Briefing paper regarding the findings of three case reviews commissioned by the Cambridgeshire LSCB in 2012-3

During 2012-3 the LSCB Serious Case Review sub-group completed three case reviews:

- A Serious Case Review regarding a child that died using the Working Together 2010 methodology
- A Management review regarding a child with complex health needs using the Significant Incident Learning Process (SILP) methodology
- A Management Review regarding a historical case of a (now) adult offender using the themed multi-agency agency case reviewing methodology

Although the case details remain confidential, the key learning regarding safeguarding practice were identified. In each case, the methodology identified to conduct the review appears to have resulted in generating useful learning and in the successful participation of practitioners in the review process:

1. There is evidence that parental alcohol misuse is often minimised by professionals as representing less of a concern about parenting capacity than parental drug use. Research however identifies that the experiences of children living in such households have many similarities and can experience the same levels of significant harm. The combination of maternal alcohol misuse and pregnancy must be viewed as a high risk scenario, both in pregnancy and in the post-natal period.

2. In cases of parental alcohol misuse, if any such assessment does not capture the reality of what actually occurred at the time that the parent was intoxicated, there will be the unintended potential for concerns to be minimised. Professionals must explore beyond the immediate picture that is presented e.g. in to the extended family network, or where parents are seemingly absent.

3. Therefore professionals need to have “respectful uncertainty” in dealing with parents, and be alert to the possibility of parents displaying disguised compliance, being mindful that an over optimistic view of parenting will be formed if this is not challenged. Non-engagement by parents appear in these cases to have been a ‘successful’ block to effective intervention.

4. Assessments of risk must take note of a variety of sources and not just the account of the parent. They must also consider historical information. Good quality assessments are supported by good practice in case recording. All cases evidenced the importance of the routine use of significant event chronologies which are easily accessible to the practitioner. The importance of sharing information across agencies during assessment and decision making is emphasised.

5. The importance of exercising ‘professional curiosity’ and challenging parents is clearly demonstrated in these cases: practitioners should be asking more questions and being less accepting of the explanations given. In these cases, parental alcohol misuse, learning disability and incidents of domestic abuse were not effectively challenged, leading to a lack of understanding of the risks to children.

6. Lack of understanding or knowledge by professionals, about a parent’s or a child’s persistent or long term medical condition, will compromise their ability to work...
effectively with the family and in particular about understanding the meaning of that
condition in terms of any impact on parenting ability or of the risk to the child of
medical needs not being met

7. The cases demonstrated that thresholds were not always applied consistently – for
referrals in to children’s social care; for progressing cases to a s47 Child Protection
enquiry, or for convening child protection conferences. And at the same time these
cases demonstrated the importance of practitioners escalating concerns where they
are not satisfied or do not agree with the actions or response of another agency. If
not, it is possible that continued risks to children will remain unaddressed.

8. Supporting the previous point, there is a need for all agencies to understand who in
the multi-agency network is or is not involved at a point in time where concern for
the child is expressed and for liaison to take place between and within agencies.

9. All of the cases identified the importance of understanding the child’s development,
behaviour and relationships with others as a possible indicator of difficulties and
risks within the home.

10. It is important for practitioners to understand the lived experience of the child and
to gear their interventions accordingly – without this it is not possible to form a true
understanding of potential safeguarding risks. The children in these cases do not
appear to have been understood heard or responded to. There was little
professional insight in to what their lives were like.

11. Issues of identity and diversity needs were not incorporated into assessments
undertaken by children’s social care and the hospital did not take them into account.
Issues of language, race, culture, religion and disability may impacted on the
parenting children receive and the way that professionals respond to concerns.

12. These cases demonstrate some of the consequences of professionals not accessing
the opportunity of receiving oversight and support from safeguarding leads in their
own agencies e.g. schools, the GP and hospital staff.

13. The SCR and the SILP reviews both evidenced some weaknesses in the clarity and
purposefulness of some multi-agency meetings in that the meetings and resultant
plans failed to clarify what was required of whom and by which date. They
sometimes failed to identify a contingency plan if key actions were not met.

14. However there was good commitment by agencies to inter-agency working to
attendance at multi-agency meetings in these cases, and clear commitment to
children and families by professionals going the extra mile to attempt to engage
them.

15. Recent feedback from family members involved in these reviews is that their recent
experience of professionals and of intervention has been positive and that
consistency of personnel is valued, and that this has been supported by a willingness
to innovate in order to improve safeguarding.

There is a joint LSCB action plan regarding responding to the recommendations from
these cases which the LSCB will be continuing to implement in 2013-4 , in order to
improve outcomes for children and young people in Cambridgeshire.