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 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.

Neglect: One of Brighton & Hove Local Safeguarding Children Board's key priorities for 2016-19 is Neglect and Emotional Harm, and we have recently completed a Multi-Agency Learning Review, into a long standing Neglect Case. Although the case did not reach the threshold for a Serious Case Review the Board felt that it was felt appropriate to conduct a multi-agency review of all agency involvement with this family, to see what we can learn about how to better manage longstanding, complex cases of neglect., and improve the outcomes for the child.

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 the LSCB

Key Learning Points:

The Learning Review identified 7 main findings about the safeguarding system in Brighton & Hove. This included the importance of maintaining multi-agency work when a case is going to **court**; use of **chronologies** to track neglectful behaviour, and the need for flexible approaches to managing **complex cases** effectively. The review also considered how professionals in Brighton & Hove can work effectively with women and children experiencing **domestic abuse**, who do not recognise this behaviour as abusive. It also raised questions over the use of **interpreters**, and whether those who provide these services sufficiently understand the complexity of Child Protection procedures and legal processes to enable them to communicate these concepts effectively.

History:

This review concerns a family with five children where there were child welfare concerns over a period of over ten years. The parents were initially from North Africa and whilst the father spoke good English, mother's English was poor and communication was difficult.

The safeguarding concerns included physical abuse and neglect of the children, domestic abuse of the mother causing emotional abuse to the children. The children were the subject of child protection plans in 2006 - 2007; 2008 - 2012; and 2013 - 2014. Services were also provided by a wide range of agencies and included financial assistance, parenting classes, language classes, and much practical support. There have also been issues with regard to the children going missing/being left unsupervised

The Local Authority initiated care proceedings on two occasions, first in 2011 which ended in 2012 with no order being made and secondly in 2014 which eventually resulted in care orders being granted for all five children.

Reflection Point 1: By insufficiently involving or acknowledging the concerns of other agencies in developing the legal case for removing children from their parent's care, social workers may be risking important evidence being overlooked or not available to lawyers and the court.

Is there enough discussion between agencies when a matter moves into from CP into legal proceedings?

Do you feel that the burden of finding the information should solely lie with the social worker, or could there be a role for a "Legal Core Group" to pull together the full information for the legal proceedings?

Reflection Point 2: In Brighton & Hove the current methods of recording child protection conference decisions do not make it easy either to review or quality assure the effectiveness of actions and their outcomes

Have you found that the new, relationship based model for Child Protection Conferences, in place from January 2017, has made it easier to grasp the current situation and risks for the child or young person?

Reflection Point 3: The absence of an effective running chronology in the Brighton & Hove CSC data base makes detection of neglectful behaviours more difficult, thus compounding the real difficulty practitioner's face in evidencing neglect.

The issues about keeping consistent chronologies, has been raised in multi-agency forums before, how can safeguarding agencies in Brighton & Hove address this concern?

Do you share your chronologies with other professionals to help them build a picture of risk?

Reflection Point 4: In Brighton & Hove, is the response of police and children's services to children being left unsupervised sufficiently authoritative?

Do we think that all reports of a child being left unsupervised are reported, and what are the expectations of agencies if it is?

How would you explain the severity of the situation, and potential consequences, to a parent that left their child without adequate supervision?

Reflection Point 5: Is the way that workload is allocated in Brighton & Hove CSC too driven by habitual processes rather than being flexible enough to think more creatively about how to manage complex cases differently?

Do you feel that the reorganisation of Children's Social Work Teams into a Pod structure, to facilitate a Team around the relationship, has allowed more flexibility with the way they work with complex cases?

How are you able to work creatively to better manage difficult cases in your service? What contacts do you have that can assist with this?

Reflection Point 6: Are professionals in Brighton & Hove sufficiently supported to work effectively with women and children experiencing domestic abuse (who don't recognise this as abusive because they see it as being culturally normal) where the perpetrators of the abuse use the issue of race and culture to threaten professionals?

How confident are you in challenging assertions that domestic violence is acceptable in certain cultures?

Can you recognise all forms of domestic violence and abuse including coercive control and financial abuse?

Who would you seek support from for a victim of domestic abuse from a minority ethnic background?

Reflection Point 7: Is there adequate training provided to professionals in Brighton & Hove about how to use interpreters effectively; and is the understanding by interpreters of the complexity of Child Protection procedures and legal processes sufficient to enable them to understand the context within which they are being asked to interpret?

How confident are you that the interpreters you use have a clear understanding of safeguarding procedure or the issues to be discussed?

Do you arrange a pre-meeting with interpreters to explain the situation and check they have a clear understanding to translate effectively?

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 these will run on:

- Wednesday 5 April 2017, 1pm - 3pm
- Thursday 6 April 2017, 10am - 12noon

Find out more and book your place at: brightonandhovelscb.org.uk/event/learning-from-case-reviews-neglect

The LSCB also run multi-agency training courses on child neglect and domestic violence. See our upcoming training at brightonandhovelscb.org.uk/events or book on through the Brighton & Hove Learning Gateway

What next: The findings from this Learning Review will feed into the development of the LSCB's Neglect strategy, as well as the findings from a multi-agency audit of neglect that is taking place in early 2017.

To be kept up to date on the Board's work on neglect please sign up to our newsletter here

Brighton & Hove LSCB local safeguarding children board

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.