# Walsall Safeguarding Partnership Newsletter

Spring 2021

**In this edition we focus on the learning from our Walsall safeguarding reviews for children and adults.**

## 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 (LCSPRs) (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 LCSPR 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.

# LOCAL CHILD REVIEW

## What Happened?

A 10 week old child was found in the early hours of the morning lifeless in mom's arms, where both had slept on the sofa.

There were several factors which suggested there was an increased risk of sudden death over the general population.

## Good Practice

Tenacity and flexibility of workers; mum would break appointments and avoid contact with professionals but they would make repeat calls, liaise with each other and at times, appropriately escalate their concerns in order to make contact.

Effective communication; Professionals with direct contact with Mum knew the identity and role of the other professionals involved.

## Learning Areas:

Assessments should identify the significance and relevance of childhood experiences when undertaking assessments of parents.

Co-ordination of support at the Early Help level can be as complex as coordinating a core group in a child protection case.

Provision of additional help for vulnerable families from voluntary organisations is important and often plays a valuable role in supporting families who are often difficult to engage / disaffected parents.

## What can you do now?

Familiarise yourself with the 7 minute briefing on SUDI.

Read The Child Safeguarding Practice Review Panel's national review into sudden unexpected death in infancy (SUDI) that can be found at the following link;

htt ps :// www .go v.uk/ government/ publica tio ns/ sa f egua rd ing -children-at-ris k-f rom-s udden-unexpected-infant-death

Remind parents of the risk of SUDI and how it can be prevented, it is a multi-agency responsibility, not just for health professionals to tackle.

# LOCAL CHILD REVIEW

## What happened?

A 2 week old child attended hospital with a fractured leg, there was concern that the injury may be non accidental.

## Learning Areas:

It is more effective and productive for child protection medicals to be performed during office hours, due to ease of access to other professionals and departments. There is no requirement for child protection examinations to be conducted outside these hours and does not prevent medical treatement that may be required.

Strategy discussions are more productive and help inform decision making when all relevant professionals are involved and these discussions are held prior to any actions being undertaken.

The safety and wellbeing of siblings should be considered whilst investigations are being undertaken and results are being awaited; consider where they are, who they are with, is there a concern for their wellbeing?

Unusual impacts of a bank holiday weekend and covid19 lockdown on services caused a lack of consistency of the professionals involved in discussions around the case, this led to contradictory information, lack of continuity and then delays.

Professionals need to ensure the message given is the message understood, there was confusion in this case over apparently contradictory information given both verbally and in reports.

Professionals should not feel pressured by others to make certain decisions or agree. Challenges can and should be made in a respectful way.

## What can you do now?

- When writing reports, they should be clear, precise, easy to read and to comprehend: Refrain from using medical jargon, acronyms or references to single agency terms and protocols which others may not be aware of.

- Ensure your message is understood by the person receiving the communication and that you have expressed your concerns in full, do not give mixed messages or make statements which are open to interpretation.

- If you do not understand or you are unsure of something during a conversation, presentation or a report, ask for clarification and explanations. Never feel pressured to make a decision you do not agree with.

- It is right to speak up if you professionally disagree and you are encouraged to do so, keeping the focus on safeguarding.

- Remember to think family when completing risk assessments and reviews and involve all relevant professionals in meetings to ensure a full picture of the family

# LOCAL ADULT REVIEW

## What Happened?

A 75 year old male with learning and communication disabilities died in hospital following a decline in his health. This was possibly affected by change in his care and moving four different accommodations including two hospital admissions in the last 5 months of his life.

## Good Practice

The gentleman previously had a good relationship with staff at his care home. The care home staff were aware he would find change, in his surroundings and the people around him, difficult to comprehend so they attended to the hospital to support him despite no longer being commissioned to care for him.

## Learning Areas:

There was a failure to appropriately engage advocacy services. Two medical decisions were initially made without an advocate, who could have also been the voice of the individual with his accommodation and the Section 42 enquiry.

The emotional wellbeing of the gentleman was not sufficiently considered. His learning and communication disabilities made it difficult to understand his feelings and this was not explored through the use of specialists and advocates

There were communication issues between the care providers, health services and Adult Social Care, records were not fully completed or up to date and information was not always shared with all other involved partners.

The communication between partners in this case was not always consistent or have a sound comprehension of what was being said or required by the respective agencies involved.

Formal processes for reviews should be utilised. Multi-disciplinary team meetings and discharge planning meetings offer good information sharing opportunities across agencies.

## What can you do now?

- Where a person has a disability affecting communication or understanding, engage an advocacy service as soon as possible to ensure they have a voice.
- Multi Agency discussions are essential and meetings should have all agencies involved with the person / family to provide the best information and opinions towards the care of an individual.
- When a person has communication difficulties it is good to ask those who have previously had a rapport with the person for guidance and advice on how best to engage with them.

# LOCAL ADULT REVIEW



## What Happened?

The adult was known to mental health services for over 30 years, also received input from other partners; Adult Social Care, Probation and Housing Support due to mental health, disengagement, potential aggression and potential self-neglect.

The gentlemen died as a result of falling from his balcony.

## Good Practice

Good evidence of liaison between probation, GP and housing support.

## Learning Areas:

Whilst it was evident that different agencies were involved in his care and liaison took place, there does not appear to have been an overarching plan on how this would be delivered.

This case illustrates the need for WSP to embed the self-neglect pathway as it evidences the need for a multi-disciplinary approach to addressing self-neglect as there were missed opportunities to engage.

## What can you do now?

- Ensure care plans and risk documentation for service users are regularly updated and are reflective of current risks/issues and corresponding agreed plans.
- When rebooking outpatient or alternative appointments you should take into account individual service user needs/ risks and document the rationale.
- Re familiarise yourself with the Local Authority Self-neglect Pathway, West Midlands Guidance and escalation processes, as part of your safeguarding practice.
- When an individual is requiring an assertive approach it should be identified within case documentation to reflect the required intervention that will promote engagement and reduce likelihood of relapse.

Click below to view our current Webinars and eLearning courses

Our catalogue of 7 Minute Briefings can be found here

Walsall Safeguarding Partnership

*Right for Children, Families and Adults*