Learning from reviews of serious cases 2014-15

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www.hertssafeguarding.org.uk
• Role and work of the Serious Case Review group
• How we approach and conduct reviews
• Number and type of reviews
• Role of reviews in the board’s business plan and improvement work
• Themes and learning from reviews
• Discussion in small groups
SCR group role and membership

• Independent chair
• Senior managers or professional advisers from
  – Local authority social care services
  – Designated health professionals (CCG)
  – Hertfordshire Police
  – Mental health service provider
  – Legal advisor
  – Education services
  – Court advisory service (Cafcass)
• HSCB Business Manager and Case Review Coordinator
Criteria for conducting a Serious Case Review

Abuse or neglect of a child is known or suspected and either

• (i) the child has died; or
• (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child

Plus other specific circumstances, such as death of a young person in custody or mental health detention
Levels of review

- Serious case review – required by statute
- Partnership case review
- Multi-agency review – small scale, local incidents and episodes
- Commission one or more individual agencies to carry out an internal review
Number and types of reviews carried out 2014-15

- 2 published Serious Case Reviews
- 2 Serious Case Reviews awaiting publication
- 1 Serious Case Review in close to completion
- 2 x Partnership Case Reviews
- 3 x single agency reviews commissioned
- 1 x local multi-agency review
Learning and improvement

• Accountability – openness and honesty about what has happened in the individual case and why

• But not enough to focus on the individual case looking back – use reviews to add to our knowledge about the strong and weak points in our services and find ways in which these can be addressed
Our starting point

• People come to work to try to do a good job
• In high risk work - errors and unacceptable poor outcomes happen
• Responding and learning is part of day to day business
• Errors have complex causes
How we do reviews

• Involve staff
• Acknowledging errors is the starting point in attempting to understand
  – The experience of staff as things happened
  – Organisational factors that impact on practice
  – Why no one saw the incident as it developed
  – Whether any of the problems is more widespread
• Avoid outcome and hindsight bias
The role of case reviews in service improvement

• Specific procedural recommendations

• Use reviews as one way of understanding recurrent, difficult problems in safeguarding
  – Occur across agencies
  – Hard to resolve
  – Reinforce one another

• LSCB should keep coming back to these areas
Group work task

• What can we do to implement learning?
• If there are the barriers to improvement, how do we overcome them?
• What do you need to do?
• What does HSCB need to do?
Linked themes

- Assessment of risk and need
- Responses to neglect
- Supervision and management oversight
- Plans and services for children in need
- Safeguarding of disabled children
- Working across adult and children’s services
- Children of Traveller families
• Assessment of risk and need
  – Contact with the child, observation, knowledge of child development
  – Listen to the words said by children, record them and give them proper weight in assessment
  – Be respectfully sceptical and be prepared to check and challenge the accounts given by parents
  – Identify and involve fathers and male carers
  – What is the impact on children?
  – What change has taken place and is it enough?
• Neglect
  – Why is there sometimes a difficulty in identifying neglect or a reluctance to name it?
  – Desensitisation (in a team or area or in individual cases)
  – Patterns of events over time are especially important
  – Neglect is usually part of wider pattern of concern (so not just a practical intervention)
  – Strategy to use the Graded Care Profile needs reinvigorating
• Disabled children
  – Vulnerability of disabled children
  – Significance of missed healthcare and education appointments
  – Difficulties in identifying abuse
    • Communication with the child
    • Identification of early signs of neglect
    • Assessment of possible physical assault can be difficult
  – History and chronology are critical
• Services for children in need
  – The right children are being supported as children in need
  – Each child has a plan of coordinated intervention
  – Activity is focused on the needs of children
  – Proper review in order to establish if the intervention is having an impact
• Supervision and management oversight
  – Supervision has a critical role in identifying children who need a more intensive or challenging intervention
  – Agency processes differ, but must be
    • Discussing the right children
    • Challenging and testing
    • Focused on improvement and impact
    • Not just focused on completion of tasks
  – Supervision of less experienced staff and students
• Working across adult and children’s services
  – Engagement – are all the relevant services in the discussions?
  – Are they communicating effectively
    • Understanding
    • Terminology used
  – Is there sufficient focus in services for adults on the impact of behaviour on children?
• Working with the children of Travellers
  – 41 sites, temporary residents and and large number of families in permanent accommodation who identify
  – How well served are the children of Traveller families by agencies?
    • Outcomes know? Services being provided? Prejudice?
      Low expectations? Heavier concentration of problems?
    • Effectiveness of specialist services?
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• What does HSCB need to do?