# Walsall Safeguarding Partnership Newsletter

Summer 2022

**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 and there is learning for the local area.

## Rapid Reviews and Referral Consideration Meetings

When a case might meet the criteria for a CSPR, a rapid review meeting is convened to consider initial agency information.

Similarly, when a case is referred for consideration of a SAR, a the Practice Review Subgroup will consider what agencies know about the situation.

Sometimes learning can be identified at these meetings and actions agreed to improve practice, without the need to progress to a SAR or CSPR.

# RAPID REVIEW

## What Happened?

A 5 month old child was found in the early hours of the morning unresponsive and not breathing.

There were suspicions of parental alcohol use and the property was unkempt but child appeared well cared for.

## Wider Family Circumstances:

An older sibling was at a grandparent's property at the time of the death. Grandparent had significant mental health issues and was under the care of mental health services.

Walsall Children's Services had previously received a number of referrals in relation to the older sibling.

Neither of the children's fathers were in contact with the children and limited details provided on records.

## Learning Identified:

Assessments should have a clear 'Think Family' approach in order to identify any caring responsibilities and the impact on mental health.

Consideration of safeguarding referrals should take into account the cumulative impact of 'low level harm'.

## What can you do now?

- Familiarise yourself with the 7 minute briefing on 'Think Family'.

- 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;

https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

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

- Look out for the launch of the new 'Working with Fathers' strategy and accompanying training/workshops.

- Attend Right Help Right Time training or refresher training.

# REFERRAL CONSIDERATION MEETING

## What Happened?

Mr P was a 73 year old gentleman who had health and mobility issues and possibly some short term memory problems but these did not affect his capacity to make decisions in relation to his care and support needs or accommodation.

He lived alone and had carers who provided care in his own property.

Mr P died as a result of a fire caused by smoking in bed.

Mr P was receiving daily support from a care provider and input from District Nurses, however no recent concerns were raised regarding smoking in bed or around fire prevention/bedding.

## Learning Identified:

Whilst it was evident that different agencies were involved in his care, issues with multiagency communication and information sharing were identified which led to a lack of collective risk assessment/management.

There was also a need for Fire safety equipment coordination planning.

## What can you do now?

- Look out for the 'Learning from Adults Reviews' event.
- Familiarise yourself with the fire safety guidance for carers and professionals

https://go.walsall.gov.uk/walsall-safeguarding-partnership/Professionals-Volunteers/Learning-and-Development/eLearning-Courses/fire-safety-guidance-for-carers-or-professionals-elearning

- If the Fire Service have recommended fire retardant bedding, make sure it is being used.
- Talk to other professionals involved with a service users to discuss risks and develop plans to manage it.

Click below to view our current Webinars , Face to face courses and eLearning courses

Our catalogue of 7 Minute Briefings can be found here

Walsall Safeguarding Partnership

*Right for Children, Families and Adults*

# CHILD SAFEGUARDING PRACTICE REVIEW - W13

## What happened?

This review focuses on the lived experience of Sam, who at the time of his death was 15 years of age.

Sam tragically took his own life; this followed three recent hospital admissions as a result of Sam self-harming. Sam had been known to services for a number years.

### Background Information

Sam was born a female but has identified as a male since 2016. Sam had been referred to the National Gender Identity development Service (GIDS). GIDS were undertaking an assessment and were due to complete a report towards the end of 2020, before which Sam unfortunately died.

Sam's behaviour had been seen as "challenging" for some time; he had attended three secondary schools and two other educational provisions and just prior to his death was undertaking a managed move under the Fair Access Protocol.

Sam used substances which he reported was to help himself sleep and cope with his emotions. This led to agencies struggling to meet his needs on occasions, for example prescribing medication was complicated, as professionals were unclear what other substances he was taking and the potential harm this may cause.

Same was upset and frustrated when agencies did not recognise his identified gender. This isolated him from services.

## What this review tells us?

### Family Dynamic

It is apparent that a deep-rooted cause of concern for Sam was his fractured relationship with his mother. This is recognised by both Sam's father and mother, as well as professionals who interacted with Sam over a period of time.

Following an incident between Sam and his mother's partner, Sam had started to live with his father. The relationship between Sam's father and mother was acrimonious and this undoubtedly further impacted on Sam.

Those who worked closely with Sam recognised emotional dysregulation triggered by feelings of abandonment and lack of attachment to his mother.

### Multi-agency meetings

Not all those involved with Sam were invited to meetings and there was insufficient link up or cross reference to the meetings or plans. The minutes were not circulated and in the final two meetings there were no clear actions and deliverables. There was no coherent lead or coordination.

It must be recognised that there was considerable focus from agencies, but this lacked multiagency thinking and coordination. There seemed to be a sense of helplessness from agencies, which mirrored Sam's own feelings.

### CAMHS Support

Sam was supported by CAMHS in the community, there was consistency in the worker who supported Sam and a positive relationship between them.

### Interventions

It is difficult to see how Sam was going to achieve the stability he needed to be considered for interventions without enhanced or a different type of support, which was not forthcoming.

## What can we do now?

Care and risk plans are a shared responsibility, ensure you are involved in relevant meetings and you are clear on your actions as a practitioner.

Always use a Think Family approach within your practice which ensures safeguarding and risk is considered and documented.

Ensure you are aware of and working within your agency's transgender policy.

Ensure you are trained in self-harm and suicide according to your role

Where necessary, consider the use of the Exploitation pathway, (information can be found here)