Learning Together from Case Reviews

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

This short briefing summarises what a local learning 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.

Safeguarding is everyone's responsibility and everybody can contribute to safeguarding and promoting the welfare of children.

Child G's Story Child G is a young child born to substance misusing parents, who had been on a child in need (CIN) plan in another area, when he moved, unplanned into Brighton & Hove. Shortly after his move G sustained a life-threatening head injury.

Brighton & Hove LSCB commissioned a Learning Review into his case. This was not a Serious Case Review and as such the LSCB will not be publishing the full report.

Sharing learning from learning reviews and serious case 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.

Finding 1: It is crucial to have access to all historical information regarding family history so as a thorough risk assessment can be completed.

Information regarding the previous removal of children and assessments of mother were not shared because this information was not readily accessible.

How easily can you retrieve historical information when you are making an assessment of risk?

Finding 2: Updated assessments should always be carried out when a child subject to a Child in Need (CIN) plan moves into the area.

Are you aware of your responsibilities in undertaking assessments to support children in need or at risk of harm?

Finding 3: The issue of temporary residents and the lack of referral onto the health visiting service was identified.

There is a 'flagging system' within practices that can highlight the child as being vulnerable on the GP system. The flagging system is not used if the family are temporary residents. G was not a permanent resident therefore he was not flagged and referred directly to the health visiting service. It is estimated that 5% of patients registered at Brighton & Hove GP practices are classed as temporary.

Do you think your agency has the same responsibility and response to temporary and transient families as it does for the permanent population?

Finding 5: The link between life threatening issues and the need to use the pan-Sussex Unexpected Child Death Protocol.

If Child G had not survived in A&E then it is highly probably that the unexplained child death protocol would have been engaged, however should Child G have died after being transferred to a tertiary care centre then it is questionable whether this would have been followed and as such other child protection agencies would not have been able to respond in a timely manner.

Do you know where to find the pan-Sussex Unexpected Child Death Protocol?

Finding 4: Frontline staff need to have the confidence to identify when a case should be referred to children's social work and know how to do so, both during and out of normal office hours.

Some safeguarding agencies were unsure of how the out of hours service operates. Health staff did not have the confidence to make a decision of risk because the diagnosis was uncertain. During office hours staff have access to named professionals for support and consultation.

Are you confident and able to make a referral to children's social work during and out of office hours?

Finding 6: The need for good links between primary and specialist hospitals.

When children are transferred to a tertiary care centre with a serious head injury, responsibility for clinical management and safeguarding decisions move with the patient to the specialist unit. This results in local paediatricians generally not being consulted about these decisions. There is a danger therefore that if a tertiary centre does not access wider information about a clinical story, family or a child's history, the interpretation of the injury and medical findings are potentially based on incomplete information.

Are there good communication lines between the various parts of your specialist areas?

What Next? The full report was presented to the LSCB at an Extraordinary meeting in July 2014.

A Multi Agency Action Plan was produced from these findings and progress on this is monitored by the LSCB's Serious Case Review Subcommittee.

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 to ensure your voice is heard.