Walsall Safeguarding Partnership Newsletter

Autumn 2020

In this edition we focus on the learning from our Walsall safeguarding reviews for children and adults. Along with some 7 minute briefings from recent Audit activity.

Reviews

Safeguarding Adult Reviews

The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, or the adult is still alive, and the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked together more effectively to protect the adult.

Local Child Safeguarding Practice Reviews

Local Child Safeguarding Practice Reviews (LSPRs) (formerly Serious Case Reviews (SCRs)) in England are undertaken when a child dies (including death by suspected suicide), and abuse or neglect is known or suspected . Additionally, Local Safeguarding Partnerships (formerly LSCBs) may decide to conduct an LSPR if a child has been seriously harmed and in accordance with the guidance in Working Together 2018.

Learning Reviews

A learning review is similar to a safeguarding adult or child safeguarding practice review but where they have not met the criteria under the relevant legislation. These are also locally conducted reviews with the aim of identifying learning to improve practice.

Multi Agency Audits

WSP undertake quarterly Multi-Agency Audits in respect of agencies working with adults or children to quality assure safeguarding practice in relation to themes linked to WSP priorities.

SAFEGUARDING ADULT REVIEW 3 - CLARA

What happened?

Clara had a long history of mental health illness. Following a bereavement in 2015, there had been increasing agency involvement due to her physical and mental health.

Fire Service responded to a call that Clara had been seen walking out of her property in flames, and then returning inside. Clara was taken to hospital with 90% burns and later died.

Background Information

Clara had been admitted twice into a psychiatric hospital in 2015 and 2016 and continued to receive support from mental health professionals and 3 x daily visits from home carers until her death. There continued to be numerous incidents which resulted in the involvement of the police, ambulance service, fire service, and community alarm to respond to physical health issues or concerns about her behaviour or presentation.

Over the months prior to her death there were many incidents where other professionals or the public shared concerns about Clara's behaviour which might be indicating a possible deterioration in her mental health, these included rapid changes in mood; agitation, verbally aggressive, distress, suicidal thoughts, threat of self-harm, out on the street inappropriately clothed. A review concluded Clara's mental health had remained stable, despite her finding it difficult to cope with her ongoing physical health problem which caused her distress.

What this review tells us?

Response to possible changes in mental health

Changes in behaviour may indicate a deterioration in a person's mental health and a possible increase in the level of risk therefore agencies noticing any changes should share this information for use in assessments.

Multi-agency working including lead agency for case co-ordination

An inclusive approach involves all relevant agencies in case planning, or information gathering when safeguarding concerns are raised.

Referrals and information sharing, including out of hours

Key information held by agencies should be accessible to crisis responders.

Risk assessment and management - including fire risks

Assessments and care plans should identify the potential to impact on a person's mental well-being and conversely take account of mental health symptoms or treatment programmes which might affect physical health.

Family involvement

It is essential that agencies have contact information for family members in the event of an emergency, or where the involvement of the family needs to be considered where a service user lacks capacity to make a decision about their care and treatment and a "best interests" decision process needs to be applied.

What can we do now?

- Ensure you are aware of the process to escalate concerns which do not meet the criteria for a formal safeguarding adults' concern or to challenge other agency decisions.
- Where agencies identify another service is required by the service user, do not rely on the service user making their own referral, take responsibility and make direct contact.
- In cases such as this where a service user has said they do not want their family involved, this issue needs to be explored sufficiently and explicitly to establish if the family should be contacted in the event of an emergency or if there was to be a time when they are unable to make decisions about care and treatment.

To read the full report click h ere

SAFEGUARDING ADULT REVIEW 4 - GRANT

What happened?

Grant was a 77 year old man who was found on the ground outside his third-floor apartment. Ambulance and Police services attended, and he was pronounced dead.

Suspicions were raised that he may have jumped from his window as the window was open, a knife was near the window inside, the restrictor had been forced and the bedroom blinds were on the garden wall outside.

Background Information

Grant had moved to Walsall from the London area in the early 1980s. He had worked locally and was an owner occupier of an apartment. He was estranged from family members and reported that he had no close friends but previously had many acquaintances through his work, political contacts and at the local public house. In 1993 (age 52) following an allegation at work he was suspended. A long protracted legal challenge ensued and resulted in an out of court settlement for him. It is reported that the stress of this incident appeared to have led to a mental breakdown and his first admission to a psychiatric hospital. Grant took early retirement in 1994 and never formally worked thereafter.

Grant became involved with mental health and community services in Walsall from 1996 up to the time of his death. He had a diagnosis of Chronic Schizophrenia and personality problems. He also suffered from several physical health conditions including gout, osteoporosis, mobility issues, was registered blind in one eye and wore glasses, he was deaf and wore a hearing aid. He also experienced Tinnitus. He was a heavy smoker and used to drink in excess in younger years but had cut down to moderate amount later in life. He had experienced a fractured neck of femur in 2013.

Grant had for many years lived in his owned apartment. Following periods of hospital admissions for his mental health he was discharged to alternative accommodation(s) including a Care Home and another Apartment where he was living at the time of his death.

What this review tells us?

There is a need to consider a multi-agency approach to self-neglect, risk management and communication with people who do not easily engage.

Clarification should be made to enable a greater understanding regarding when referrals are to be made as a Safeguarding issue and when it is for Care and Welfare issues.

All relevant agencies need to ensure there are arrangements in place where practitioners could refer concerns about adults who do not engage or are at risk of self-neglect.

A multi-disciplinary approach is required to ensure a holistic view of the individual and their circumstances, with a collaborative approach to offering advice, information, specialist knowledge and practical support.

What can we do now?

- Ensure you are familiar and working within the self - neglect path way
- View and share our 7 minute Briefing on Self-Neglect
- Consider if a Multi-Disciplinary Meeting would be beneficial to assist with concerns about self-neglect, risk management and communication with people who do not easily engage.

To read the full report click here

SERIOUS CASE REVIEW 11 - ALEX

What happened?

Alex sustained serious and life-threatening injuries whilst in the care of her connected carers. At the time of suffering these injuries Alex was 11 months of age.

Background Information

Alex was the eighth born child to parents who have significant previous involvement with children's social care.

When Mother was pregnant with Alex, pre-birth planning commenced, Alex was placed into local authority foster care immediately following birth.

An extended family member of Alex's mother was identified as a possible connected carer for Alex in order that Alex could stay within the family.

Following a positive viability assessment, the extended family members were accepted to go forward with full assessments to become permanent carers of Alex.

The connected carers did not live locally to Alex's immediate birth family.

When Alex was 11 month's old, Alex was taken to hospital and was found to have sustained significant injuries.

What this review tells us?

Post Placement Support

Statutory visits should provide a robust assessment of ongoing placements. Unannounced visits also provide a window on the placement.

Children who are looked after may be at risk of harm; being looked after in foster or connected care situations does not automatically mean safety.

The nature of connected carer arrangements may lead to a better understanding of any risk.

It is important that professionals recognise the difference between various fostering arrangements and prioritise visits and reviews accordingly.

Coordination and Communication within and between areas.

Changes to service delivery can lead to unexpected risks and challenges. A forum for identifying issues quickly with a prompt response is necessary in order to safeguard children.

Proactive professionals ensure that there is no service breakdown when a child who is looked after moves placement.

Communication between health and social care regarding looked after reviews and outcomes must be robust to ensure children are safe.

What can we do now?

- View and share our 7 minute Briefing on connected carers.
- Where you are working with a family, actively seek to be involved with and/or provide information for reviews for a child who is looked after.
- Ensure notifications of placement include the type of placement (differentiating family and friends care from foster care), next health assessment due date and date of next child looked after review.
- Ensure notifications of placement are followed up to confirm receipt.

To read the full report click here

ADDITIONAL LOCAL REVIEWS

What happened?

The child sustained serious and life-threatening injuries whilst in the care of the parents. At the time of suffering these injuries the child was 10 months of age.

What this review tells us?

More focus and awareness on the status of young people as former care leavers in the criminal justice system highlights their vulnerabilities and what support is required both in prison and upon release. This will assist the transition between Youth Offending Services and Probation Services to be more effective and support the offenders.

Where there is no statutory framework for management on offenders who have completed their whole sentence, there needs to be consideration on how they can be managed in the community once released, recognising any violent and challenging behaviour in prison.

Sharing relevant information establishes accurate risk assessments. These should be reviewed in a timely fashion. They should show a clear consideration of the current personal circumstances and the changes.

What can we do now?

- Ensure when undertaking risk assessments, you establish as much information as is possible regarding family structures and to be particularly curious where important members, such as fathers are not identified.
- Ensure information is shared in a timely manner between agencies you are working with about risk.
- Effective use of the MAPPA framework and ensure due consideration is given to using it to effectively manage violent offenders.

What happened?

Child died whilst in foster care placement with his mother.

What this review tells us?

What worked well

- Multi-professional contributions to the regular LAC Reviews.
- Identification of mother as a child and having her own social worker.
- Information sharing between all agencies.
- Reviews being held sooner than statutory guidance.
- Finding a placement for both mother and child together.

Assessment Information

Ensuring all professionals involved with a child remain alert to blurring of boundaries that could lead to collusion and optimism, and to remain child focused.

Information from unexpected source

When information about a child's safety or welfare comes from an unexpected source, it is important that the lead professional has access to all relevant information and is able to maintain a chronological overview of what has happened.

Partnership Working / Mixed Messages

Expectations between professionals need to be clear, if not it potentially leads to frustrations, delays and misunderstandings.

When children have complex needs that require the involvement of multiple professionals there will be a named lead professional to maintain oversight of missed appointments and multi-agency working.

Strategy meetings should be multi-agency as far as possible and should involve all key professionals known to, or involved with, the child and family. Local authority children's social care, health and the police should always attend.

What can we do now?

- When working with a family within a multi-agency approach ensure the lead professional is aware of your input and invites you to strategic meetings.
- Regularly review and update notification systems so information is not missed that is required, such as a child being in a looked after placement.
- If you wish to recommend the involvement of another professional to a parent, always gain their consent.
- Look out for the revision of the 'was not brought' policy.
- View the new I n for mat ion about bruising and injuries to non- mobile infants that will be published.

ADDITIONAL LOCAL REVIEWS

What Happened?

The child was in the care of her parents, both of whom have learning disabilities, there was historical alleged sexual abuse along with historical violent offences by the grandfather.

The child has significant disabilities and is not able to communicate, concerns were raised around potential neglect and sexual abuse.

Good Practice

- Social Worker was authoritative and professionally focused; the impact of this practice is that the child was safeguarded through an Interim Care Order.
- Nursery showed good evidence of multi-agency working and awareness of safeguarding risks. They offered good support to the family, even visiting the child in foster placement after they had left the nursery.

Learning Areas:

Uncertainty as to whether practitioners recognise indicators of child sexual abuse and/or are confident to raise concerns about sexual abuse as they would other forms of harm.

There was a lack of understanding of the risk posed by offenders and, in particular, the risk categories used by Probation.

There was little evidence of practitioners understanding the needs of the parents to support the child and therefore the appropriate support was not available.

What can you do now?

- Be confident to report concerns, and be aware that not finding physical evidence does not rule out the possibility of sexual abuse.
- Ensure you are aware and working within the Mental Capacity Act.
- Ensure you are aware of the specialist role of the LD service within adults' social care.
- Ensure you are making 'good' adult safeguarding referrals and working together to engage service users.

What Happened?

Whilst in the care of parents, at 4 weeks old, the child was taken to hospital with unexplained bruising.

At 8 weeks old the child was taken to Hospital in another Local Authority where they were found to have a fractured leg.

Good Practice

- The swift paediatric assessment of the child by out of hours Dr (upon the first admission to Hospital).
- The police consideration in respect of the safety of other children in the household ensured an out of hours response (Safe and Well check).

Learning Areas:

Unclear interpretations of the medical opinion re: the bruising/injuries across agencies and an over optimistic view when the medical opinion described the cause of bruising as 'unexplained'. In this case it was meant there was no plausible explanation provided to explain/account for the injuries which makes non accidental injury a much greater likelihood.

Professionals were not aware that petechial bruising is a strong indicator that injuries are more likely to be non accidental.

The need for multi-agency assessment of the risks to a child by all professionals involved in the strategy discussion rather than an over reliance on medical opinion.

Discharge planning meetings offer an opportunity to review all information, evaluate and promote professional challenge.

Second opinions on all child protection skeletal surveys, by the same consultant where possible, should be undertaken on all cases of possible non accidental injuries.

What can you do now?

Look out for the awareness training that will be developed around bruising in non-mobile babies including the interpretation of medical opinion and recently launched regional guidance.

ADDITIONAL REVIEWS

What Happened?

Child was in the care of her mother and maternal grandparents.

Mother had difficulties understanding the needs of child which led to failure to thrive. There was little family and paternal support.

There was significant hoarding in the family home.

Good Practice

Concerns were raised with regards to mother's lack of emotional attachment and understanding, leading to learning disability and parenting assessment and referral to children's services.

Learning Areas:

Lack of communication and partnership working between partners, especially cross border.

When consent is refused and there are safety issues, you may not require consent to refer to another agency.

What can you do now?

- Establish good communication links and update promptly partners who need to be aware. Keep talking to each other.
- Be aware of self-neglect and hoarding, when to refer and when consent is required - building on our 'Think Family' approach. Dare to Share when thinking of safeguarding.

Following this learning from our reviews, here is a round up of what you can do within your practice:

- Ensure you are aware of the process to escalate concerns
- Ensure you are making 'good' adult safeguarding referrals and working together to engage service users
- Be confident to report concerns
- Ensure when undertaking risk assessments, you include family structures and history
- Do not rely on service users making their own referrals for support from agencies
- Always gain consent from the adult if you wish to involve another agency or when contacting other family members unless in the event of an emergency or if they are unable to make decisions about care and treatment
- Ensure you are familiar and working within relevant legislation and guidance such as the Mental Capacity Act, the self-neglect pathway and the MAPPA framework
- Consider if a Multi-Disciplinary Meeting would be beneficial to assist with concerns
- Establish good communication links and update partners promptly who need to be aware
- Regularly review and update notification systems so information is not missed that is required such as a child being looked after by a foster / connected carer
- View and share our 7 minute Briefings

Look out for :

- the revision of the 'was not brought' policy
- new Information about bruising and injuries to non-mobile infants
- the awareness training that will be developed around bruising in non-mobile babies

Click below to view our current Webinars and eLearning

Our catalogue of 7 Minute Briefings can be found here and our latest briefings from Audit Activity included in the following pages