Learning from Essex Serious Case Reviews

Practice Learning Briefing - July 2017

Welcome to the first edition of the Essex Safeguarding Children Board's (ESCB) Serious Case Review briefing.

As safeguarding is everyone's business, the purpose of this briefing is to provide a concise update of important learning points from recent Reviews so that agencies and individuals can learn lessons to improve the way in which we work together to safeguard and promote the welfare of children in Essex.

Introduction

One of the roles of the Essex Safeguarding Children Board (ESCB) through its Serious Case Review Sub-committee is to identify key learning points from our reviews to inform our multi-agency safeguarding practice when working with vulnerable children and their families. The Sub-committee has reviewed three Serious Case Review (SCR) reports and a Partnership Learning Review report involving Essex children and this briefing gives a description of each case, alongside the key learning points from each review for practitioners to consider within their own practice.

We recognise just how complex multi-agency safeguarding and child protection practice can be. It is understandable that on occasions professionals will not necessarily make the right judgement, may be overly-optimistic, and will clearly want vulnerable parents to succeed, may make flawed assessments, may not share information appropriately, or not be curious enough. This happens within the context of forming meaningful working relationships with families (and with other professionals) to help and support families effect change within their family functioning and improve the outcomes for their children.

We need to recognise the importance therefore of agencies working together to address the complexities, uncertainties and changes in circumstances when working with families. There is a need for professionals to raise questions, to discuss

Authors: Maria Barnett & Paul Secker

differences of views with each other and to reflect upon our multi-agency practice in relation to safeguarding children and young people.

The ESCB has made a number of significant changes to our pre-birth practice as a result of these Reviews.

CASES

Child J

At the age of 11 weeks, Child J was admitted to hospital having suffered a brain injury. This was considered to be a non-accidental injury, sustained whilst in the care of his parents, who had been in a relationship for about a year. At the time of the injury, Child J was subject to a Child Protection Plan (category of neglect).

Both parents had a history which involved drug and alcohol misuse, and criminal convictions which included violence (in Father's case, this included domestic abuse to a previous partner).

The Mother had four children from a previous relationship removed (by another local authority), and the Father also had children from a previous relationship who had been on Child Protection Plans.

Child J survived, but suffered considerable developmental needs as a result of the injury.

Key learning that emerged from this review included:

- The importance of Social Care obtaining a detailed family history of both parents, and ensuring that professionals from partner agencies understand the family background
- There was a significant change of direction in relation to the plans for the unborn baby, and the rationale for this was not clearly explained to partners.
- Legal Planning Meeting decisions were changed, but the rationale was not explained to multi-agency partners
- There was limited / inadequate assessments of both the parental relationship itself, and the parents' capacity to care safely for the child
- The Child Protection Conference was convened only days before the child was born, and key professionals were unable to attend
- Agencies had undertaken their own individual assessments of the family, but these were viewed in isolation and not considered collectively

- There was a combination of disguised compliance from parents, an over-optimism on the part of professionals, and practitioners understandably wanting Mother to succeed with her new baby
- There was insufficient weight given to identified risk factors in respect of the overall assessment of risk
- There were issues in respect of information-sharing and integrated working between partner agencies
- The importance of management oversight and supervision – resulting in decisions not followed, assessments not completed
- A lack of clarity, if not confusion, as to who was overseeing Father's contact with the child
- A lack of understanding by professionals about the Public Law Outline and its implications.

There was also some identified key learning points for all of us in relation to work with vulnerable families, in respect of:

- The importance of always exploring and taking into account the cultural background and heritage of each family we work with
- The importance of how agencies respond to parents who do not attend appointments (how well do we record these, share this information with partners, analyse the patterns, reflect on the meaning of failed appointments, and how do we all address the issue of missed appointments)
- Although particular agencies expressed concern about the plans for the baby, no partner agency challenged the plans, or escalated the concerns. How can professional colleagues be supported to challenge each other constructively?

Child G

At the age of 3 months, Child G was taken to hospital and found to have very serious injuries which had been inflicted upon her whilst in the care of her mother and her (relatively) new partner.

The Mother had herself had a rather troubled childhood and adolescence, and was described as having learning difficulties as she attended a special school at primary phase, though she attended a mainstream secondary school. Her first child (half-sibling to Child G) had been the subject of a pre-birth Child Protection plan three years earlier; this was due to concerns about mother's mental health / emotional vulnerabilities, and domestic abuse from her partner at that time.

Mother had only been with her new partner for six weeks; this partner was known to Probation as a result of a number of offences, and had been known to other Local

Authorities due to concerns regarding domestic abuse and risks to children. The injuries sustained by Child G had life changing consequences.

Key learning that emerged from this review included:

- The nature, extent and impact of mother's learning difficulties were not fully understood, or taken into account and did not inform the initial assessment of her parenting capacity when the half-sibling was subject of a Child Protection plan
- The need to develop effective national systems for tracking men who are known to be violent and a physical risk to children
- Information sharing systems between health agencies did not facilitate the development of a full understanding of mother's vulnerability by any one practitioner
- The information that mother's first child had been on a Child Protection plan was not considered by Health professionals during mother's second pregnancy
- A number of low-level incidents / injuries to the half-sibling were not aggregated and analysed – Health practitioners could have been more curious about these incidents and the delayed presentations of the child for medical help
- Professionals often do not have clarity as to the extent of family support (especially when children are on child protection / child in need plans, and families are anxious that the child may be removed), resulting in a lack of understanding regarding how much of the parenting is actually being undertaken by the extended family
- The importance of detailed and outcome focused Child-In-Need plans, which include an assessment of the sustainability of changes made within families which reduce risks to children.

Child L

Child L's Mother had a long-standing history of anxiety-related mental ill-health. She had five children with three partners (Child L was her fifth child). Mother's anxiety made her quick to seek medical advice for both her own and her children's health.

Child L's biological Father had an extensive criminal record and history of substance and alcohol misuse.

A wide range of voluntary and statutory agencies were involved with the family, and there had been a recent Child-In-Need meeting.

At the age of three months Child L was admitted to Accident & Emergency, as his parents reported him to be floppy, unresponsive and that he was vomiting. Following two days of investigation, extensive sub-dural haemorrhages were detected and

Child L was transferred to a specialist hospital. Further observations revealed bilateral retinal haemorrhages, and the conclusion was that his injuries were 'non-accidental'.

Key learning that emerged from this review included:

- There was little sense of the parents' own childhoods and the likely impact of these experiences upon their ability to parent; it emerged latterly in the review that both parents had been in care at times as children
- The professional involvement appeared to reflect the degree of chaos and dysfunction within the family; this was not however a case of being over-optimistic, more a case of professionals being overwhelmed by the intractability of the issues they were facing
- Interventions focussed on the adults within the family; there was no voice of the child (there were a number of older siblings in the family). Importantly there was no sense of "what it was like being a child in this family"
- Efforts to support the family were unhelpfully spread across a large number of agencies and respective roles were not always clear or understood; the focus was on day-to-day support rather than a co-ordinated plan for change
- There was insufficient / inadequate multi-agency coordination especially amongst primary health care and mental health related services
- The impact of the parental functioning on the children was widely under estimated. This was particularly the case in respect of the Mother's mental health needs which were of central importance to the safety and emotional well-being of all her children
- There was insufficient exploration of domestic abuse issues
- The practical support offered to this family, whilst certainly well-intentioned, inadvertently obscured just how much the family was not coping.

Child K (Partnership Learning Review)

Child K was born and died on the same day. The cause of Child K's death was unclear at the time, and has remained so.

Her parents experienced difficult childhoods in dysfunctional families, including abuse, separation and periods in care. Both parents became long-term drug-users in their early teens.

They had five children together, the oldest two were removed and adopted by another local authority due to concerns about the drug-use and the impact upon the couple's parenting. The third and fourth children were living with their parents.

Key learning that emerged from this review included:

- The parents' experiences of having their first two children removed from their care seems very likely to have been a significant factor in the family's avoidance of professionals when mother became pregnant again, and this did not appear to have been recognised by all professionals
- Information-sharing between agencies should ensure that all agencies are aware of the family's previous history, are alert to issues of concern, and can respond appropriately to changes in circumstances
- Pre-birth assessments and planning should always consider both the family history and the current capacities of parents to care for their children
- Non-attendance at appointments/avoidance of contact with professionals must be noted, shared with partners, interpreted and addressed
- The family had demonstrated at different times enough stability and consistency of parenting for the case to be appropriately closed to Social Care. All families experience changes in circumstances and the appropriate re-assessments were only undertaken both very late in the pregnancy and were not well co-ordinated
- Agencies need to ensure appropriate challenge to other partner agencies where there is a disagreement with the planning for children
- There was too much reliance by Social Care on the fact that other agencies were not reporting significant concerns during Mother's pregnancy. Other agencies did have increasing concerns; however no one agency held the full picture
- There was an over-optimistic view of the family, and a lack of professional curiosity
- This case again emphasised the importance of good quality assessments which take into account both the parental relationship and their parenting capacities at the time and in the future
- There was a minimal focus on the two children living within this family in the pre-birth period.

Recurring themes throughout these Reviews

Poor communication and information sharing between agencies

All of the SCR's identified episodes of poor communication and information sharing between agencies. Agencies that hold a rich mix of information on children should consider how they can store that information in a format that can be shared effectively when there is an appropriate requirement.

Assessments

Assessments were not considered to be thorough or comprehensive and therefore did not contribute to effective decision-making and action. These are critical elements of our practice, which need to consider all aspects of a family, including family history, the strengths of the parental relationship, the parental capacity, the capacity of families to make and sustain positive changes, as well as the identification and assessment of risk. In some of the cases family history, chronology and genealogy were not considered as part of the assessments.

Neglect

Neglect was a key feature, and in some cases there was clear evidence of inter-generational neglect. Children and young people not in school, or with poor attendance, can be especially vulnerable. Children who suffer neglect may not speak out or tell anyone what is happening, if the neglect has been a consistent element of their lives they may not have experienced anything different. Some children may hide and minimise the abuse they are suffering; they may need to keep quiet to survive.

Domestic abuse

The impact of domestic abuse is harmful to all children and young people and it can have a serious impact on a child's behaviour, and their physical and emotional wellbeing. Parents or carers frequently underestimate the effects of the domestic abuse on their children. This is often because they don't recognise the domestic abuse themselves, they may not want to acknowledge what is happening or they may fear the authorities' responses.

Domestic abuse was a feature within each review.

Managing Risk

Recognising, assessing and addressing the levels of risk and need are themes across all of the SCR's. Understanding the vulnerability of children and identifying some of the factors that place them at a higher risk of abuse and neglect is an essential skill. Assessing risk requires an understanding of underlying issues within a family taking into full account the family history, and not just considering the current or presenting incident.

Both risk and protective factors in the parent(s) and the wider environment need to be understood and analysed, with a focus on the impact on the child. Professionals working with pregnant and new mothers need to consider the long term impact of unresolved childhood trauma and abuse on future parenting capacity.

In two of the SCRs there was little professional curiosity and scepticism around fathers and other males. Significant change such as a new partner or non-attendance at appointments is a cue for reappraisal of the risk assessment.

Lack of engagement from families

Many of the families in these cases had a history of poor engagement with both Children's services and other services. This included failure to attend medical or other appointments, a lack of take-up of supportive services (Early Help), and a lack of engagement with school staff, etc. all of which resulted in the children being left at a level of risk. In some of the cases the families were very reluctant or resistant to engage, and in such circumstances we should always focus on what such resistance might mean for the child.

Examples of some of the actions taken by the ESCB or individual agencies as a result of these reviews:

- Promoted the 'Whole Essex Information Sharing Framework - Safeguarding Protocol: https://weisf.essex.gov.uk/Pages/default.aspx

- Updated the SET Child Protection Procedures, including chapter for escalating concerns or challenging decisions, and expectations around information sharing: http://www.escb.co.uk/Portals/67/SET%20Procedures-April%202017-updated.pdf

- Published a guide to the Public Law Outline: http://www.escb.co.uk/Portals/67/Documents/professionals/Public%20Law%20Outline%20-%20guide%20for%20practitioners.pdf

- Published additional multi-agency Pre-birth Assessment Protocol and delivered training in each quadrant area for all partner agencies: http://www.escb.co.uk/Portals/67/Documents/Local%20Practices/Pre-birth%20Assessment%20multi%20agency%20protocol%202015-V4%20final.pdf

- Offered ESCB training opportunities to strengthen understanding about child protection processes: http://www.escb.co.uk/en-gb/learninganddevelopment.aspx

- Published the Joint Commissioning Strategy for Domestic Abuse 2015-20: http://www.escb.co.uk/Portals/67/Professionals/DA/2015%2009%2024%20Essex%20DA%20Strategy.pdf

- Launched the new Domestic Abuse Multi-Agency Risk Assessment Team (MARAT) in July 2016.
- Published the SET Domestic Abuse Information Sharing Guidance May 2017:

http://www.escb.co.uk/Portals/67/Domestic%20Abuse%20Information%20Sharing%20Guidance%202017.PDF

- Delivered the ESCB annual conference in 2016 on Learning from Serious Case Reviews delivered to 250 people working with children and families in Essex: http://www.escb.co.uk/en-gb/learninganddevelopment/annualconference.aspx
- Delivered multi-agency partnership briefings across Essex over 2016 – 2017 on the learning from recent local Serious Case Reviews and Partnership Case Review.

- Published ESCB Neglect Multi-Agency Practice Guidance March 2017:http://www.escb.co.uk/Portals/67/ESCB%20Neglect%20Practice%20guidance%202017%20-Finaldoc.pdf

- Multi-agency themed case audits on Domestic Abuse and Children In Need were commissioned and the findings will be shared with the ESCB later this year.

What we are asking you to do

We think it is important, and would also be helpful to ask professionals within all agencies to:

- Reflect on the findings of these reviews and consider the implications both for your service and your own practice
- Consider what you and your team might do differently to improve practice as a result of these reviews
- Discuss with your Team / Line Manager how this could be achieved

Sharing learning from Serious Case Reviews in order to improve safeguarding practice is extremely important.

Recurrent findings from National research into Serious Case Reviews

There is not an exhaustive list, but typically the recurrent findings from Serious Case Reviews nationally include:

- The lack of the voice of the child or young person
- Adult-focused practice
- The lack of involvement of fathers
- Inadequate information-sharing
- Agencies not working together in an integrated and co-ordinated way
- Over-optimistic thinking
- Lack of professional curiosity
- Flawed assessments and judgements
- The focus upon support for families rather than identifying , assessing and managing risk
- Chaotic family functioning mirrored by the professional network
- The lack of management oversight and reflective supervision

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Other useful links

ESCB Serious Case Review Toolkit
The SCR toolkit can be accessed on the ESCB website. It sets out the arrangements by which the Essex Safeguarding Children Board will conduct case reviews.

National Case Review Repository
Holds all Serious Case Reviews published in the UK from 2013 and can be found on the NSPCC website.

The Essex Safeguarding Children Board is currently undertaking one Serious Case Review and two other Partnership Learning Reviews

We will aggregate the learning from these three reviews when they are completed, and publish a further briefing.

If you have any questions about this briefing paper, please contact the ESCB on: **escb@essex.gov.uk**

Authors: Maria Barnett & Paul Secker