

LEARNING FROM SERIOUS CASE REVIEW: Child B

Summary

On 8 March 2008 when CHILD B was at home with his father, he was sent to his room as a punishment. He was later found hanging from the bedroom door. Sadly he never revived.

This paper outlines what we have learnt from the Serious Case Review (SCR) that followed and how we have improved services as a result of implementing the subsequent action plans in all agencies.

CHILD B was born on 3 December 1992. During his childhood, there were indications within the family of alcohol misuse and domestic violence and concerns about the parents' ability to safely parent their four children, especially the two boys. Throughout CHILD B's life there were numerous professionals/ agencies involved including Children's Social Care, Family Centre, special schools, and CAMHS.

His name was placed on the child protection register, along with his siblings, from 1995-6 and again in 1997-9. Intervention was characterised by significant difficulties in engaging the family and lack of any real change. There were phases of family support interspersed with consideration of legal proceedings but no clear plan emerged. Later periods of family support were reactive rather than proactive and typified by ongoing non-engagement.

CHILD B was subject of a special educational needs statement owing to delayed development and challenging and dangerous behaviour. He attended special school, where he was said to be unhappy and talked of being bullied. He was diagnosed with ADHD and prescribed Ritalin in 2002. He reportedly had a fascination with death and talked about wanting to kill himself.

A Serious Case Review (SCR) was carried out and the Executive Summary was published in February 2009.

This concluded: 'It is not possible ... to identify any one significant event or action by any agency, which if done differently would have changed the sad tragedy of (CHILD B's) death.'

The Overview Report and all agencies involved recognised the significant progress made over the time span of the review in terms of the national and local context of children's services. However there was a clear commitment to learning lessons and making improvements. The action plans addressed internal procedures and practice but particularly focused on the inter-agency context of safeguarding.

The executive summary can be found at www.mkscb.org

The Overview report applauded the process adopted by Milton Keynes Safeguarding Children Board (MKSCB), which facilitated an honest and transparent learning experience and demonstrated an effective partnership approach. The Ofsted assessment of the SCR gave a grading of 'good', but the important work was in implementing the action plans to ensure that the lessons learned were acted upon.

Actions taken to address lessons learned

1. This was a case which spanned many years during which there were a number of identified points when things might have been done differently and *might* have produced different outcomes. In many ways the incremental changes in national policy, clinical practice, theoretical knowledge and overall approach to the development and delivery of children's services has provided the context in which improvements have been made and ensured that many of the problems encountered in working with CHILD B and his family should not be issues in future interventions.
2. The SCR Panel learned from the process of this review. The SCR process has been revised and new guidance developed (in line with the revised *Working Together 2010*) to refine the process of managing a SCR and disseminating learning. This includes clarification re the decision-making process determining when a SCR should be carried out and alternative processes such as individual agency management reviews (IMRs) and how these impact on inter-agency practice. Dedicated staff in key agencies are responsible for IMRs and actions. A standing SCR sub-group reviews individual cases and progress. The Quality Assurance (QA) sub-group monitors and scrutinises IMR and SCR action plans and partnership implications.
3. The importance of robust inter-agency communications, information-sharing and planning and a shared understanding has been reinforced. A Professionals' Safeguarding Practice Forum has been established. This is open to representatives of all statutory and non-statutory organisations. The purpose is to provide a regular monthly awareness raising and practice development forum where practitioners are able to share knowledge and experiences and engage in mutual learning and creative problem-solving. The forums are facilitated by local 'practitioner experts' and are interactive. They focus on themes and issues identified through a variety of sources such as findings from SCR/IMR, audits, national and local research and practice issues around particular topics such as mental health, substance misuse, domestic violence, working with hard to engage families, etc.
4. MKSCB provides briefings as part of its training programme on topics of relevance to the children's workforce, including policy and procedure and inter-agency practice issues. This is essentially an information-providing forum with Q &A sessions. The Inter-Agency Training Programme and

5. Use of different media in all agencies to disseminate and promote publicity materials and information. MKSCB Communications & Engagement sub-group has produced 'Safeguarding: it's everybody's business' information such as 'credit card' *what to do if..* guidance to all staff and publicity in different forms to public, including CYP.
6. Specific issues relating to process and practice have been addressed through Policy and Guidance developments, for example:
 - Revised MKSCB Inter-Agency Procedures and Children's Social Care Procedures, both now available electronically and routinely updated.
 - Bullying policy, implemented and monitored via new post of Addressing Bullying Policy & Development officer.
 - Hard to Engage Policy facilitating a coherent multi-agency response
 - Schools Safeguarding Policies supported by single agency training
7. Participation of CYP and stakeholder groups in service development and delivery is a key priority area for MKSCB and the Children's Trust. The MKSCB Business Manager is working in conjunction with the Communications & Engagement sub-group to establish a range of groups of CYP with whom meaningful consultations can be held.
8. The model of effective support and early intervention for children with additional needs is now being put in place across the children's workforce. Where specialist interventions are required the assessment framework, Working Together and a multi-agency family support approach are well understood by safeguarding professionals in MK. We have put in place systems and services to ensure that:
 - Coordinated multi-agency interventions seek to be proactive and focused.
 - Intensive Support Services provide structured interventions and assessments to high risk cases, enabling robust decision making
 - The multi-agency Family Advice and Support Team provides targeted family support
 - Children are always spoken to individually as part of any assessment
 - Risk is managed through family support in consultation with the Child Protection Coordinators.
 - Use of the common assessment framework (CAF) in the context of new locality teams around the child now being implemented, will facilitate wider understanding of thresholds, needs and services.
 - A coordinated response to Domestic Abuse has been developed in collaboration with the Community Safety Partnership. This includes a programme for work with perpetrators of DV.
 - Engagement with CAMHS is enhanced. Specifically, a mental health practitioner is attached to the Young People's Service (as is a community substance misuse worker),

9. Case and staff performance management are more consistent and effective. Assessment and decision-making is more robust and better evidenced through recording.

- There is increased management capacity in Children's Social Care.
- The CSC supervision policy has been revised and practice clarified to ensure consistency and accurate recording of decisions.
- Use of supervision to: identify training needs and monitor professional development; monitor individual casework and prevent 'drift'; monitor implementation of procedures and application of knowledge base.
- Good practice is underlined by the Public Law Outline (PLO), ensuring a very clear process for decision-making where legal intervention is being considered. This includes the use of the council's legal section to draw up agreements with families prior to the initiation of care proceedings.

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