Learning from Serious Case Reviews

MSCB Training Pool

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MANCHESTER SAFEGUARDING CHILDREN BOARD

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Learning from Serious Case Reviews

Aim: - To share the learning from Serious Case Reviews undertaken locally and nationally.

Learning outcomes

- Explain the relevant functions of Manchester Safeguarding Children Board.
- Outline the criteria and purpose of a SCR as outlined in Chapter 8 'Working Together 2010'.
- Identify the learning and recommendations from local cases.
- Define local and national themes.
- Develop analytical skills and reflective practice.

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Learning from Serious Case Reviews

Criteria (Working Together 2010): -

- When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death.

The LSCB should **always** conduct a SCR into the involvement of organisations and professionals in the lives of the child and family.

This is irrespective of whether local authority children's social care is, or has been, involved with the child or family.

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Criteria continued: -

These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse.

In addition, a SCR **should always** be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Youth Offending Institution (YOI) or a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005.

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LSCBs should **consider** whether to conduct a SCR whenever a child has been seriously harmed in the following situations: -

- A child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or
- a child has been seriously harmed as a result of being subjected to sexual abuse; or
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult;

and

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…the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

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Purpose: -

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra-and inter-agency working and better safeguard and promote the welfare of children.

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The purpose is not to: -

- Inquire into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.
- Facilitate part of any disciplinary inquiry or process relating to individual practitioners.

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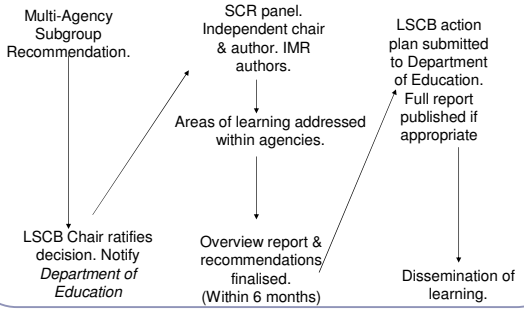
Process



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Break

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Serious Case Review 1

Child H & I

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Group exercise

Case study 1

Exercise: -

- Discuss the circumstances of the case and identify 5 or 6 key issues (potential learning points).
- List the issues on the flipchart paper.
- You have 20 minutes to complete this exercise.
- Be prepared to share your findings with the whole group.

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Learning from Serious Case Reviews

Child H & I key issues: -

- Mental health.
- Role of fathers.
- Substance misuse – Drugs, cultural issue?
- Cultural issues – Previous residence, support?
- Response to emergency situation on the day.
- Mother's history (Child Protection/safeguarding).

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Learning from Serious Case Reviews
Child H & I Multi-Agency Recommendations

- MSCB & the Manchester Safeguarding Adult Board to demonstrate evidence of working in order to ensure a coordinated & balanced approach in catering for the needs of a vulnerable adult whilst safeguarding any children for whom they care.
- MSCB to develop specific practice guidance to assist professionals in assessing children and families' culture, race, language, religion & disability, including the impact these factors may have on the relationship with practitioners.
- MSCB to assist the Voluntary & Community Sector Forum in producing guidance for staff undertaking the role of Lead Professional that provides clarity about working with partner agencies, including sharing information.

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Learning from Serious Case Reviews
Child H & I Multi-agency Recommendations continued

- MSCB to produce practice standards & a specific assessment tool to assist professionals in understanding the role of fathers, including absent fathers, and their specific needs, and involving them in their work.
- MSCB to produce regular briefing papers for frontline staff about the lessons learnt from Serious Case Reviews.
- MSCB to organise awareness-raising training to assist staff in identifying the indicators of parents' deteriorating mental health & what action to take in such an eventuality.
- MSCB to include reference to risk & protective factors within the multi-agency audit methodology that is currently being produced.
- MSCB to produce a joint procedure for managing emergencies where a child may be at immediate risk of harm due to an adult's acute mental health needs.

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Learning from Serious Case Reviews

Child H & I Inter Agency Recommendations: -

- All NHS Provider Trusts in Manchester to fully implement the Common Assessment Framework (CAF) & the Integrated Working Model, & provide evidence of improved performance to the MSCB.
- The relevant NHS Trusts should review the accessibility of their mental health services taking account of the preference of some potential users for an open-access provision.

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Recent theme

Child V

Lack of effective supervision & reflective practice

Child development

Child U

Lack of effective management oversight

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When do you reflect?

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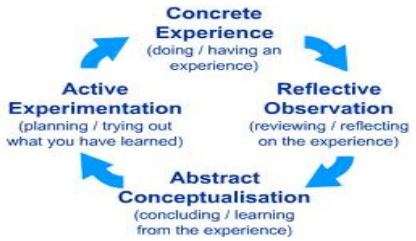
Reflective & reflexive practice

Kolb's reflective cycle



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Double loop learning

Argyris & Schon, 1978

Single-loop learning seems to be present when goals, values, frameworks and, to a significant extent, strategies are taken for granted. The emphasis is on 'techniques and making techniques more efficient' (Usher and Bryant: 1989: 87) Any reflection is directed toward making the strategy more effective.

Double-loop learning, in contrast, 'involves questioning the role of the framing and learning systems which underlie actual goals and strategies. The basic assumptions behind ideas (governing variables) or policies are confronted. Double-loop learning is necessary if practitioners and organizations are to make informed decisions in rapidly changing and often uncertain contexts.

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Brookfield's 4 lenses (1995)

- our own view (which he refers to as *autobiography*)
- that of our students (in safeguarding the child)
- that of our fellow professionals
- and the various theoretical perspectives propounded in literature

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Lunch

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Serious Case Review 2

Child O & P

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Group exercise

Case study 2

Exercise: -

- Discuss the circumstances of the case and identify 5 or 6 key issues (potential learning points).
- List the issues on the flipchart paper.
- You have 20 minutes to complete this exercise.
- Be prepared to share your findings with the whole group.

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Child O & P Key Issues

- Neglect
- Domestic abuse (seen as 'incidental')
- Parental alcohol misuse
- Parental mental health
- Family history/chronology not taken into account
- Disguised compliance
- Children's voice not heard
- Learning difficulties not responded to
- No one agency had full picture

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Child O & P recommendations

- MSCB Neglect training to be reviewed to ensure assessment of neglect is a continuous process
- I.A not to be signed off until family history assessed.
- DA policy for acute health staff in line with CMFT & MSCB guidelines.
- DA policy for Police to explicitly state that bail conditions must protect victims.

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Child O & P recommendations

- Probation must refer or contact CSC in all cases of DA where there is children in family.
- Early years staff to understand impact of alcohol misuse on parenting…

…many other including those relating to risk assessment, fire risk assessments, recording information & reviewing safeguarding polices.

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Break.

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Learning the lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008 (50 cases)

- Concerns about **drug and alcohol misuse** were identified in 17 reviews

  There was a failure of agencies to adequately assess the risks posed by drug and alcohol misuse, particularly to very young babies

- Concerns about **domestic violence** featured in 15 serious case reviews

  The failure of agencies to understand, accept and assess the impact of domestic violence on children was a frequent finding

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- **Mental illness** featured in 14 serious case reviews and was not always appropriately considered as part of the risk assessment to children

  The cooperation of mental health NHS Trusts and other specialist services with serious case reviews varied from good to poor.

- **Learning difficulties and/or disabilities** were often linked with mental health issues for both parents and children

  There was insufficient assessment of the impact of the learning difficulties of adults on their capacity as parents and on their own mental health

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Key messages

- Poor understanding of basic child protection signs, symptoms and risk factors by staff in mainstream services.
- Agencies responded reactively to each situation rather than seeing it in the context of the case history.
- No single agency had a complete picture of the family and a full record of all the concerns.
- Staff accepted standards of care that would not be acceptable in other families.

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- Little direct contact was made with the children to find out what they thought about their situation.
- Professionals were uncertain about the significance of issues in complex and chaotic families and too much reliance was placed on what parents said.
- Families were often hostile to contact from professionals and developed skilful strategies for keeping them at arms length.

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- **Families not keeping appointments.** The missed appointments were recorded, but no-one collated the information or questioned its significance. In one case the drug and alcohol service had a policy of discharging new patients if they failed to keep two appointments.

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Overview of Manchester SCR's

December 2010

6 SCRs involving 9 children (8 deaths):

- 6 children were 5 years old or under (younger than 2009 overview)
- Domestic abuse significant
- Parental alcohol misuse significant
- Mental health issues highlighted
- 4 of 6 cases overcrowding (current or historical) was an issue

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Practice themes (Manchester)

1. Failure to recognise risk and safeguarding responsibilities
2. Inadequate assessment
3. Inadequate intra & inter agency communication
4. Failure to follow safeguarding procedures
5. Flawed planning & review

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Practice issues

- Record keeping
- Sharing of information within and between agencies
- Contributing to assessment of parenting capacity
- Knowing and responding to indicators
- Following basic procedures
- See the situation from the child's perspective
- Focus on the child
- Not taking the parents word at face value (respectful uncertainty)
- Missed appointments (neglect)
- Not assuming other people know/and are responding
- Evidencing improved practice
- Evidencing improved outcomes
- Quality assurance-single & multi-agency
- Training
- Assessing and responding to racial, cultural, linguistic, religious identity and disability

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Professional dangerousness

- Rule of optimism
- Stockholm syndrome
- Professional accommodation syndrome
- Concrete solutions
- Assessment paralysis
- Stereotyping
- Disguised or false compliance

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Professional dangerousness continued

- Omnipotence
- Role confusion
- Family & children unheard
- Start again syndrome
- Unsafe working

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Example case of good practice in Manchester

- One protective parent
- Clear leadership
- Both parents recognising impact of behaviour on parenting
- Parents understanding consequences
- Transparency & consistency of message from all professionals

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Hypothesising

- Develop at least four hypotheses: what are these based on, how will you test them?
- Review: have you been able to test them out, can you discard any, have new ones emerged?
- Evaluate: Have you tested them all rigorously, is this recorded in your assessments, what recommendations do you have?

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Concluding remarks

Thank you

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Don't forget to leave your feedback n the training website

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