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.

Child E: Brighton & Hove Safeguarding Children Board undertook a Serious Case Review (SCR) regarding E, a child in care who was seriously injured by hanging in December 2014, and who died in hospital the following day. The coroner recorded an open verdict. The SCR report was published in September 2016

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/child-e**

Key Learning Points:

- There is an inherent tension regarding the respective roles of the local authority as Corporate Parent, and Family and Friends Carers who are seen as 'parents' or 'family'. This can result in blurred boundaries and a difficulty in asserting the LA's statutory responsibility for a child or young person when required.
- In Children's Social Work Services, it is difficult to access the various sources of a looked-after child's past records. The result in many cases is that the Corporate Parent may not easily know the life story of its children.
- The tools for transmitting background information about a child (transfer summaries and chronologies) are not produced to a consistent standard. This means that new workers may not have the background which would support a holistic understanding of the child and family & their needs /risks.
- The review asks if 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 does not want them to be.
- Nationally, there is no framework for multi-agency professionals to meet outside of Pathway Plan reviews, leaving the responsibility with an individual practitioner to convene a meeting. 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.
- 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.
- In Brighton & Hove 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.
- 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.

History:

E was a 17 year old boy, approaching his 18th birthday, when he died. He had been looked after by Brighton & Hove Council (via a Full Care Order, conferring Parental Responsibility on the local authority) from the age of 3 years, in a 'Family and Friends' placement with his maternal aunt and her partner. E's parents had split up when he was a baby, and his father's whereabouts unknown, throughout much of his childhood.

E's mother, who had mental health and substance misuse problems, was unable to care for him, and died of a drugs overdose when E was 8 years old. Before her death, she had continued for several years to have inconsistent contact with E, who is recorded to have been distressed by her absence.

In these circumstances, his placement with his close maternal relatives was extremely fortunate. The family regarded child E as their son, and were committed to giving him a secure and loving family life. Although Adoption and a Residence Order were both considered by the family, neither was proceeded with, on the grounds that they believed extra support for E from the local authority (LA) would be needed as he grew up and especially in adolescence.

E was described as a charming, polite and willing student – thus popular with school staff as well as pupils. Elsewhere, however, his behaviour, especially as he reached adolescence, became increasingly challenging at home, and risk-taking elsewhere, he began to come to the notice of the police, sometimes in association with other young people, and there were concerns that he was experimenting with alcohol and drugs. There were also signs that he was very anxious at times, and troubled about his identity and his past, about which he wanted to know more.

Just before his 16th birthday, E's birth father telephoned Brighton & Hove Children's Social Work Services and expressed his wish to know about and have contact with his son. E was told about this a few months later, after his GCSEs had been completed. Initially, he wanted only 'online' contact with his father, and this remained the situation until shortly before his death.

During E's first year of college, his anti-social behaviour outside the home, and anger and sometimes violence within it, increased. The placement was for many months at severe risk of disruption, and this eventually happened in October 2014. At this point, E went into respite foster care in a nearby town.

E returned home after about 5 weeks, following a burglary at home, for which he blamed a friend and his 'associates'. E's subsequent assault on this boy led swiftly to an exchange of social media threats which apparently terrified E and prompted his desire to leave Brighton immediately. Under pressure from E, a temporary plan was agreed by his carers and Children's Social Work Services for him to stay 'under the wing' of his father in another part of the country, while an urgent foster placement was sought in that area. Five days after this move, E was discovered to have hanged himself in his father's friend's house where we was in fact staying, and died in hospital shortly after.

Methodology:

This review was conducted using the Social Care Institute for Excellence (SCIE) Learning Together methodology. It was conducted by two lead reviewers, both independent of any of the organisations involved in the case, and looked at how the events identified as key practice episodes reflect on child protection systems in place in Brighton & Hove. Reviewers were supported by a Review Team of senior managers from across the safeguarding partnership, who assisted in reviewing and collecting information, considering the findings, and confirming if this learning was unique to the circumstances of this child or transferable in a wider context.

Frontline staff who worked with the family were encouraged to take part in the review by sharing their experiences through individual conversations with the lead reviewers, as well as contributing to the development of the findings through consultation events. Some of Child E's family also participated in the review.

An action plan is in place to improve local practice based upon this learning, and the progress on this is overseen by the LSCB's Case Review Subcommittee.

Conclusions & Reflection Points

It is clear that all SCRs (serious case reviews) are individual in nature and circumstance.

Reflection Point 1: In this particular instance, child E was placed with external family, with the local authority also acting in "**loco parentis**" . It would seem that this clouded the ability for services to provide the appropriate level of input at times. There is a need therefore to reconsider the review of the care pathway, not only on a yearly aspect, but also at "**significant times of change**". 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.

What are the benefits and challenges of longstanding Family & Friends Carers placements?

Reflection Point 2: This case highlights the importance of clear, full and accurate recording of the history of the child or young person, including their understanding and knowledge of their family, and also around their personal identity. Personal identity and personal history are highly significant to children who have lost a parent or parents. Child E had a family history of suicide.

Reflection Point 3: Transfer summaries (and, where possible, face-to-face handover meetings) and chronologies are essential tools for workers and their supervisors to rely on

What are your experiences chronologies being used consistently across teams? Do they provide you with as full a picture as possible?

How do you establish and record conversations with children and young people about their personal identity and history?

What are your expectations with regards knowledge and understanding of a case at the point of transfer?

Is all necessary information accessible to you when you start working a case?

Reflection Point 4: Views of the child or young person are central to the Pathway Plan Review process. 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. It is important to strike 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. If the young person is able to determine what information is discussed at meetings it could limit or detract the ability to resolve some issues if not talked about. It is suggested therefore that a record is made within the meeting of any subject that is not to be discussed, thus assisting the workers in the progression of the care planning.

Do you think you/ your service has the right balance between facilitating the views of the child or young person and effective safeguarding?

Reflection Point 5: If there is a need to, consider the organisation of multi-agency meetings, "**outside of the PPR process**", staff should feel confident to do this, as "**Placement Stability Meetings**" are part of this process and will enable the fuller sharing of information.

How confident are you to a request a multi-agency professionals meeting, if you have concerns about multi-agency working not meeting the needs of the child or young person?

What escalation processes are in place if requests to hold a multi-agency meeting are ignored?

Reflection Point 6: The review shows us that there is a tendency to concentrate on the "female" carer, who often has the primary role. The perspective of both care givers provide professionals with a richer understanding of what life is like for the child. It enables the partnership between local authority (and in this case, therefore Corporate Parent) and the carers to be stronger. It empowers both carers to be heard and to regard themselves as influential in the child's life. Most of all it allows the child to be better protected and supported as all those involved in their care will have a stake in their upbringing.

Do you think it is a fair expectation for the non-primary carer to be as involved as the primary carer?

How do you go about developing and maintaining trusting, open, professional and supportive relationships with the child's carers?

Do you have any strategies you employ to hear the voice of the non-primary carer?

Reflection Point 7: It also seems that on occasion, agencies do not always follow their own guidelines or procedure for information sharing. It is important that this "**free flow**" of information is passed between multi agency partners, as it can complete the "**jigsaw**". 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.

How do your services systems support and/or hinder efficient timely record keeping?

Reflection Point 8: In this case E was a looked after child and the police were unaware this. Irrespective of this 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 should be raised. Sussex Police, in consultation with other agencies, need to now review the circumstances in which a SCARF should be completed and update Force Policy accordingly.

Do you consider anti-social or potentially criminal behaviour as a potential indicator of safeguarding concerns?

Additional learning from the review

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. He went to 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.

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.

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.

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:

Tuesday 11 October 2016, 2-4pm
Tuesday 18 October 2016, 2-4pm

To find out more and book your place please visit brightonandhovelscb.org.uk/event/learning-from-case-reviews-child-e

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.