Serious Case Review Newsletter
Volume 1, Issue 1 – April 2011

Serious Case Reviews – Sharing Learning

This is the first newsletter published by Bradford Safeguarding Children Board (BSCB) to focus on Serious Case Reviews (SCRs).

There have been significant changes to how SCRs are undertaken with a strong emphasis on having independent oversight and challenge. We also expect that Professor Eileen Munro's review of Child Protection will recommend further changes to the conduct of SCRs. Whatever developments there may be in the future, the importance of sharing learning from SCRs in order to improve practice continues to be highlighted. Therefore we recognise the need to share learning on a regular basis across all the partner agencies. The professional learning detailed here has implications for all agencies involved in BSCB.

There will also be additional specific actions and recommendations for your agency and your role. Please ask your manager, or contact your representative on the BSCB, to find out more.

While it is important that we learn from weaknesses identified in SCRs, it also important that we recognise and learn from the good practice that is also regularly commented upon in these reviews. I hope that you will read the executive summaries of Bradford's SCRs which are published in the SCR section of the BSCB website: http://www.bradford-scb.org.uk/scr.htm

Updates about Serious Case Reviews will be published on a regular basis, and will include information about local, regional and national Serious Case Review findings. Thank you for taking time to read this newsletter.

Professor Nick Frost, Independent Chair, BSCB

Bradford's Serious Case Reviews

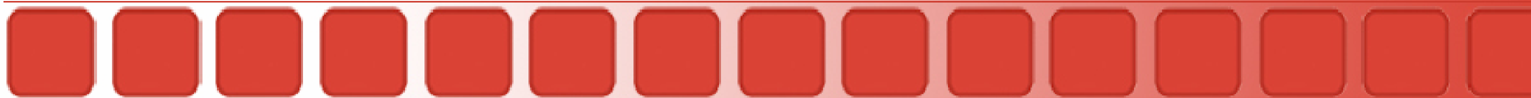
Over the last the four years until the present time, Bradford Safeguarding Children Board has completed four Serious Case Reviews. Two of the children were under 3 years old at the time of the incident/death, whilst the other two were aged 9 and 12. All four children were boys. Out of the four children, three died whilst one child experienced a life-threatening incident.

The issues that were prevalent in families of the children that were the subject of SCRs in Bradford reflect the national findings. The main issues were substance misuse, domestic abuse, and mental health and in most of the SCRs there was more than one of the issues present. One of the parents involved in the SCRs had a care history of their own with associated issues resulting from this. All of the SCRs reminded agencies about considering the whole family.

Focus on Learning from Bradford Cases

Child HD

This is a 2 year old child who died as a result of ingesting methadone. When he was born there were concerns about mother's drug use and his name was placed on the child protection register at birth (category of neglect). HD and his mother received significant support from a range of agencies and the review acknowledged the level of partnership working was good and the specific focus on HD's safety was clear. The Executive Summary report can be accessed at: http://www.bradford-scb.org.uk/scr_documents/HD_Exec_Summary.doc



Professional learning

Multi agency meetings should focus on an analysis of the information being shared and what actions need to be taken.

Where there are services being provided separately to members of families, agencies should not be working without full information of the whole family. It is important to avoid services for the child and services for the parent working in isolation.

It is important to have a critical, analytic and reflective approach and be prepared to "think the unthinkable" i.e. the child could be given both illegal and prescribed substances.
Also to recognise the need to reassess the situation, accept that parents may not always be truthful so not be too reliant on the "rule of optimism".

<u>Child AI</u>

This is a young baby who has sustained serious head injuries in a family where there were maternal mental health issues. Family were new to the country and little was known about their family history. This case covered cross-boundary working between two neighbouring LSCBs. The Executive Summary report can be accessed at: http://www.bradford-scb.org.uk/PDF/AI_SCR_Exec_Summary.pdf

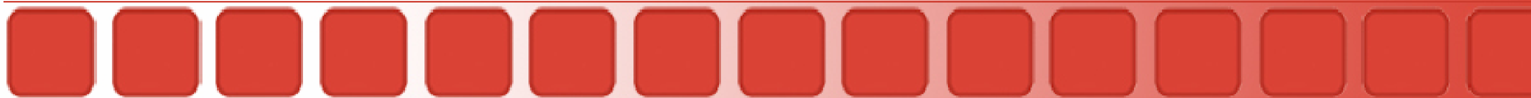
Professional learning

The importance of maintaining a safeguarding focus, initially safeguarding procedures were adhered to and there were examples of good practice but this was not maintained.

It is crucial to have a full understanding of the family history and dynamics. There needs to be an appropriate means of communicating with both parents where English is not the first language.

In order for a thorough risk assessment to be completed there needs to be clarity between professional about specific terms used and their significance for e.g. in this case the term "command hallucinations" was misunderstood by some professionals.

Significantly this case highlighted there are no new lessons to be learned from this SCR but there are a number of reminders to follow existing procedures, protocols, guidance or suggested good practice.



Child D

This is a disabled child of 12 who died due to smoke inhalation in a house fire. Whilst the care and support Child D received was unconnected to his death, he and his family received services from a range of agencies during his life. The SCR concluded that while agencies focused on Child D and his needs, they should have looked more closely at how his health and disability affected his family. The Executive Summary report van be accessed at: http://www.bradford-scb.org.uk/PDF/Child_D_exec_summary_020211.pdf

Professional Learning

The importance of keeping the child in focus, ensuring the child does not become an "Invisible Child" and considering what is every day life is like for the child, both at home and in other settings.

The child and their sibling were assessed separately without consideration of how their individual needs impacted on each other. It is important, even when there are difficulties in communication that professionals establish the child's perspective.

Professionals should not be prepared to accept living conditions for a disabled child that would not be acceptable for a child without disabilities.

In complex cases professionals need to consider assessment as an ongoing process and in particular take the opportunity to reconsider parenting capacity and risk assessment.

Professionals need to be aware of focusing on the needs of the child rather than having a task led approach around providing services.

Child J

This review followed the death of a 9 year old boy who was stabbed by his adult brother. The adult brother has a history of disturbed and challenging behaviour, and prior to the incident had been diagnosed as suffering from paranoid schizophrenia. The review considered the work of agencies with the whole of the child's family over a 15 year period leading up to the death. The Executive Summary report can be accessed at:
http://www.bradford-scb.org.uk/PDF/Executive_Summary.pdf

Professional learning

Agencies need to make sure that the assessments they undertake join up, so that there is an inter-agency understanding of how family life is impacting on children's well being.

Managers need to make sure that staff undertake assessments and enquiries that consider the impact of the involvement of all agencies, and previous agency involvement. Assessments and enquiries should not be sequential.

The failure of agencies to communicate effectively with each other reinforces the tendency for agencies to focus on individual children and fail to understand the extent of families' difficulties.

Professionals must consider the impact of domestic violence on the whole family, on family relationships, and particularly on children's well-being.

Professionals in all agencies need to ensure that the role and impact on families of fathers and other significant men are considered in assessments.

Common themes from Bradford's Serious Case Reviews

The SCR Sub-Group of BSCB has devised a matrix identifying the common themes from the recommendations and action plans of the four completed SCRs. These themes were:

- Record keeping
- Assessments (including CAF)
- Communication and information sharing
- Supervision / Management oversight
- Training
- Policies and procedures

The matrix also displays the number of actions related to each theme and how many completed as shown in the table below:

	Child HD		Child AI		Child D		Child J		Total**	
Main Themes	**No of Actions**	**No Completed**	**No of Actions**	**No Completed**	**No of Actions**	**No Completed**	**No of Actions**	***No Completed**	**No of Actions**	**No completed**
Record Keeping	12	12	2	2	1	1			15	15
Assessments	3	3	12	12	8	8	3		23	23
Communication & Information Sharing	1	1	4	4	4	4	3		9	9
Supervision	7	7			1	1	3		8	8
Training	21	21	11	11	3	3	4		35	35
Policies and Procedures	3	3	6	6	1	1	2		10	10
Total	**47**	**47**	**35**	**35**	**18**	**18**	**15**		**100**	**100**

**At the current time it is too early to comment on whether actions from the Child J SCR have been completed.*
***The totals do not include actions from the Child J SCR.*

Next steps

BSCB Sub-Groups are auditing and analysing the completed actions from the SCRs in order to establish and identify further learning.

1. **Professional Practice sub-group** is auditing the actions that have taken place around Record Keeping, Supervision and Policies and Procedures. The first stage of this is to consider agency supervision standards and procedures in regards to safeguarding.
2. **Training sub-group** has commissioned an independent evaluation of specific BSCB Multi – agency training courses to attempt to establish the impact of training on practice.
3. **Performance Management, Audit and Evaluation sub-group** is to ensure Assessments and Communication and Information Sharing are audited as part of the BSCB multi-agency audit programmes such as the Joint Agency Case Audit around Section 47 investigations and the Challenge Panel audits.

National Learning and Developments

There is now a requirement that "Local Safeguarding Boards should publish overview reports of all new Serious Case Reviews initiated after the 10th June 2010."
The aim is ...."to ensure that the context in which the events occurred is properly understood so relevant lessons are learnt and applied as widely as possible."
(from Tim Loughton MP parliamentary Under secretary of state for Children and Families)
Some LSCBs have decided to publish the full overview report of cases they have completed prior to this date.
Birmingham Safeguarding Children Board is the first to publish such a report about the case of, Khyra Ishaq a child who died in 2008.
The report can be found at www.lscbbirmingham.org.uk/downloads/Case+14+New.pdf

Local Learning and Developments

- Bradford Safeguarding Children Board has training about "Serious Case Reviews and lessons to be learned" on its annual training programme. In addition briefings and professional practice forums provide an opportunity to share lessons and improve practice from both local and national serious case reviews.
- Further information about the various learning opportunities can be found at www.bradford-scb.org.uk
- Training and ongoing support is also provided to managers who are required to write an Individual Management Review (IMR).
- Ongoing support for IMR authors is provided as required by each case.
- There is now a greater emphasis on including staff involved in a case in the process of the review.
- We are encouraging all our partner agencies to have a pool of potential IMR authors. If you are a manager who needs this training please contact Rachael.Hammond@bradford.gov.uk

If you would like to read more about why we undertake Serious Case reviews and how please read Working Together 2010, chapter 8 also available at www.bradford-scb.org.uk

If you need to refer to BSCB Serious Case Review procedures they can be found at http://www.proceduresonline.com/bradford/scb/chapters/contents.html#serious

We are keen to hear your views and ideas about this publication please email info@bradford-scb.org.uk with your suggestions.