authority invested in it as Corporate Parent to ensure the best possible outcomes for a child or young person.

Ofsted's Review of the Brighton & Hove LSCB also recommended that we improve our links with the with the Corporate Parenting Board to provide a greater focus to looked after children living outside the authority area and to better understand why thresholds for care or accommodation are reached. This finding supports our need to tighten our links as a priority.

Proposals

1.1 Board make a recommendation to the Families, Children & Learning Directorate that delegated authority arrangements are reviewed at every Looked After Child and Pathway Plan Review by Independent Reviewing Officers.

1.2 Board make a recommendation to the Families, Children & Learning Directorate that the Family & Friends Carers policy and procedures are reviewed to ensure they incorporate learning from this SCR.

1.3 The Board will contact the Corporate Parenting Board to ensure they are advised of findings from this serious case review.

1.4 Children's Social Work service provide an update to Board on how Family & Friends parenting capacity is assessed in relation to the changing needs of the child.

1.5 Children Social Work service to provide a report to Board on the attendance at Friends & Family Carers training take up and scrutiny of non-engagement.

Finding 2: In Children's Social Work Services, it is difficult to access the various sources of a looked-after child's past records, leading to an associated response of not prioritising this essential preparation; the result in many cases is that the Corporate Parent does not easily know the life story of its children.

Board Response

Findings 2 and 3 are linked, but have slightly different nuances. Finding 2 is concerned with the accessibility of past information and its impact on the Corporate Parenting fulfilling their responsibilities. Both findings reinforce issues of identity and personal history being highly significant to children who have lost a parent or parents. It is our view that this should be high up on the Corporate Parent's list of responsibilities.

This review has led us to question how social work staff taking on a new case undertake a review of a child's history and access relevant information held about the child. Frontline staff who contributed to this review cited such difficulties as: not enough time, combined with inaccessibility of old files, and profusion of records in different formats which do not join up to make a comprehensible whole. This is not the first time difficulties accessing historical records/ source material has been highlighted to the Board. We fully accept that the situation can be to the detriment of planning and decision-making. Over the past year the Board have been regularly updated on the extensive work that the Families, Children & Learning Directorate have been undertaking to overhaul disparate information systems and have been advised that at this point in time information is properly indexed and easily accessible to staff.

The Board recognises that a failure to take into account relevant information about the child could inhibit the Corporate Parent's responsibility to record and maintain an account of the child's story. This review has urged the Board to consider what review systems are currently in place to ensure 'life story' work is maintained for children in care. We are advised that the six monthly social work report compiled for Looked After Children Reviews, overseen by the child's Independent Review Officer, includes a question, under the heading Identity, which asks for a summary of what support has been provided to the child to help them understand their life story. It has since been recognised that the current life story

work policy on Operational Procedures relates only to children who have a care plan for adoption, although the guidance remains relevant, this needs to be updated to include all looked after children. Issues of identity and personal history are looked at again in Finding 3.

Since this review the Local Authority have clarified to the Board their expectations with regards workers' knowledge and understanding of an individual case at the point of transfer. The Board are advised there is an expectation that there is a face to face handover between workers, or their manager if the worker is absent, that case records, or at very least key documents such as reviews, health assessments, education plans, family history and chronology, are read. A discussion with the Independent Reviewing Officer should be take place and a meeting with young person/carer and family, if appropriate. The Board needs to assure itself that this expectation is clear, and fulfilled across social work teams, this action links with an action in Finding 3.

Proposals

2.2 The Board recommend that the Families, Children & Learning Directorate update their Life Story Work Policy to include all looked after children.

2.3 Children's Social Work to provide an update to Board regarding the systems in place that ensure life story work is maintained for children in care.

Finding 3: The tools for transmitting background information about a child or YP (transfer summaries and chronologies) are not produced to a consistent standard, meaning that a new SW may not have the background and qualitative information which would support a holistic understanding of the child/YP and family and their needs and risks.

Board Response

As per Finding 2, the Board accept that where full and accurate sources of the history of a looked after child are not reliably available, there is the clear risk that this history will be poorly understood by workers. We agree with the report that transfer summaries (and, where possible, face-to-face handover meetings) and chronologies are essential tools for workers and their supervisors to rely on. We acknowledge that frontline staff participating in the review advised that transfer summaries do not consistently provide adequate in-depth information and analysis. All our partner agencies, in fulfilling their safeguarding duties, must remain focussed on the child and understand the importance of their history in relation to assessing and planning for future functioning.

The review could find no evidence of chronologies being used consistently across the teams in Children's Social Work Services. It is the Board's view that the current chronology format has limitations. We are told that skeleton chronologies of key events in the life of a child are available on all case records. There is an expectation that social workers familiarise themselves with these and plan time with their managers to read and digest this information, and are provided adequate time to do so. The One Story model will be introduced in October 2016, and up to date chronologies are a key part of this model and will be monitored by managers and quality assurance. The Board will want to hear progress updates on this.

The Board have been advised that the implementation of the Pod model [2]has resulted in a reduced number of case transfers across teams. However, the consistency of keyworkers has been affected by having to have a number of agency social workers to ensure statutory duties are complied with. Brighton & Hove City Council have recruited a number of new permanent staff and it is anticipated that the

[2] In October 2015, Brighton & Hove's Social Work services adopted a new model of practice which moved away from separate assessment, child in need and child protection teams to a "Pod" structure. There are now 16 pods, each with around 8 social workers, and a child will be allocated to a specific worker in a particular pod upon assessment and then remain with this team throughout the time they require this intervention. This has removed the risks associated with the introduction of a new social worker at transition points between services, for example when a child goes into care, and also allows for stronger relationship-based practice. A Group Supervision model ensures that the Manager and other members of the Pod are aware of the cases, and are thus able to better cover for the allocated worker during absences than the previous system of duty cover.

number of agency staff will have radically reduced by Autumn 2016. The Board will want to receive an update on this matter to satisfy itself that consistency of keyworkers has improved.

Proposals

3.1 The Board recommend that Children's Social Work remind practitioners that chronologies should be available on all cases and be regularly updated.

3.2 Children's Social Work to report to Board on social work staff turnover rates.

Finding 4: Is there a risk for professionals, in following Care Planning, Placement and Case Review Regulations, to give too much responsibility to young people over their Pathway Plan Reviews, with the result that difficult subjects are not raised if the young person objects?

Board Response

Findings 4 and 5 both concern the Pathway Planning Review (PPR) process. Finding 4 is concerned with the contents of the PPR meeting and the professionals present, both determined by the young person at the centre of the review.

The Board would like to make clear it supports the views of the child or young person being central to the PPR process, and agree that the active participation of the young person in their review should always be encouraged – especially as they enter the transition period of leaving care and becoming an adult. What finding 4 asks us to consider is if the Corporate Parent has struck the right balance with regards to keeping the young person's wishes central to the care planning process and it remaining able to address any areas of serious concern for the young person.

The Board consider that the young person's need, and right, to privacy should be respected, and that there may well be valid reasons that any young person approaching adulthood would not want to discuss sensitive personal matters in front of their teachers or youth worker, or their parent/carer if they are present. That said, the Corporate Parent needs to make certain that if discussions are not taking place within the PPR, that there is a forum, as part of the wider care planning process, to discuss any sensitive or contentious issues, and that the Corporate Parent, or those to whom it delegates authority, remain sighted on these issues.

The Board are advised that in such instances a separate discussion or series of discussions or separate meetings are had with the young person or carer. The review acknowledges that a professional meeting outside of the PPR, at least on two documented occasions, was proposed. Finding 5 discusses alternative forums for such discussions in more detail.

Proposals

4.1 Board recommend that the Pathway Plan Review and Looked After Children Review paperwork is updated to include recording of issues that need discussion outside of review process

4.2 Board request that Children's Social Work undertake audit on quality of Pathway Plan Reviews and report findings to the LSCB (to include the views of young people).

Finding 5: Nationally, there is no routine framework for multi-agency professionals to meet outside of Pathway Plan reviews, leaving the responsibility with an individual practitioner to convene such a forum. The result is that planning and decision-making for a child often proceed without the benefit of a joined-up discussion of others' perspectives and concerns about a child

Board Response

This finding highlights the lack of any formal or regular meeting which includes the *full range* of professionals involved with a looked after child, or other children in need, which subsequently implies a weakness in partnership working and information sharing.

The Board understand there are a multitude of reasons why extra meetings might be required, given how much can transpire in the time frame of 6-months between Looked After Children Reviews and PPR meetings. We are of the view that it is vital that any member of the professional network can confidently request a professionals meeting, or call forward an extra review meeting. The Board believe this should be the accepted norm, supporting both the worker with the rising concerns and the young person to receive the timely care and attention that may be needed in response to serious problems. Since this review the Board are advised that such arrangements are in place currently, in the form of Placement Stability Meetings; Strategy Meetings, Network Meetings (for CIN & LAC). However, the finding from this serious case review may be indicative that not all frontline staff are aware that these alternative forums can be utilised alongside the PPR.

Proposals

5.1 The Board recommend that a reminder of practice highlighting the purpose and function of Placement Stability Meetings for looked after children should be circulated to front line managers and staff.

5.1 The Board request that all partner agencies remind staff of the need to request professionals meetings when required.

Finding 6: There is a pattern of focusing only on the primary (usually female) carer for a child in care, and not giving sufficient attention to the role of the non-primary carer (usually male). This can result in professionals' lack of awareness of both positives and negatives that the other carer may bring to his role.

Board Response

From this review we recognise that there may be a tendency to focus on the primary carer when engaging with families. This is a matter which has been identified in a previous Brighton & Hove Serious Case Review (Baby Liam, October 2015) which found that the booking form used by midwives 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. We recognised that it was an issue across a number of agencies hence we added a standard, *Consideration of fathers and other significant adult males*, to the Section 11 audit[3]. The standard asks partner agencies to evidence that there is guidance in place for practitioners to consider fathers, male partners and other significant adult males in the family when gathering family information as well as in all assessments addressing the needs and welfare of the child. In the case subject to this SCR we see that communication between the Corporate Parent and the primary carer broke down so much that communication was only carried out by email and engagement with the non-primary carer was sporadic.

The Board believes that the perspective of both care givers will provide professionals with a richer understanding of what life is like for the child. It will enable the partnership between local authority (and in this case, therefore Corporate Parent) and the carers to be stronger. It will empower both carers to be heard and to regard themselves as influential in the child's life. Most of all it will allow the child to be better protected and supported as all those involved in their care will have a stake in their upbringing.

After careful consideration we are not, at this point, satisfied that the expectations of foster carers are clear, less so around non-primary care givers. We have considered whether indeed such expectations are reasonable. What we do know is that good practice looks like developing and maintaining trusting, open, professional and supportive relationships between carers and the professionals they come into

[3] Section 11 of the Children Act 2004 requires key persons and bodies to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. Partner agencies are requested bi-annually to undertake a self-assessment to provide evidence of their organisational and strategic level safeguarding arrangements in response to these requirements.

contact with. What is not clear right now is what variety of engagement strategies professionals employ to hearing the voice of the non-primary carer. Nor how professionals are trained, enabled and supported to engage with non-primary carers where there are underlying difficulties in engaging with the primary carer. There is a clear benefit in ensuring that the non-primary carer is provided with information and the opportunity to engage when the placement is in breakdown, whilst recognising that this may not always be a realistic option when the placement is settled.

The Board regard it our responsibility to assure that both carers are engaged and involved in any decision making and interventions around a child, as far as is practicable. For the reasons given we feel that that is both in the interests of the child and of effective planning and practice. We feel on balance that there should be a higher expectation of engagement for foster carers levelled with a flexible range of opportunities through which each carer's voice can be heard.

The Board needs to assure itself that the default position should be to engage and hear both carers. Particularly with Family & Friends carers, the Board needs to be sure that there is an explicit expectation for both carers to engage with the Corporate Parent. To that end, and recognising that carers will have conflicting priorities (e.g. work), the Board needs to be assured that a lack of engagement by non-primary carers is identified and understood and flexible options are provided to help them engage.

Proposals

6.1 The Board will strengthen its S11 audit expectations around how agencies meet the current standard applied.

6.2 The Board will seek reassurance from the relevant agencies that their supervision policies and practice (including training) address the benefits and challenges of engagement with all carers for a child

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Finding 7: In B&H Children's Social Work Services, there is inconsistent recording. Without a complete and accurate record, it is difficult for practitioners and their managers to analyse the facts and context of a child's situation, and to make appropriate decisions and plans.

Board Response

Accurate and timely recording of events and decision making provide for auditable and defensible practice which, too, aids forward planning and greater understanding of a child's journey and that of their care and support.

The Board acknowledges that it requires reassurance that case records across **all** agencies are appropriately maintained. This, and other serious case and learning reviews, have highlighted that record keeping is variable and that can lead to risks for both practice and professionals. On many levels the expectations of good quality and accurate record keeping are high, but the application of these can be frustrated by; unsuitable systems, culture, leadership, resources and time each not being conducive to efficient recording. It has been made clear through this review that time is a precious commodity. With increasing workloads and static resources the expectations on staff around contact time are given greater priority than record keeping.

Recognising the reality of the availability of resources, the Board would expect to see a culture reflected across all agencies that accurate, timely and proportionate decision making, and recording thereof, is championed through the leadership and through supervision so staff understand it is as important to their practice as contact time.

The Board would also expect that systems support rather than hinder efficient timely record keeping, reducing bureaucracy as far as possible, yet allowing for full and accessible records to be available for supervision, audit and inspection. Furthermore, where professionals' knowledge and understanding of

their responsibilities around record keeping is found to be lacking, workforce development strategies should be put in place to address this.

Proposals

7.1 All agencies to provide an update to Board regarding recording practices and adherence to recording expectations.

Finding 8: Sussex Police do not always act in accordance with their own guidelines by informing Children's Social Work Services about their observations of, contact or interventions with young people. This means that opportunities for joint thinking, decision-making and interventions may be lost.

Board Response

In this case E was a looked after child (LAC) and the police were unaware of his LAC status. Irrespective of his status as a LAC there were numerous police recorded incidents over a 24-month period some of which should have been the subject of a referral to Children's Social Work. This finding raises questions for police and Children's Social Work Services about current guidelines around the circumstances in which a SCARF[4] should be raised.

Sussex Police have confirmed that Force Policy requires that a SCARF should be completed when police "have any involvement……. with a child". The policy and subsequent guidance to officers has been directed towards those officers who have direct involvement with children, particularly uniformed response, neighbourhood teams and those officers working in schools. Police audits on compliance with this policy have indicated that these notifications are not always completed in these circumstances, despite regular reminders to staff. The reasons for this are not clear, but should be seen against a rise in the number of domestic abuse incidents attended by police, where a SCARF is required to be completed and compliance is high. This may have focussed officers' attention on more serious incidents, and away from the lower level interventions officers have with children, where historically SCARFs (and the previous notification form MOGP/1s) were completed.

In addition, in recent years the introduction of risk indicators within the SCARF or MOGP/1 have guided officers to focus on interventions where there are clear safeguarding issues. This may have further influenced the decision-making by staff on when a SCARF should be completed, and at a strategic level, requests by Children's Social Work in some areas for the police to reduce the number of notifications, may also have had some impact.

It is the LSCB's view that the current uncertainty as to when a SCARF is required indicates there is a need for a fundamental review of the circumstances in which a SCARF should be completed.

Proposals

8.1 The Board recommend that Sussex Police, in consultation with other agencies, to review the circumstances in which a SCARF should be completed and update Force Policy accordingly..

8.2 Board to assure itself that, once the Force Policy is updated, operational practice regarding sharing safeguarding information through SCARF reflects the revised Force expectations.

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[4] Police officers are expected to complete the Single Combined Assessment of Risk Form, SCARF, in a number of circumstances that are outlined in policy, and it combines a number of previous forms and assessments that were used. In the context of children it replaces the old MOGP/1 that officers completed when they had some direct intervention with a child. However it is also used in relation other areas of police work, and has replaced the old vulnerable adult notification (VAAR) and other forms in relation to domestic abuse, stalking etc.

Additional Learning 1:
Accessing Child and Adolescent Mental Health Services (CAMHS)

Like many/most young people, E declined to use the Child and Adolescent Mental Health Service (CAMHS) to which he was referred in autumn 2012. He went for one appointment, and decided it wasn't for him. The case was closed by CAMHS shortly after E's decision. His reluctance to engage with CAMHS echoes the findings in two recent Learning Reviews in Brighton & Hove, both in relation to the deaths of vulnerable adolescents. These have highlighted what is a local and national issue: the need to create different, 'young-people friendly' ways of improving access to CAMHS for adolescents.

Board Response

We look forward to the outcome of the Local Transformation Plan for Children and Young People's Mental Health Services insomuch as it develops a range of routes to services who meet the emotional wellbeing and mental health needs of children and young people in Brighton & Hove. It will also support parents and carers to enable them to understand and help their child/young person with their emotional distress. Learning from this Serious Case Review and the two aforementioned learning reviews have been included in the recent Joint Strategic Needs Assessment (JSNA) and actions are being implemented through the Transformation Plan to address change and improvements.

This Transformation Plan is held to account through NHS England with local co-commissioning arrangements in place across the Brighton & Hove Clinical Commissioning Group and the Local Authority. The process of assurance to the Board will be agreed with the Brighton & Hove Clinical Commissioning Group.

We feel there is a place for a universal service (similar to antenatal services for first time mothers) that can be accessed by looked after children that, recognising the trauma that will have resulted in them becoming looked after, allows them to engage in services to help them while providing professional therapeutic support to identify underlying factors before they escalated into mental health problems.

Young people will continue to have the right to exercise choice when accessing mental health services unless there needs are such that they require care under the Mental Health Act.

Proposals:

9.1 Brighton & Hove Clinical Commissioning Group will report progress to the Board in Autumn 2016 on the following points:

- Re-procurement of the Wellbeing Service to include all ages
- Development of Primary Mental Health Worker offer within schools and colleges
- Improvements to mental health pathway for looked after children
- Development of training offers for front line staff working with children and young people to improve knowledge and understanding of mental health
- Development of a mental health anti-stigma campaign and a single online point for all information, help and support around mental and emotional health
- Development of a more consistent outreach model for delivering tier 3 CAMHS (building on the Teen to Adult Personal Advisor (TAPA) model)
- Development of a Sussex-wide response to children and young people in crisis (building on the Urgent Help Service)

Additional Learning 2:
Support for staff

During the undertaking of this serious case review the Review Team were told by some frontline professionals that they had not had an opportunity, before the serious case review process, to speak with other staff from across the multi-agency network about what had happened to E. The Review Team

were advised that telephone counselling can be accessed, (or possibly face-to-face counselling after a telephone 'triage' assessment).

Board Response

The Board were surprised that the serious case review was the first opportunity that some staff had to speak about what happened to E and their responses to that. Although it is perhaps not so surprising that this will have been the first time staff from across the safeguarding partnership would have got together to discuss what had happened. The Board needs to ensure when planning the initial meeting for staff that the possibility that this may be the first time colleagues have met is taken into consideration.

On a slightly separate, but related point, the Board will want to look to all agencies to provide a flexible and accessible counselling or support service that encourages and presumes take up when required and promotes this further through supervision.

Proposals:

10.1 Future learning reviews commissioned by the Board will involve consideration of impact upon staff of initial joint learning events.

Additional Learning 3:
Timing of the SCR

The review highlighted that the grief that followed from E's death was profound for many, and they found taking part in the serious case review extremely distressing. The Review Team suggest that such circumstances need to be thought about very carefully when planning to commence a serious case review.

Board Response

In combination with the response outlined under the Support for Staff learning above, the Board has to balance identifying and rolling out learning from reviews in a timely way with the ability of family members and professionals to be ready and able to contribute meaningfully to this process. The statutory expectation is reviews will be carried out swiftly, but that there should be a balance.

The Board does not consider that any delay should be lengthy. That said, there may be times when a short period of time is necessary to allow family members and staff to be able to be in a place where they are able to contribute to what is always a difficult and emotional process. In terms of staff it is unlikely that such a delay would be authorised unless effective support measures are in place within the respective agencies.

18 SCR Quality Markers have been produced as part of the Learning into Practice Project, a one-year DfE-funded project conducted by NSPCC and SCIE between April 2015 and March 2016. Quality Marker 8 is concerned with the management of the serious case review, including timeliness. Since this serious case review Brighton & Hove LSCB have self-assessed ourselves against these quality markers, reflecting on the challenges of balancing the need to put into practice the learning from the case with the need to allow staff and family members the space to grieve.