

Lessons from Case Reviews

The logo for Salford Safeguarding Children Board features the text "Salford Safeguarding Children Board" in white, bold, sans-serif font, set against a solid green rectangular background. This green box is positioned over a blurred, grayscale image of a person's face, which is partially visible in the background of the entire page header area.

Introduction

There have been a series of reports providing an overview of Serious Case Reviews (SCRs) findings in England & Wales.

This report attempts to do a similar thing in respect of Case Reviews (including SCRs) in Salford, whilst also referencing findings from SCRs outside Salford. It identifies several common themes that recur in case reviews in Salford and nationally, namely:

- Communication/Information sharing
- Challenge & Escalation
- Assessment & Analysis (including use of historical evidence)
- Recognition & Referral
- Working with Resistance
- Equality & Diversity
- Voice of the Child/Child in focus

The most recent SCR in Salford is re Child H published as an Executive Summary in 2011. Further information about this case can be found at <http://www.partnersinsalford.org/sscb/casereviews.htm> and information about previous Salford SCRs at <http://www.partnersinsalford.org/sscb/sscbcasereviews.htm>

An excellent resource for SCRs conducted elsewhere and also for national surveys is the NSPCC website at http://www.nspcc.org.uk/Inform/resourcesforprofessionals/serious_case_reviews_homepage_wda82779.html

Follow through

You are encouraged to follow through your reading here and your understanding from the conference presentations with some additional reading. Weblinks are provided for that

purpose. But it is important to share your learning with your colleagues in the workplace and in supervision with your manager.

As you read this paper you will notice that although it is assembled in themes, there is a great deal of overlap between the themes so that when examples are given, they could be categorised simultaneously under two or more themes. This reflects the complexity of the work we do in safeguarding children, promoting their welfare and working with everyone who can do those things.

Communication/Information sharing

Information sharing is a regular feature of SCRs in England. Brandon et al note that *“the need for better information sharing, both between and within agencies, was central to many of the recommendations made, and was addressed in some respect in 19 out of the 20 reports”*. (p.26)

This is also reflected in Salford. For example, the Child H Serious Case Review is critical of the information sharing and communication systems within and between agencies. There were numerous examples where information should have been routinely shared between agencies but was not. This effectively meant that there was only a partial understanding by many agencies about the full extent of problems within the family.

In the Child D SCR, Adult A also gave information about her drug use to different professionals. This served to mislead them. There was ineffective communication between agencies and records were not always reviewed for historical information. This resulted in a lack of follow up, a lessening of concerns and case closure without all aspects of Adult A and Child D’s life being considered.

In Case1 (a Case Review, not a SCR), a carer developed Mental Health problems but those details were not shared with Children Services partly because mental health practitioners did not know about the carer’s responsibilities and because they only had brief involvement they expected other staff to assess potential safeguarding concerns. Also on at least 2 occasions Strategy meetings were not convened which would otherwise have given the opportunity to share information.

Incompatibility of systems is not unusual; for example in Case 1, Children’s health clinical records were still in paper form, which meant that the School Nurse didn’t have access to them when attending a Statutory Review meeting.

The government has excellent information sharing guidance and the Greater Manchester Safeguarding Children procedures provide useful guidance based on these.

Follow through:

- 'A Study of recommendations arising from serious case reviews 2009-2010' - Marian Brandon, Peter Sidebotham, Sue Bailey and Pippa Belderson. DfE 2011. (see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182521/DFE-RR157.pdf)
- http://greatermanchesterscb.proceduresonline.com/chapters/p_info_sharing.html
- <http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/a0072915/information-sharing>

Challenge and Escalation

In the SCR re Child H the decisions made in the early Child Protection Review Conference in 2003 and May 2009 were fundamentally flawed and not based on an accurate understanding of the level of risk, the capacity for Adult A to change or the true impact on the children. It was particularly worrying that there was a lack of challenge to the recommendations and decisions being put forward by Children's Social Care. The SCR identified that is a priority that there is a cultural change whereby legitimate professional challenge ensures that there is a true multi-agency dimension to complex decision making in safeguarding children.

In the SCR re Child D, the following findings were made:

- Health agencies should have taken action in their own right and challenged rather than defer to Children's Services if they considered that thresholds of intervention were met and referred to Children's Services.
- SSCB should ensure each agency has in place comprehensive supervision policies which identify areas of professional differences of opinion and which strengthens the position of all professionals to challenge the decisions of Children's Services.

There is evidence from the first Practice Audit in 2013 that there is an increased level of challenge between agencies but the Case 6 learning event did identify that where there was a lack of challenge it was related to practitioners not being prepared to raise their concerns with other agencies. Therefore challenge is also intrinsic to information sharing. If information is shared that in itself can constitute a challenge to the other practitioner/agency to consider what they know and the level of risk in the light of the new information.

Once again, this issue of challenge is not confined to Salford and has been a feature of other SCRs elsewhere in England. For example the SCR *"In respect of the Serious Injury of*

Case No.2010-11/3 published by Birmingham SCB in August 2013 found that staff in the nursery were reluctant to challenge the staff member who was later convicted of child sexual abuse offences. The report commented that, *Staff teams who are in conflict, and focused on their own needs rather than those of the children, are unlikely to be in environments where constructive challenge of each other's practice will be seen as a positive contribution to the wellbeing of children.* (6.30). It also found a lack of challenge from Ofsted inspectors in respect of the decision by children's services not conducting a s47 investigation.

Therefore the Birmingham SCR shows that challenge, or the lack of it, can feature at all levels of practice and management and that it can be embedded in an organisational culture of practice. In Salford this has been recognised by the increased emphasis on challenge in the Board's activities. For example, the exec and board are presented with challenge questions from the performance management function. The case review function has a clear remit and has made several recommendations that both challenge partner agencies and raise the profile of the importance of challenge in practice. Compliance with the actions arising from these is monitored closely. SSCB training courses have been revised to ensure that the importance of challenge is emphasised.

Case 1 in Salford has shown that sometimes it is necessary to challenge the assumptions held about a situation or the people involved in it. In this case the foster carers' ability to parent safely was taken as a given possibly by the very fact of them being foster carers. This case was also marked by a lack of focus on the child's needs at the point when the problems arose for the carers. Which suggests that lack of 'critical reflection' or 'challenge' can result in the child's best interests being put after concerns about the adults.

Follow through:

- http://www.lscbbirmingham.org.uk/images/stories/downloads/executive-summaries/Published_Overview_Report.pdf

Assessment/Analysis/use of historical info

In the case of the SCR re Child H although there was a significant amount of historical information known about Adult A, that information was never adequately analysed and used appropriately to help gain an accurate understanding of the level of risk to the children. The Serious Case Review stresses the importance of the use of historical information in assessments of family functioning. In this case there was an over optimistic and unrealistic perception of Adult A's capacity to care for the children.

The full impact of this historical information on the children was not fully appreciated by professionals working with the family. There were also some concerns that staff within the Drug Service were not always familiar with the links between child protection and illicit

drugs misuse. The combination of drugs misuse, domestic violence and parental mental health alongside historical factors should have led to a much higher level of concern than was seen in this case.

The SCR re Child H identified that there should be a priority considering the use of existing models of assessment. It is clear from both this Serious Case Review and national evaluations of Serious Case Reviews that assessments can be of poor quality, often failing to sufficiently analyze historical information and are static instead of taking an ecological perspective. This is a significant point of learning for LSCBs.

The SCR re Child H also recommended that the LSCB should review the use of existing models for assessment, including Initial assessments, Core Assessments and the Common Assessment Framework. The Review should consider both the quality of assessments, and the skills required by practitioners to undertake assessments. This has wider national implications in that the quality of assessments, particularly the lack of analysis of historical information, is a common theme of Serious Case Reviews.

Recognition/Escalation/referral

Deficiencies in recognition and referral have regularly featured in the results of SCRs, not least the cases of Victoria Climbié and Peter Connelly. Closer to Salford, for example, the Bury SCR in 2006 re Child A05 and A06 (with some history of residence in Salford) stated that ‘The key issue in this case is the failure by all professionals to recognise that Child A and Child B were being neglected by their parents. Her Honour Judge Newton states in her summing up in the Care Proceedings: “I accept the evidence that these children were subject to severe neglect over a period of many years and that they have therefore suffered very significant harm indeed. In my judgement, the key to the failure to recognise and act upon what was happening to these children over so many years is the lack of appropriate interdisciplinary working”’.

The Executive Summary also identified that there were issues relating to cross-border information sharing and the proper use of historical information to inform on-going assessments.

Work to address this has taken place on a Greater Manchester-wide basis and resulted in the publication of the Greater Manchester procedures:

4.7A – ‘Greater Manchester Protocol in relation to Children in Need Moving Across Local Authority Boundaries’

4.7B – ‘Greater Manchester Protocol in relation to Children with a Child Protection Plan Moving Across Local Authority Boundaries’

In the case of Child H, the decisions made in the early Child Protection Review Conference in 2009 were fundamentally flawed and not based on an accurate recognition of the level of risk, the capacity for Adult A to change or the true impact on the children. It was particularly worrying that there was a lack of challenge to the recommendations and decisions being put forward by Children's Social Care. It is a priority that there is a cultural change whereby legitimate professional challenge ensures that there is a true multi-agency dimension to complex decision making in safeguarding children

One way in which the SSCB is encouraging challenge is to emphasise the role of escalation and a procedure has been developed for this purpose. Thus in the case of Child H there is a clear admission that Children's Social Care got it wrong. But responsibility does not lie with them alone. Other services should have challenged. In this case it refers to challenge at Case Conference Reviews but in other SCRs it means at the point of referral to Children's Social Care. At any stage there must be professional challenge and if a practitioner or manager is not satisfied that another agency's actions are appropriate to the level of need or risk, then the escalation procedure can be used.

Follow through:

- <http://www.bury.gov.uk/index.aspx?articleid=4823>
- <http://greatermanchesterscb.proceduresonline.com/index.htm>
- http://www.partnersinsalford.org/sscb/documents/Escalation_policy.pdf

Working with resistance

An area where there has been significant learning is that of the skills required in dealing with highly resistant families. There are a number of initiatives that could be considered including, co-working, reflective supervision, peer case discussion. At present there is evidence of a skills deficit and the SSCB has addressed this through additional guidance ('Working with Uncooperative/resistant families') and through training, both a specialist seminar ('Working with Resistant Families' – 19th November 2013) and making the topic integral to all training courses. The Greater Manchester Safeguarding children Procedures also contain a helpful chapter on dealing with persistent non-engagement with services.

In Salford, Case 2 involved a primary school age child whose parent withdrew the child from services, including school and controlled contact with those services. The parent also attributed the child's presenting problems to circumstances that did not exist.

Nationally, the case of Peter Connelly ('Baby P') featured well-publicised examples of resistance to professional intervention. The original executive summary noted that the mother of the child had previously maintained a perceived high level of cooperation with

agencies but the presence of a significant male in the household was not discerned by any professionals. Therefore resistance can be very subtly deployed and this led Lord Laming to coin the term 'disguised compliance' to describe such behaviour.

In Child H there was a pattern of DNAs and the report author identified that this should have been seen as a sign of uncooperativeness by the parents. More recent case reviews have highlighted again DNA appointments at CAMHS so this is still a significant factor. The only reason the children are difficult to reach is because the parents won't allow them, for whatever reason, to access services.

Getting early help into such families is also essential and it is worth pointing out that the Working Together to Safeguard Children (2013) emphasizes the importance of Early Help as indeed did the Munro Review of Child Protection before it. The SSCB is working with the Salford Children & Young People's Trust (SCYPT) to re-launch the Early Help strategy together with a refreshed 'Thresholds of Need' document. Look out for news of the consultation on this in December 2013.

Follow through:

- <http://greatermanchesterscb.proceduresonline.com/index.htm>
- http://www.partnersinsalford.org/sscb/documents/Working_with_Resistant_Families_2011.pdf
- <http://www.partnersinsalford.org/sscb/sscbseminars.htm>
- <http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/reviews/a0065483/serious-case-review> (to access both 'Baby P' SCR reports)
- <http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children>
- <https://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system>

Equality & Diversity

The Ofsted Inspection of local authority arrangements for the protection of children in October 2012 identified an improvement action for the SSCB, namely, *ensure that systematic consideration of equality and diversity is established within the work of Salford Safeguarding Children Board.*

There were also some key issues about ethnicity identified in this Serious Case Review re Child H. Although the family had a complex ethnic makeup many of the agencies involved with the family were either unaware of this dimension or had failed to record ethnicity

accurately in their documentation. This contributed at least in part to issues of “identity” never being satisfactorily addressed with Child H.

The recent publication of the SCR by Coventry LSCB in respect of Daniel Pelka contains the following passage which perhaps gives an indication of factors that may be relevant for migrant families (although the point must be stressed that most migrant families cope and thrive in England generally and Salford in particular):

Professionals failed to understand to what extent pressures that Ms Luczak’s immigrant status may have had upon her ability to parent effectively or upon her attachment to her children. Nevertheless it may well have been a factor. In respect of migrant families, “The erosion of cultural and personal identity makes it hard for individuals to pursue their conception of a good life and construct a coherent sense of personal identity, which can lead to a wide range of psychological and social problems, for example depression, unhappiness, anger, a sense of meaninglessness and poor family cohesion.” (Connolly et al). Certainly Ms Luczak periodically suffered with depression and regularly misused alcohol but the reasons for this or of any cultural context was never understood. As far as was known, Ms Luczak only had relationships with Polish men who themselves may have had challenging issues to deal with as immigrants to this country. It was concerning that there was never any real attempt to understand these issues in order for more meaningful interventions to be developed. (p.65 of the SCR, and quoting ‘Culture and Child Protection – Reflexive Responses’ – Connolly, M, et al – Jessica Kingsley 2006).

In 2007, the SSCB carried out a SCR re Child C which also involved a migrant family, in this case of Chinese origin. The mother of Child C was also a child and may have been trafficked into the UK. She was also an asylum seeker who failed in her application to stay. The SCR report identified that a more robust and inclusive multi-agency approach was needed to recognise and meet the needs of asylum seeking children. Specific initiatives were also likely to be needed to try to reach minority communities and especially those individuals acting in a clandestine manner because of their immigration status (in itself another manifestation of parental behavior that could be perceived as resistant or uncooperative).

Follow through:

- <http://www.ofsted.gov.uk/local-authorities/salford>
- <http://www.coventrylscb.org.uk/dpelka.html>

Voice of the Child/Child focus

The Office of the Children's Commissioner promotes and protects children's rights under the United Nations Convention on the Rights of the Child, ensuring Article 12. **Article 12 states that every child has a right to have say in all matters affecting them, and to have their views taken seriously.**

A focus on the child can sometimes be lost by over focussing on the presenting issues of the parent. This was picked up by the Ofsted report in 2011, for example, *A lesson from some of the serious case reviews was that practitioners had not listened sufficiently to the child or had not paid enough attention to their needs. This was because they had focused too much on the parents, especially when the parents were themselves vulnerable. As a consequence, agencies overlooked the implications for the child.* (p.13 'The Voice of the Child: Learning lessons from Serious Case Reviews') It is possible to identify such a dynamic in several of the examples already quoted above in this paper.

This quote (describing a period nearly 2 years before the child's death) from the SCR in respect of Kyra Ishaq (Case 14) in Birmingham is one of many examples where the weight of issues presented by the adults has the potential to overwhelm the focus of the child, so the 'child's voice' is silent:

Adult relationships present as extremely fragile, domestic abuse was alleged and reported to the police and also to the family GP, who despite evidence provided by the mother, that the father presented a safeguarding risk to the children, did not follow prescribed procedures by informing Children's Social Care, instead encouraging the mother to do this herself. (p.5)

In the Salford Case 2 the resistance by the parent probably led to the child, age 10, not being asked about their situation as fully as would have enabled earlier intervention in making things right for the child.

Similarly in Salford Case 6 there was a large degree of resistance to practitioner engagement with the children in the family. When the children disclosed issues of concern and then retracted them, this information and behaviour was not seen as indicative of the children saying something about the situation they were in. Thus, the 'voice of the child' is not just expressed verbally, it is also expressed in behaviour and practitioners should be alert to this.

Daniel Pelka's voice was also not heard partly because of the barrier of language, with Polish as his first language.

Follow through:

- <http://www.unicef.org/crc/>
- <http://www.lscbbirmingham.org.uk/downloads/Case+14.pdf>
- <http://www.coventrylscb.org.uk/dpelka.html>
- <http://www.ofsted.gov.uk/resources/voice-of-child-learning-lessons-serious-case-reviews>