Learning Lessons Workshop

Focus on Serious Case Reviews

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Predicting which children will be safe and which will be at risk is an uncertain business. We can only aim to reach the decision that is 'best' according to our current general knowledge and understanding of the particular case. The inevitability of some mistakes in this type of work has been overshadowed by cases where the errors seemed avoidable. Which errors of judgement are due to our limited knowledge and which to inadequate investigation and woolly thinking?

Both the general public and social workers need a clear understanding of the distinction between avoidable and unavoidable errors. Inquiries which then blame social workers tend to capture the limelight and are reported by the media in vivid detail. But although the death of a child is proof that the services failed to protect him or her, it is not proof that anyone acted improperly.

The main purpose of inquiries is not to allocate blame but to see if any valuable lessons can be drawn from the tragedy to improve services in the future. To change your mind in the light of new information is a sign of good practice, a sign of strength not weakness.

Munro review of child protection: final report - a child-centred system (2011)

- The remit of this review included a specific request to consider how Serious Case Reviews (SCRs) could be improved. There has been considerable criticism of the current SCR methods and evidence from professionals report that:

- ‘There is an overwhelming sense that there is too much emphasis on getting the process right, rather than on improving outcomes for children, of the process being driven by fear of getting it wrong, of practitioners and managers feeling more criticised than supported by the process, and that the Ofsted evaluations do not support learning’

- Ofsted noted ‘Serious Case Reviews were generally successful at identifying what had happened to the children concerned, but were less effective at addressing why’
Learning Aims

- This workshop considers the learning arising from this local inquiry and how we implement the learning in our practice and change the way we work with families in order to protect children.

- Following this workshop we will be contacting you to ask how you have taken the learning forward both within your own practice and within your organisation.
Context of Serious Case Reviews: Messages for Policy and Practice

Karen Dale
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Why hold a Serious Case Review?

• The death or very serious injury of a child from abuse or neglect calls for careful consideration of the circumstances to ascertain whether lessons can be learnt and changes made that might improve the quality of services in all cases and prevent or reduce the likelihood of such events occurring again.

• Every report has been accompanied by a call for a change in the system – how best do we learn?
Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB’s function in relation to serious case reviews, namely:

• 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
• (2) For the purposes of paragraph (1) (e) a serious case is one where:
  • (a) abuse or neglect of a child is known or suspected; and
  • (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
Dennis O’Neil
(died 1945 aged 12yrs)

• Care of Newport Borough Council
• He suffered a heart attack following a brutal beating to his chest and back with a stick by his foster father
• Issues that contributed to his death – poor record-keeping and filing, unsuitable appointments, lack of partnership working, resource concerns, failing to act on warning signs, weak supervision and “a lamentable failure of communication”
• Failings did not die with Dennis
What have we learnt?

• Despite most, if not all, cases being similarly avoidable, a general analysis of the inquiries does not throw up a picture of gross errors or catastrophic failures by individuals, but rather a succession of errors, minor inefficiencies and misjudgements by several agencies. We have quite simply too often got the basics wrong.

• Often parents’ views were ignored (e.g. request for a child to leave the home) and children were regularly not listened to.
7 steps to better protection
Dennis O’Neil to Victoria Climbie

• Multi-agency working
• Understanding of other agencies roles
• Communication
• Recording
• Supervision
• Risk assessment and risk management
• Decision-making
Serious Case Review

The circumstances of this child’s death (referred to within this report as the ‘Young Person’) was considered by Cornwall and Isles and Scilly Children’s Safeguarding Board (the LSCB) and it was agreed that the criteria for a serious case review (SCR) as set out in Chapter 4 of “Working Together to Safeguard Children - a guide to inter-agency working to safeguard and promote the welfare of children” March 2013 were met.
Learning

From the review analysis a number of themes emerge from which learning points and recommendations have been extrapolated. For the methodology used there is no action plan devised for the LSCB. It is for the LSCB to consider the recommendations and then plan accordingly on discussion on where the priorities should lie for the LSCB. In considering the areas of learning and recommendations made by the SCR Independent Author the LSCB has accepted the learning and actions detailed below:

**Learning:**
An emerging theme arising from the SCR centred upon the identification and management of possible fabricated and induced illness (FII). In particular it was felt that the SCR highlighted the need for agencies to:

*Always consider and understand the voice of the child and their lived experience.*
Professionals should assess the child and their abilities outside any assumptions that may arise from a specific diagnosis within the safeguarding process

**All Agencies – Learning Group - Reconstruct**

Listening to the child is a cornerstone of sound safeguarding and is vital for a child centred approach. Professionals should be supported by senior staff to challenge any dynamic that blocks the child’s viewpoint being clearly expressed.

**All Agencies – Learning Group - Reconstruct**
Learning

**Professional response to parental mental health problems.**
There should be effective challenge of parental attitude toward their own mental health needs to ensure it is seen as essential in attaining positive parenting. The potential impact on the child should be clearly set out- as long as this would not put the child at greater risk.

**All Agencies – Learning Group – Reconstruct**

Indicators of risk and threshold document should be understood by all LSCB agency members and be considered in reflective supervision alongside the Signs of Safety approach in all cases.

**All Agencies – Learning Group – Reconstruct**

**Identification and management of suspected FII.**
LSCB to commission training for specific professionals around the identification and management of suspected Fabricated Induced Illness cases and capture ‘best practice’ and the learning identified within this serious case review.

**Learning Group & Reconstruct**

LSCB to agree an overarching practice protocol around Fabricated Induced Illness to bring clarity on management for the spectrum of cases. This is currently being considered using shared approaches and polices used nationally in preparation to adopt best practice for FII. This will need to be actively promoted by the LSCB and then adopted multi agency. This needs to remind professionals around information sharing protocols and their importance.

**Learning Group & Reconstruct (South West Safeguarding and Child Protection Procedures)**
Learning

- Family members outside the parents appear to have had quite a good insight into the underlying problems that were impacting on the Young Person’s life and brought this to the attention of Children’s Services. Good practice should be followed in that:-

- Family members reporting their concerns need to be listened to, have their concerns acknowledged, recorded and followed up. These concerns should be included in chronologies.

- Family members who contact agencies do so based on their observations of the child, parents’ behaviours and/or their previous experience of being parented by the parents and this should be acknowledged.

- Where it is a sibling reporting this may be because they do not want what happened to them to be repeated in their younger sibling.

- They may have concerns in relation to the mental health of their parents.

Learning Group & Reconstruct

- All family contact should be recorded and needs to be taken seriously, respected and given credence in relation to the information provided when assessing children especially where Fabricated or Induced Illness (FII) is hypothesised.

Learning Group & Reconstruct

- Information sharing in relation to family contacts is not currently part of multi-agency training and this should include information provided by family members.

Learning Group & Reconstruct
**Actions**

- **Always consider and understand the voice of the child and their lived experience.**

- Core assessments need to be completed in a timely fashion – this is monitored through the Children’s Social Care Quality Assurance Performance Framework and management oversight. **All Agencies**

- Core assessments – all agencies need to contribute in a timely fashion and involve families. **All Agencies**

- **How do we evidence that we have achieved this?**
Actions

**Inter-agency co-ordination to a chronic health problem.**

The integration programme for health and social care should consider the viability of shared IT systems to allow professionals across various health providers in the community and the hospital to better understand the child’s needs outside of the one dimensional outpatient clinic appointment. In the interim some form of local memorandum of understanding between the various components of health would assist along the lines that exist for multiagency information sharing. This should include information about the parents on a need to know basis for safeguarding. **Health & Social Care**

It is recommended that the NICE guidance for this chronic condition is acknowledged and fully adopted cross all agencies immediately. **Health**

A review of organisations’ DNA policies is recommended to support practitioners to ‘think safeguarding’ at each opportunity. **All Agencies**

Primary care needs to conduct a governance review/audit upon repeat prescribing practice in the context of sound medicines management and safeguarding children. **Health**
Actions

Considerations when a child exits mainstream education.
That the Children’s Trust Board reports to the LSCB on an annual basis with regard to the satisfactory provision and actions taken in relation to home educated children. (Reference: Report to the Secretary of State on the Review of Elective Home Education in England. Graham Badman).

Children’s Trust – Schools

The Department of Education considers the learning arising from this serious case review in relation to safeguarding concerns where children and young people are subject to ‘Home Elective Education’. National Serious Case Review Panel
Actions

Professional response to parental mental health problems.

The impact of parental mental health on their ability to parent needs to be explored under parenting capacity and whole system family therapy and other therapeutic approaches used if indicated. Cornwall Partnership NHS Foundation Trust – Mental Health Services

If a parent alludes to previous mental health needs but does not directly give permission for this to be explored with their own GP, then advice needs to be sought from mental health professionals/legal team. Cornwall Partnership NHS Foundation Trust – Mental Health Services & GPs

Where parents do not consent to take help and their mental health influences positive parenting consideration should be given to escalation to multi-agency discussion – Early Help & Multi-Agency Referral Unit All Agencies

GP’s have a major role to play in supporting the parent with mental health problems in the family context and in taking forward the safeguarding concerns if they arise. It is recommended that GP’s safeguarding leads emphasise this in the mandatory child protection training programmes and GP accountability and responsibility to be proactive rather than passive. Health & Wellbeing Board
Actions

Identification and management of suspected Fabricated Induced Illness.

A multi-agency consultation group to be established to consider cases where FII is considered should be established. **LSCB**

Social care, when contacted, needs to evaluate the information gathered and share with relevant agencies, and ensure that the views of medical professionals are part of the decision-making process, especially when FII is suspected. That said, it will be necessary to challenge where there is a difference of professional opinion and where necessary to escalate using the LSCB escalation policy. **Social Care**

Where possible a multi-agency (integrated) chronology should be used to establish patterns of behaviour, share information and identify risk. **All Agencies**
Actions

The child who refuses health care/services.
Health staff need to be reminded of the legal framework around consent for children who would be deemed to be competent to consent but are refusing treatment or care that health professionals deem is necessary and is in the best interest of the child. This should include going to hospital even when the primary objective of being seen at the hospital is to assess rather than treat immediately. Professionals should understand that on occasions proportionate force is required and proportionality is considered in terms of the gravity of seriousness. The more grave the situation the more proportionate it is to use reasonable force. **Health**

Professionals need to undertake formal assessments of mental capacity within the legal frameworks so that they can assess if a child can understand the consequences of not being treated and whether they can weigh that up and make a truly informed choice. All assessments of this nature must be recorded in detail and conducted with the child alone preferably to prevent any overt or covert duress or coercion from family members either way. This relates to the Fraser guidelines and whether a child would be considered primarily to be competent to consent to care. **All Agencies**
Conclusion

This serious case review has highlighted many learning points and in areas that present real challenge to professionals around decision making where there may be an indication of Fabricated or Induced Illness (FII) or where a chronic medical condition requires a sophisticated approach due to complexity.

This review also emphasises that there is a spectrum of FII type scenarios for professionals to navigate but navigate these they must. **However, it must also be remembered that FII was not diagnosed in this case and the Young Person died from cardiac arrest resulting from a long standing health condition.**

For children who need additional help, every day matters and the child’s needs must always be paramount. While there is much learning in previous SCR’s around the impact of parental mental health upon children within a family this review has certain novel features that open up a real opportunity to embed some changes in ethos as well as process.