April 2014

CUMBRIA LSCB
CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

Special Practice Review Newsletter

The Local Safeguarding Children Board (LSCB) referred 3 children's cases to the Case Review/Child Death Overview Panel for review. The recommendations and findings from the reviews have been collated in to one report.

Child One

- A 3 year old child who had been abandoned outside her home on a Bank Holiday Weekend. The family are Polish and speak limited English.
- The case had been highlighted in the national news due to the severity of the concerns. The mother was described as being too intoxicated to know where her child was.
- There is history of alcohol abuse, domestic violence and neglect.
- The child is now placed in foster care and the subject of an interim care order.

Summary of the key learning

When sharing information between agencies it is important that the principle of "Follow Through" is undertaken and that those sharing information take responsibility to check out others have received it. It is insufficient to just pass it on, you must always ensure others have received it.

Children can be at their most vulnerable at weekends and bank holidays. The Practice Review Group felt that a condition of bail, where child neglect is concerned, is that the subject should not have contact with the child concerned.

Individuals are not following policy and procedures.

Key Actions and Recommendations

All - when incidents come to light they should not be responded to in an isolated way. A more holistic assessment of the situation should be taken.

All - when passing information to another agency there is a responsibility to "Follow Through" and ensure that the other agency has received and acted upon the information, where appropriate.

All - agencies to reinforce the use of the conflict resolution policy as agreed by the LSCB. If an agency is aware that statutory procedures are not being followed then this must be addressed and escalated.

All - to be aware of the vulnerability and the significant risk to children under two years, in families where alcohol, domestic violence and neglect are a significant factor.

All - due to the knowledge that children can be more vulnerable over weekends and holidays, agencies need to reassure the LSCB that they have appropriate cover at the right level out of hours.

Police - if there is a child present during a domestic dispute then a Vulnerable Child form must be completed as this will give the contact the right level of scrutiny.

Recommendation to Policy and Procedures Group - the chapter relating to individual children is amended to state that there should always be a strategy discussion (this can take place over the telephone) to make sure that the arrangements for children are agreed, understood and communicated.

Child Two

- An eleven year old boy who was known to be self-harming and expressing suicidal thoughts which resulted in him being moved to an out of county placement.
- Child and family seemed very reluctant for a return home so arrangements were made to accommodate child in an out of county placement.
- Child reported to have settled reasonably well in this placement with a plan now for rehabilitation to his family.

Summary of the key learning

Effective multi-agency working with an identified lead professional should have recognised the needs of the child and developed a coordinated early intervention plan across all agencies.

Commissioners of emotional health and well-being services (Tier 1 to 4) should use this case example to support their understanding of how poorly understood and coordinated provision leads to poor outcomes for children.

Child and Adolescent Mental Health Services (CAMHS) clinicians should be encouraged to deliver learning sessions to Children's Social Care staff to raise awareness of their work.

Recommendations

Case Review Group - There is evidence that schools ought to be involved in the case and practice review process.

All - that all Police incidents relating to safeguarding children are shared with Children's Services via the County Triage Team.

Child Three

- A young man with complex medical and learning needs who presented in crisis in August 2008 with multiple minor injuries.
- Throughout his life to 2012, there were numerous occasions when there was limited engagement with professionals. There were concerns about a number of injuries he had which were attributed to his younger sibling and the failure of his parents to protect him.
- In addition, in the early part of his school age years, the family decided he should be home educated rather than attend the local special school.
- The Serious Case Review Group felt that although the case did not meet the criteria for a serious case review, it did highlight issues with respect to interagency working and in particular on how professionals work together to safeguard children and young people with disabilities.

Summary of the key learning and good practice examples

	Good Practice	Learning Points
Child Protection and Mental Capacity	The commitment to safeguard was shared by all agencies. This was more evident from 2012 onwards when services were better co-ordinated when there was a 'Lead Professional'.	• Management oversight was absent in single agencies and an absence of strategic oversight. • Lack of clarity of the legal framework being followed. • Evidence of neglect and/or physical injury needs to be well documented and robust.
Transition Issues	All agencies acknowledged the challenges when children move from Children's Services to Adult Services in Health, Social Care and protection (Police).	• Evidence of a lack of certainty where the most appropriate place was for the child. This impacted on the family and the care of the child. • Lead Professional – who is this?
Interagency Working	Evidence that a 'team around the child' model is being used with child.	• There was evidence of a lack of professional curiosity. • Lack of objectivity due to the relationships with the family.
When a Child is Invisible to Significant Agencies	No evidence of good practice at the time but now the Children's Community Nursing Teams to provide greater oversight.	• All agencies need to be responsible for identifying concerns when a young person (specifically with complex needs) goes 'off the radar'.
Parents And Carers	Good quality information provided as early as possible promotes long term resilience.	• There was little evidence that good quality information was provided consistently to the family. • Parenting capacity was never assessed properly. • Advanced Care Planning needs to be used appropriately and sensitively and introduced at the right time.

Key Actions and Recommendations

Policies and Procedures Group - A review of the current guidance on the interface between children's safeguarding and adult mental capacity act legislation focussing on issues relating to young people with complex needs and their transition between child and adult services.

Policies and Procedures Group - A review of policies and guidance relating to home tuition and safeguarding ensuring that there is a focus on those children with complex needs.

Learning and Improvement Group - Revise and update the training for staff in respect of Child Protection and children with disabilities/ complex needs.

Learning and Improvement Group - Deliver training to the Learning Difficulties and Disabilities and Children Looked After Teams in Children's Services, to Transition Workers in Adult Services, and to Paediatricians and Therapists in Health, as a priority.