Walsall Safeguarding Partnership Learning from Case Reviews

March 2023

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 Walsall Safeguarding Reviews for adults and Rapid Reviews for children.

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, there is learning for the local area.

Rapid Review for Referral Consideration

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, 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.

SAFEGUARDING ADULT REVIEWS

What Happened?

Adult was 74 when they died. They had a diagnosis of mild learning disability, autistic features and recurrent depressive order. The causes of death were given as: Frailty & Learning Disability and Parkinsonism.

In the months following their death a LeDeR review was undertaken grading the care as below standard. It was felt that actions or lack of actions may well have contributed to their death. Due to this a Multi-Agency Review (MAR) was undertaken which concluded their death was potentially avoidable and recommended a SAR be conducted.

Learning Identified:

- Whenever a safeguarding referral is received by the Local Authority, be they for the client, the carer or other residents, the wider ramification must be considered.
- The need to make explicit that when the concern questions whether a carer has harmed their client, the police must be notified so a thorough criminal investigation can be undertaken.
- Consideration should be given to any support or additional therapeutic interventions the client may benefit from.
- The time taken for GP records to be transferred from one practice to another is impacting on GP's being able to assimilate new information in the context of the patients previous health and social care information.
- Whenever a client/patient is refusing food and fluids, a robust multi-agency plan of care needs to be developed, which focusses on all the potential reasons for food refusal and the risks.
- Practitioners were not making best use of legislation to aid their decision making in relation to their clients' needs. Consideration of Mental Capacity Act (MCA) should be integral within all Multi Disciplinary Team (MDT) meetings for persons with cognitive impairment.
- There was a need for greater managerial oversight when a person in care provision is admitted to hospital and a shared care arrangement is made.
- Good practice would always be for practitioners to afford families the time and space to speak with them individually not only in meetings.
- A number of disciplines were not well integrated in the partnership approach. The GP was not an integral part of MDTs, the police were not part of safeguarding enquiries and the accommodation provider did not see themselves as playing any part in their care.

What Happened?

Adult was a 54 year old who was alcohol dependent. They lived alone in a flat, where they were found dead. They were in contact with a number of agencies in response to self-neglect and alcohol dependence. Agencies struggled to engage with them, as they frequently changed their mind about taking part in detoxification for alcohol dependence.

Learning Identified:

- Despite knowledge of the self-neglect pathway, practitioners found it problematic to use and were not aware of the self-neglect panel.
- There was no clear evidence that the impact of long-term alcohol use on mental capacity and decision making was recognised by agencies.
- Services were not responsive to working with mental health problems and alcohol use at the same time.
- There was a lack of exploration of the reasons for self-neglecting.
- There was a lack of systematic work with the wider network including family and friends.
- The restrictions in place as a result of Covid-19 made contact easier but resulted in reduced contextual awareness of needs.

What can you do now?

⇒ Revisit the webinar on...Trauma informed practice

⇒ Revisit the webinar on...self-neglect

⇒ Read again...self-neglect 7 min briefing

⇒ Read again...Regional Policies & Procedures

⇒ Read again...Decision Making Support Guide

⇒ Read again...information on MCA & MSP

⇒ Read again...Position of Trust 7 Min Briefing

⇒ Access eLearning...MCA

⇒ Attend Training...Learning from Reviews

⇒ Attend training...safeguarding vulnerable dependent drinkers & Blue Light Training

SAR 5 & SAR 6 reviews have been published and are available to view on the WSP website under learning from adult reviews.

RAPID REVIEW

What Happened?

16 year old went missing from home. They were open to the Disabled Children and Young People Team under Child in Need (CIN) following a child and family assessment being undertaken and had also been added to the health Dynamic Stratification risk register.

The last text message to their relative implied that they did not wish to be alive. They were found in a local area where they had taken their own life by hanging.

Wider Family Circumstances:

There had been a concern raised about sexual inappropriate behaviour in the family and concerns of domestic abuse.

Investigations into the difficult relationships within the home had been undertaken and family were being supported as part of a CIN plan. There were no immediate safeguarding concerns in regards to parents that suggested any greater level of protection was required at that time.

West Midlands Police were called out to a number of incidents involving interfamilial domestic abuse.

Learning Identified:

- The Child in Need Plan and safety plan (for children that remain in the home) should consider: the whole family context and dynamic within the home.
- Children's assessments should always consider adult vulnerabilities and risks (such as mental health, domestic abuse and sexual abuse) and the impact on children as part of the assessment.
- Ensuring when devising safety plans that the people responsible for the plans implementation understand the expectations on keeping the individual safe.

What can you do now?

⇒ Read information about...Child Sexual Abuse

⇒ Read again...CSA Strategy

⇒ Read again...CSA 7 min briefing

⇒ Listen again...podcast: Child & Adolescent mental health

⇒ Read again...CDOP Suicide 7 min briefing

⇒ Attend training...Child Sexual Abuse

⇒ Attend Training...SP-EAK Suicide Prevention

⇒ Read and watch...Suicide prevention and support

What Happened?

On the day of the incident, a child was found unresponsive face down in a pool in the family garden after being left unsupervised. Following attempted resuscitation procedures the child passed away.

Wider Family Circumstances:

The child was part of a large sibling group. There were ongoing concerns with regard neglect in relation to home conditions, poor supervision and inconsistent parenting.

Parent was known to have a history of low mood and depression. They were supported by GP services and in September 2020 was prescribed antidepressants. They were also referred to the mental health service in September 2020.

Learning Identified:

- When working with families where there is prolonged neglect assessments need to demonstrate whether families have the capacity and ability to maintain effective change to keep children safe over a sustained period of time.
- Professional curiosity remains a concern.
- Recognition and response to neglect needs developing amongst professionals.
- Level 3 multi-agency and single agency training is required to provide enhanced awareness raising to ensure health professionals can identify and are aware of how to respond to concern regarding neglect (including the need for information sharing interagency and when thresholds are met for a referral into the MASH).

What can you do now?

⇒ Read information about...Neglect (including the Neglect Strategy, Needs Analysis & resources)

⇒ Attend training...Understanding Neglect

⇒ Read again...Multi-agency neglect audit briefing

⇒ Read again...Professional Curiosity 7 min briefing

⇒ Read again...Information sharing 7 min briefing

⇒ Read again... 7 Golden Rules (information sharing) 7 min briefing

RAPID REVIEW

What Happened?

The police referred a child into children's services due to concerns raised of threats towards the father and damage to the home. The referral was screened by Multi Agency Safeguarding Hub (MASH) and it was identified that the child had an elder half-sibling who passed away. Due to specific circumstances, an Interim Care Order was secured for the child.

Wider Family Circumstances:

The child's mother is a young mother who has been known to Children's Services the majority of her childhood, which was marred by abuse. She was placed in a mother and baby foster placement. The assessments conducted within Care Proceedings concluded that the mother was unable to parent her child.

Learning Identified:

- Be alert to the duty of care to parents no longer involved with Children's Social Care but who are subject to specific proceedings. Practitioners should act to ensure they do not lose sight of parents and / or ensure there is a key point of contact, support or advocate that will keep in touch.
- Professional agencies are required to establish the facts, approach matters with respectful uncertainty to check out version of events provided by parents and not to rely solely on their disclosure as the fact. This requires effective follow up, information sharing and receiving (and requests for) information from partners.

What Happened?

Family with three young children referred to Children with Disabilities Team by school. Concerns included low school attendance, poor home conditions, missed health appointments, lack of parental supervision and damage to the home.

Wider Family Circumstances:

During a home visit, there were concerns raised in respect of sexualised behaviour. There was a perceived lack of parental supervision with concerns of unsupervised sexual contents being viewed on the TV by the children. As well as the children's lack of toys for stimulation, it was reported that the children were not being taken out to play and their diet was considered poor with little food in the home. The children were observed to be wearing nappies and were noted to have been drinking out of baby bottles.

One of the children was diagnosed with Global Developmental Delay. Parents reported that they felt unable to cope with this child's behaviour and were struggling to meet their needs.

Learning Identified:

- It was felt there was no professional curiosity
- Cross agency communication needs improving.

What can you do now?

⇒ Read again...Professional Curiosity 7 min briefing

⇒ Read again...Information Sharing 7 min briefing

⇒ Read again... 7 Golden Rules (information sharing) 7 min briefing

⇒ Read again...Neglect Audit 7 min briefing

⇒ Read again...Communication 7 min briefing

⇒ Watch & Listen...Trauma Informed Practice

⇒ Attend training...Understanding Neglect

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