# West Sussex Safeguarding Children Board

## Board Response to Brighton & Hove Serious Case Review - Liam

**April 2015**

## 1. Introduction

1.1 This review concerns the services provided to Liam who experienced head injuries, when seven weeks old, whilst in the care of his father. Liam is not the real name of the child but is a pseudonym to ensure anonymity is maintained.

1.2 Both Liam's parents were young and prior to Liam's birth, his mother was not supported by any agency apart from core services such as GP. Liam's father had previously been 'looked after' by West Sussex County Council Care Leaving Service and was a 'care leaver'. He was known to have abused alcohol and drugs and was considered to have a volatile temper and had a criminal history of petty theft with some violence to peers.

1.3 This serious case review was commissioned by Brighton & Hove Safeguarding Children Board because of the serious injuries experienced by Liam during the first seven weeks of his life and Brighton and Hove was the area in which the injuries to Liam occurred. Although Liam survived and is now well, these injuries were life threatening and he could have died. The review involved two local safeguarding children boards and staff from two children's social care departments, two GP practices, two midwifery teams as well as health visiting, police and probation staff. As per guidance when a serious case review is undertaken, one LSCB needs to lead on this and be responsible for the review. West Sussex Safeguarding Children Board fully participated in the review and assisted with the process. The review focussed on safeguarding systems within Brighton & Hove but there are findings which are relevant to West Sussex

1.4 At the time of Liam's birth his parents were living in a privately rented flat in Brighton and both midwifery and health visiting services were involved. His father was the subject of a probation order and he was also receiving support from the West Sussex County Council Care Leaving Service who provided financial assistance in furnishing the flat. The family were also supported by the maternal grandparents who lived in West Sussex. Soon after the birth of Liam the police were called to a domestic abuse incident involving the parents and this information was shared with children's social care who passed the information on to the health visitor.

1.5 During the first seven weeks of his life Liam was injured on at least two occasions and experienced fractured ribs, a fractured femur and bilateral skull fractures. It is thought that Liam's father caused the injuries and a criminal prosecution has resulted in a custodial sentence. There have also been civil care proceedings which concluded that on balance of probability the father caused the injuries. In addition, they concluded that the mother did know enough of the father's aggressive or volatile behaviour to have been able to make a reasonable judgement that he was not a safe sole carer for her new baby and hence did not act with levels of protection deemed reasonable for a mother.

1.6 Liam has recovered from his injuries and is currently living with his maternal grandparents and has regular contact with his mother.

1.7 This case has highlighted the challenges in working with young parents and identified the importance of effective assessment processes that highlight additional supports that may be needed where there are specific vulnerabilities such as having been previously 'looked after'. This is especially true when assessing fathers, as many agency procedures are insufficiently robust in their approach to men. It has also identified some areas for improvement around multi-agency working out of hours particularly when responding to complex medical conditions that may have differential diagnoses.

1.8 The case was additionally perceived to shed light and address the following questions:

- How effective cross border working relationships are for vulnerable children and children in need?
- How do agencies work together when a child presents with a serious injury and a different diagnosis is adopted?
- How effective are systems for assessment of young parents where there are vulnerabilities such as having been previously in care?
- How effective are assessments of fathers?

1.9 Statutory guidance[1] requires SCRs to be conducted in such in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings

1.10 In order to comply with these requirements Brighton & Hove Safeguarding Children Board has used the SCIE Learning Together systems model[2]. This approach endeavours to understand professional practice in context, identifying the factors in the system that influence the nature and quality of work with families and make it more or less likely that the quality of practice will be good or poor.

1.11 West Sussex Safeguarding Children Board met in April 2015 to review the full report from Brighton & Hove when it fully accepted the findings outlined in Chapter 4 of the Report. The Report was formally signed off in conjunction with Brighton & Hove following the conclusion of the criminal trial and consultation with the family completed.

[1] Working Together to Safeguard Children, 2013 Chapter 4
[2] Learning Together, Fish, Munro & Bairstow SCIE 2008

1.12 West Sussex Safeguarding Children Board has implemented an action plan based on the serious case review findings relating to West Sussex. The plan incorporates actions already taken as a result of the learning and identifies actions required to strengthen practice by all agencies in West Sussex. This action plan and updates have been shared with Brighton & Hove Safeguarding Children Board.

## Findings

### 2. Finding 1

*2.1 Does the primarily advocacy role adopted by the West Sussex OLAC team and the lack of understanding of the correlation between maltreatment in childhood and the impact upon them as a parent, mean social workers do not adequately identify the risk that care leavers might pose to their own or other children, meaning that they are left without the support they need as parents, and children can go unprotected?*

### 2.2 WSSCB View:

2.21 WSSCB is in the process of ensuring that there is a culture of continuing learning in order to strengthen a consistent safeguarding perspective within the Children Looked After Service. All staff are completing basic safeguarding training as a required standard**.** The impact on practice will be monitored through supervision and audit.

### 2.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:

2.31 WSSCB is aware that a range of interventions have already taken place to strengthen the safeguarding perspective within the Children Looked After and Young People's Service. All staff and managers are completing refresher safeguarding training and specific training is being commissioned on the potential impact of care experience on parenting capacity. Briefings by the responsible Principal Manager have taken place with all managers and staff within the Children Looked After Service and a similar exercise has taken place in the Young People's Service. The briefings have focused on the findings and learning from this SCR and have reiterated expectations of all staff in relation to safeguarding practice with care leavers. The Young People's Service now have responsibility for delivering a service to Care Leavers.

2.32 Relevant safe-guarding training is now a requirement for all staff and managers.

2.33 Work has been undertaken to establish the safeguarding training requirements for the Young People's Service

2.34 The service has identified all young people who are Looked After and/or care leavers about to become parents and are ensuring each has a pre-birth assessment with good management oversight of each case.

## 3. Finding 3

*3.1* Is there a pattern in Brighton & Hove *and West Sussex that where social work cases are held on a duty system the work becomes task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes? (Management Systems)*

### 3.2 WSSCB View:

3.21 The Board recognises that within the period examined by the review, the Older Children Looked After Service (OCLA) had a small number of care leavers who were unallocated and managed on duty. Whilst it is recognised within the review that there are always a small number of cases at any one time unallocated and managed through a duty system the issue in this case was the poor quality of practice when working with cases on duty and the lack of robust management oversight. A review of the duty system has been carried out and improvements instigated. All care leavers have an allocated worker .

### 3.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:

3.31 An evaluation of the current duty system has been completed to determine any risks.

3.32 Steps have been taken to ensure that pathway plans are not completed on duty. If the rare occasion does occur when this is required then expectations will be clearly specified by the relevant manager including a thorough assessment to be completed involving the young person.

3.33 Instructions have been reinforced to ensure IROs are consistently compliant with the IRO handbook in relation to care leavers eligibility and their expectations of Social Workers. Practice will reflect this.

## 4. Finding 4

*4.1 The Frameworki IT system in West Sussex does not include the provision for stand alone case transfer summaries, leaving workers and managers without easily accessible case history information on which to assess risk.*

### 4.2 WSSCB View:

4.21 The Board recognises that the IT system does not have a separate transfer summary episode record.

### 4.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:

4.31 A Case summary/case transfer episode has been created in Framework 'I'. This episode has a requirement of 'management sign off'.

## 5. Finding 6

**5.1** *Is there a pattern in West Sussex OLAC Service a lack of consistently robust oversight of how Leaving Care Grants are spent, leading to potential risks to and from care leavers not being recognised? (Management Systems)*

**5.2 WSSCB view**

5.21 The Board recognises that there was a lack of consistent management oversight in relation to Leaving Care Grants for Care Leavers who were unallocated and managed through the duty system.

**5.3 Actions taken/or planned in response to the questions posed to the Board by the Serious Case Review Team:**

5.31 Guidance on spending principles for Children Looked After and Care Leavers has been re-written. The revised guidance has been distributed to all managers and staff with clear expectations regarding compliance with this guidance.

5.32 An Audit was undertaken based on a sample of recent spend on Independent Living Grants (ILGs). The findings of the audit concluded that ILG spend on the cases examined was appropriate.