Walsall Safeguarding Partnership
Learning from Reviews

March 2024

As a Safeguarding Partnership we have a duty of care towards children and adults with care and support needs, to explore how practice can be improved through changes to the system established though learning gained from multi-agency reviews.

In this edition we focus on the learning from our Children's Reviews and Adult Reviews in Rapid Time.

Local Child Safeguarding Practice Review (LCSPR) Referral Process

To make a referral for consideration of a Rapid Review or LCSPR, please download the referral form found on the local policy and procedures pages of the WSP website.

Please send your completed referral by email to the Safeguarding Business Unit: safeguardingbusinessunit@walsall.gov.uk

CRITERIA

Local Process Flowchart

Referral Consideration

Once a referral for a Local Child Safeguarding Practice Review (LCSPR) or Safeguarding Adult Review (SAR) is submitted the three statutory partners will meet to confirm the referral meets criteria.

Following agreement, scoping information will be gathered and a partnership meeting convened to identify further details about the referral and establish initial learning.

Sometimes all learning can be identified at this point and the review may be completed in rapid time.

Alternatively, there may be a need to progress to a full LCSPR or traditional SAR to gather further learning and make recommendations for areas of improvement.

Safeguarding Adult Review (SAR) Referral Process

To make a referral for consideration of a SAR, please download the referral form found on the West Midlands Regional Adult Safeguarding Information Hub website.

Please send your completed referral by email to the Safeguarding Business Unit: safeguardingbusinessunit@walsall.gov.uk

CRITERIA
Local process flowchart

LEARNING FROM CHILD REVIEWS

Child 1

What Happened?
An 18-day old baby to first time parents died unexpectedly. Post-mortem CT examination of the head showed extensive head trauma. The family were known to Health (GP, Midwifery and Health Visiting Services).

Good Practice:
* ICON advice provided to both parents.
* Positive engagement with universal and Acute health services.
* From a multi-agency perspective there was no evidence of missed opportunities or poor practice or communication.

Learning Identified:
⇒ Professional Curiosity - who was the male in the home? What did family support look like?

⇒ It was agreed that Walsall Healthcare Trust would benefit from internal single agency review.

Child 2

What Happened?
Child experienced a significant injury following a road traffic incident.

There had been multiple referrals to MASH and limited Early Help intervention, exclusion from education and alternative provision and police involvement with domestic abuse within the family and "low level" criminality.

Good Practice:
* Child continues to work with Early Help, Turnaround and CAMHS.

Learning Identified:
⇒ There is a need to rebuild focus and engagement from all agencies involved and be creative in the way engagement is sought and maintained.

⇒ Consent to not be a stumbling block to working with agencies.

⇒ Assurance from MASH Management Group was required and an understanding of process for repeat contacts/referrals.

⇒ Better use of multi-agency chronologies.

Child 3

What Happened?
Delivery of a stillborn baby. Mother was in a volatile relationship with numerous episodes of police involvement and social care referrals. Mother was discussed in MARAC and there was lots of involvement from agencies across different areas/ boroughs.

Good Practice:
* British Pregnancy Advisory Service had been tenacious in their approach with mother.
* Referral to Mental Health Services was addressed in a timely and proportionate manner.
* Mother continues to be supported by and accessing midwifery bereavement team at Walsall Healthcare Trust.

Learning Identified:
⇒ Triangulation of conversations between all agencies and parent required.

⇒ Non-engagement should be reason to escalate not to close.

⇒ Professional curiosity lacking.

⇒ Consideration of reproductive coercion.

⇒ Lateral checks to be more thorough where other local authorities involved.

⇒ Cross border awareness and communication amongst Children's Services to be improved.

⇒ Regional learning event to be arranged to highlight learning, strengths and areas for development .

What can you do now?
Read : about ICON on the WSP ICON webpages and use the contact form to order resources.

Read : ICON 7 minute briefing

Read : Professional Curiosity 7 minute briefing

Read : Information Sharing 7 minute briefing

Read: Information Sharing Agreement to enable agencies to work together

Read : Pre-birth Assessment Protocol

Read: Right Help Right Time Guidance

Find out about : Reproductive coercion on the BMJ webpages

Attend Training:
Ending Male Violence against Women and Girls
30 May / 27 June / 24 July

Complete the eLearning:
ICON "babies cry you can cope"

LEARNING FORM ADULT REVIEWS

SAR11—in Rapid Time

What Happened?

Adult was a 41 year old British Asian woman who had learning difficulties and mental ill-health. She was found in cardiac arrest due to choking and was taken to hospital where she sadly died.

Good Practice:

* Good interaction with the Community Psychiatric Nurse service prior to death.

* The Health Visiting Service had asked for a PAMS assessment (Parent Assessment Module) which is used where a parent has a learning disability.

Learning Identified:

◊ Interconnectivity between adult's and children and communication sharing.
◊ More attention needs to be paid to the culture and heritage of those we support and the application of an Equity, Diversity and Inclusion lens should be included.
◊ Consideration of independent advocacy.
◊ Consideration of engagement with carers.
◊ Increased collaborative working and information sharing.
◊ Lack of professional curiosity about the family dynamics.
◊ Clarity required regarding Learning Difficulty, Learning Disability, mental health & where there is a diagnosis or not.

◊ **All professionals to 'look' at the person in front of them.**

SAR12—in Rapid Time

What Happened?

Adult was a 61 year old White British woman, with restricted mobility and diagnosed mental health conditions including paranoid schizophrenia. She was subject to S117 under the Mental Health Act 1983 amended (2007). She was found deceased following a fire at her home address. Her husband also died as a result of the fire.

Good Practice:

* Adult had received fire safety visits that resulted in the deployment of equipment such as fire retardant covers for her chair, a fire mat and a fire bin for her cigarette ends.

* Mental Health Support Worker was acknowledged, with their excellent record keeping being noted as well as being an effective conduit to other services

* West Midlands Fire Service have introduced an improved data system that allows more effective checking of any previous contact with someone
* Good inter-agency working between West Midland Police and the adult's GP.
* GP prioritised face-to-face appointments for the adult.

Learning Identified:

◊ To produce a learning briefing that highlights the benefits of protection planning and multi-agency meetings, thus reducing the risk of missed opportunities to safeguard vulnerable individuals
◊ Recognising the key role of the Fire Service in supporting individuals who may Hoard and Self-Neglect.
◊ Promote awareness of the Mental Capacity Act.
◊ To remind colleagues of the importance of concerned curiosity when considering family relationships.
◊ To produce learning materials to remind colleagues that where there is a possibility of familiarity with a person's situation leading to diminished professional curiosity, regular supervision can assist in maintaining vigilance.
◊ The need for proactive and concerned curiosity was recognised

What can you do now?

Read : Communication 7 minute briefing

Read : Information Sharing 7 minute briefing

Read : Professional Curiosity 7 minute briefing

Learn about : Making Safeguarding Personal

Access : WSP Self-Neglect & Hoarding Pathway

eLearning available:

Safeguarding Adults Awareness - Level 1

Understanding Mental Capacity Act—Level 2

Read SAR11 Safeguarding Adult Review

Read SAR12 Safeguarding Adult Review

Click on the words / links below to view a catalogue of WSP

Training Courses—eLearning—Further training/webinars/briefings: adult / child