Leicester Safeguarding Children Board

Briefing – Learning from Reviews and LSCB Audits
August 2019

"The purpose of reviews of serious child safeguarding cases, at both national and local level, is to identify improvements to be made to safeguard and promote the welfare of children" (Working Together 2018)

Learning from reviews

The responsibility for identifying learning from reviews at the national level lies with The Child Safeguarding Practice Review Panel (the Panel) and at the local level with the safeguarding children partners (currently the LSCB).

This briefing presents key points and findings from analysis conducted by CareKnowledge of 24 Serious Case Reviews (SCRs) published nationally since January 2019. The focus was on what new learning might be gained rather than on previous messages although those of special emphasis across reviews may be included. Some of the findings resonate with those from local reviews and LSCB multiagency audits, and key messages from two local reviews are also presented. This briefing is aimed at managers and practitioners working with children and families and should be shared with colleagues.

Learning from 24 national serious case reviews

- About 6 of the cases involved serious injury as the prime reason for concern
- Many of the children had died; some of the others experienced life-changing injuries
- Where gender can be clearly identified, there is an even balance between boys and girls
- Domestic abuse is mentioned in the background of a significant number of the cases
- There is one case clearly resulting from child sexual abuse
- There is some mention of substance misuse in a number of the SCRs, and a few where mental ill health is specifically referred to in the summary information
- Two of the SCRs are thematic in nature – looking at the deaths of a number of adolescents and at circumstances in a secure training centre
- One case involved the death of 17-year-old who had experienced adoption breakdown
- One involved the stabbing of a care-experienced girl by a boyfriend
- One involved the death of a young adult who had originally been assessed as a refugee child
- At least one child is identified as a disabled child

Key Findings – Perhaps less-mentioned in previous reviews

- The need to recognise that later events – including those that lead to SCRs – are often influenced by factors that relate to the early lives of children, and that failure to invest in preventative and early support services can mean lost opportunities for care improvements and accumulating circumstances that can underpin cases of serious harm
- The need for greater recognition of, and response to, children's emotional health and wellbeing, particularly as it relates to older children and those who have experienced loss and bereavement
- The importance of considering the need for full and effective pre-birth assessment and planning where there are pre-existing concerns about families, prior to the arrival of new children
- The associated importance of recognising the acute effects that childbirth may have on the psychological status of mothers
- The need to ensure the proper assessment of, and response to, children's overall health status and needs, and which takes a holistic view of those factors. This should include a formal Child Protection Medical where there are concerns about non-accidental injury
- The central importance of ensuring that there are appropriate arrangements in place for social workers to receive good quality legal advice which is recorded and acted upon
- The need to review the effectiveness of tools used to assess neglect and ensure that staff have access to those that are seen as most reliable; and that staff are trained and supported in their use
- Consideration should always be given to the need for those who 'screen' referrals in a range of models, to have direct contact with the referrer to ensure that an accurate picture of their concerns is obtained
- The need to recognise – and take into account in service responses – the increased risks of violence at the point of leaving an abusive relationship and on a partner's discovery of a new relationship, including the potential risk to any children involved

Key findings - Perhaps less mentioned in previous reviews (cont'd)

- The potential role for housing providers to make referrals where they may have indications that give rise to concern that families with young children are starting to struggle and may benefit from more support
- The need for agencies to have clear policies on the use of announced and unannounced visits to families
- The need for full involvement of relevant mental health services in safeguarding arrangements where there is a history of ongoing treatment for parents and where there are identified concerns about the wellbeing of children
- Consideration should be given to reviewing the guidance in Working Together to Safeguard Children (2018) and Safeguarding Children who May be Trafficked (2011) to determine the suitability of the system of risk assessment, S47 enquiries and Child Protection Plans to children who are at risk of trafficking or who may have been trafficked
- LSCBs and their partner agencies should review practitioner knowledge and skills in understanding, assessing and responding to hidden substance misuse by parents, such as use of cannabis and other common drugs. This should include awareness of the possible clinical signs and impact of (accidental) drug ingestion or exposure by children
- Councils should ensure that a strategic multiagency needs assessment is carried out in relation to families from new, emerging communities
- The need for safe recruitment processes in residential care facilities and for enhanced arrangements for listening to children's views including ensuring their understanding of, and access to the full range of complaints procedures
- The need to understand and effectively manage behaviour control arrangements in residential care facilities and ensure that there is a safe and appropriate approach to any use of restraint techniques
- The need to have in place an effective supervision system to address wider staff development needs in residential care establishments
- The need to provide additional support at the point of any important transition and, in particular, to consider and plan for the needs of care leavers before and after end of any period in care
- The need to have an awareness of additional factors for suicide risk and to consider the best ways of linking Children Looked After (CLA) and CAMHS teams

Key findings - Given added significance in these reviews

- The need to focus on the daily lived-experience of children – including assessing the results of their witnessing of incidents of domestic abuse
- LSCBs should consider a review of the way in which children who are involved in domestically abusive relationships are assessed in terms of risk of harm
- The particular importance of full investigation where injury to non-mobile babies may have occurred, especially where there is evidence of bruising
- The need to understand the possible post-traumatic effects of domestic violence on mothers and their behaviour and to ensure the availability of long term, tailored support which shows an understanding of the ongoing nature of coercive control and its impact on women and children
- In general, there is a need to ensure an adequate focus on the men in families including fathers, and to have a clear picture of their strengths (including protective capacity) as well as their weaknesses
- The challenges of working with parents who are resistant to involvement or who use disguised compliance and the importance of knowing about controlling and coercive control in adult relationships in making informed decisions about risk to children
- The need to ensure focus on other children in families in addition to those about whom there is primary concern
- The importance of a pattern of missed health (and other) appointments as an indicator of accumulating concern
- Understanding parental history and vulnerability is hugely important to assessing actual, or potential, risk to children
- The importance of appropriate, routine professional challenge and the use of escalation processes needs to be embedded in multi-agency child protection arrangements
- Practitioners working in adult focused services such as offender management, substance misuse, mental health services, and primary care services should have sufficient information and professional support to identify and respond to the risks posed by the adults they are working with, to children and young people

Local Serious Case Review - Nadiya

Nadiya – aged four months was taken to hospital by her mother with unexplained injuries to her nose and face and bite marks to her limbs. Further examinations identified a lower leg fracture, several brain haemorrhages and retinal haemorrhages in both eyes. Nadiya subsequently made a full recovery and has, since the time of the injury, been in safe and appropriately assessed care.

Key findings (Nadiya & Siblings)

- The four children in the family were known to Child Protection Services for most of their early lives for neglect, poor supervision and the impact of domestic abuse.
- Each child was taken to hospital in a one-year period with injuries which indicated either very poor supervision or deliberate abuse.
- Except for the injury to Nadiya, all the other injuries received limited attention from professionals. This was not in line with expected practice as it left them all at continuing risk of harm.
- Although the subject of seven Child Protection Conferences and over thirty Core Group Meetings during the period of the Serious Case Review there was not a clear and proactive Child Protection Plan in place as there was no assessment or analysis of the nature of the risks facing the children.
- The mother and father (of a sibling) were never challenged about their non-engagement with very few demands made upon them within the Child Protection process.
- The four children lived most of their lives in chaotic circumstances and the services provided also mirrored that chaos as there was a lack of coordination of assessment and planning across agencies.
- This appears to have produced a Child Protection process which was not effective in the main goal of keeping children safe from harm and did not provide the context for any professional to deliver a high-quality service.
- The four children lived most of their lives in chaotic circumstances and the services provided appeared to mirror that chaos as there was a lack of coordination of assessment and planning across agencies.

Local Serious Case Review - Robyn

Robyn – aged five months was presented at the emergency department by her parents with a swollen leg. Medical investigations identified a spiral fracture to her leg deemed to be a non-accidental injury.

Key Findings (Robyn)

- At the time of the injury Robyn lived with both her parents at the home of their maternal great grandmother.
- Both parents had high needs and had grown up experiencing abuse and neglect.
- Both parents had mental health problems.
- Very few agencies recorded any information in respect of this.
- Robyn's mother was classed as a Looked After Child and received leaving care services.
- In September 2014 Robyn was presented at A&E by her parents with a swollen right leg. Medical investigations identified that Robyn had a spiral fracture which was deemed a non-accidental injury.
- Subsequent investigations discovered that there were fractures of the right femur, ribs and lower left leg. These fractures were said to have occurred on at least three separate occasions and required at least five separate applications of force.
- Prior to these injuries being seen Robyn had come to the attention of agencies on several occasions. This was primarily due to poor home conditions, neglectful care and concerns regarding the mental health of the father and mother.
- Also, there had been bruising seen on Robyn the previous month by the out of hours GP, Robyn was presented at hospital three days later with blood in vomit and Robyn was observed with multiple bruising by the Health Visitor the following week.
- Despite Robyn being a non-independently mobile baby Child Protection procedures were not followed.

Key themes emerging from both local reviews

- Ineffective Child Protection Processes
- Investigation of injuries – potential for physical abuse
- Pre-birth assessment Processes were not followed
- The marginalisation of fathers – their role in family ignored/history not considered
- Parental risk factors not assessed - domestic abuse, substance misuse, relationship instability, previous history of parenting
- Identification and assessment of parent risk factors - poor
- The range of risk factors known regarding both parents were not investigated or interrogated in a meaningful way
- Working with parental non-compliance and hostility
- Ineffective information sharing
- Additionally for Robyn - despite evidence to the contrary, professionals displayed optimism about the parent's ability to provide appropriate care for her

Next steps

- Recommendations for the LSCB and partners to improve safeguarding practice included review of relevant LLR LSCB procedures; undertaking audits to further test practice and for the LSCB to be assured in a number of areas. Some of the work around improving safeguarding practice was already underway including review of LLR LSCB procedures for example the Safeguarding procedures on Pre-Birth and Management of Marks of Concern in Pre-Mobile Babies and Non-Independently Mobile Children
- Practitioners should read the review reports and follow the LLR LSCB procedures to safeguard children.
- The review reports for Nadiya and Robyn are available on the LSCB website at the following link: http://www.lcitylscb.org/learning-from-reviews/
- The LLR LSCB procedures are available on the LSCB Website at the following link: https://llrscb.proceduresonline.com/

Learning from LSCB Audits

Working together to Safeguard Children (2015) requires Local Safeguarding Children Boards to evaluate the effectiveness of multi-agency working. This can take place through multi-agency joint audits of case files alongside data scrutiny.

The aim of the LSCB multi-agency audits was to understand the quality of safeguarding practice, compliance and seek assurance that these was consistent application of the LLR LSCB multi-agency safeguarding procedures and threshold, as well as partner agency identification and response to safeguarding children. A critical part of the audit was to identify learning which supported improving and strengthening practice to safeguard children.

The topics for the audits were identified through national/local reviews, Ofsted Thematic inspections, LSCB priorities and local practice issues which are agreed through the LSCB Performance Analysis and Assurance Group (PAAG) and Board. Where possible, the audit topics and process were aligned with the Leicestershire and Rutland Safeguarding Board for joint Leicester, Leicestershire and Rutland (LLR) audits.

The key themes identified are from the following audits conducted between 2018 and 2019:

- LLR LSCB CSE audit (2018)
- Familial Sexual Abuse (2018)
- Domestic Abuse (2018)
- LLR LSCB Familial Sexual Abuse (2019)
- LLR Children Who Go Missing (2019) – LLR report being written

Summary briefings on completed audits are available via the LSCB website.

For information on safeguarding events/training practitioners and managers should access the LLR LSCBs Safeguarding Learning and Development page

Key themes emerging from audits in relation to quality of multiagency safeguarding practice Whilst practice is improving, it is still variable across services and agencies. There are examples of good practice but also practice that requires improvement.	
Compliance to procedures, including multiagency procedures and standards	Compliance to procedures is improving but not in all cases and across all agencies. Therefore, there is a need to ensure compliance. *Tools and processes not followed consistently; genograms and/or chronologies are not up-to-date and/or are of poor quality.*
Lived experience of the child/voice of the child	There is a need to continue and improve on obtaining and 'hearing' children's views as well understanding their lived experience (what is life like for this child?), including younger children and those with communication/additional needs and requiring interpreters. *Young children's views were not sought due to their age; interpreters not made available for those who required this or using children as interpreters (which is inappropriate). Lack of putting together what children say, what they want and what surrounds their circumstances.*
Case file recording	There is a need to ensure that full demographic information, including ethnicity, language and religion of the child and the family is recorded and is accurate (including spelling). Relevant information to the child such as plans and other documents should also be recorded. *Names spelt incorrectly; wrong date of birth; religion and ethnicity not recorded or inconsistently recorded; plans and relevant document not available on the record.*
Equality and Diversity	Ensure equality and diversity is considered throughout safeguarding planning and the child's journey. The diversity of conditions (for example, learning disabilities) should also be considered. *Lack of consideration of ethnic background in assessments/plans and whether this impacts on safeguarding planning; consideration of diversity widely and not just in relation to ethnicity/religion.*
Referrals	Timeliness is improving, but referrals need to include all relevant information on children, including unborn. Children should be referred to the relevant agencies/services to receive support (such as UAVA). *Unborn child not mentioned in referral to CSC resulting in this safety of the unborn not being considered at the time of the referral; delay.*
Assessments	Assessments need to include the use of tools, consider outcomes from other documents, such as EHCPs. Ensure parents/carers are involved including absent parents/fathers. *Tools and research not always used to inform assessments. Lack of engagement/involvement of partners/fathers – need to be curious of who is around in the family environment and caring for the child (or posing a risk); what are the absent parents/fathers views.*
Plans	Plans need to be SMART, consider other plans and be shared and progressed. *Plans not being SMART leading to drift and delay in meeting expectations and outcomes for the child/family.*
Communication and information sharing	There is need for improved and timely communication and information sharing between practitioners and agencies. *Information not always shared between and with relevant agencies resulting in not having a fuller picture of the child's circumstances.*
Multiagency working/meetings	There is need to improve partner agency representation and contribution to multiagency meetings, plans are progressed to meet intended outcomes, avoid drift and delay, and are escalated where relevant. The administration of multiagency meetings need to ensure that the relevant practitioners are invited, minutes are accurate and distributed in a timely way. *Not all agencies invited to multiagency meetings and not all agencies are ensuring the safeguarding plans are meeting outcomes.*
Management oversight/supervision	There is need for management oversight and supervision to be robust. *In some case management/supervision procedure is not being followed. Although supervision takes place, it is not always directive and leading to improve management of the case.*