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Northamptonshire Safeguarding Children Board

Learning Summary – Child X

Date Learning Summary completed	13th June 2016
Type of review conducted and overall purpose	(Please include details of methodology, chairing/authoring, how case(s) were selected) – Case Mapping Exercise, jointly led by Children's Social Care & Northampton General Hospital – Initial meeting with Children's Social Care, Northampton General Hospital and Business Office to identify key events. – Agencies asked to respond to particular events. – Half day workshop to discuss events and to identify actions, learning and good practice.
Month/year of incident	Various incidents over the course of summer 2015, but Section 47 on 14th September 2015 led to the Review.

What you learnt about the case: key themes/early learning

(Specific issues or general areas of concern or good practice)

Concerns/Findings/Learning

- No Child In Need Plan was implemented following Supervision Order granted by Court. The case remained held by a Looked After Children specialist worker, with no management direction evidenced to implement Child in Need planning processes.
- No Strategy Meetings undertaken (in July / August 2015) to share information in a multi-agency arena.
- Supervision not undertaken within relevant agencies to discuss the case and to unpick concerns until after the incident of concern (September 2015).
- Reliance on Professionals identifying concerns in cases and escalating as appropriate (internal & with partners).
- No evidenced management oversight or forum for multi agency challenge.
- There were a number of missed opportunities to convene a Strategy Meeting / Section 47.
- Information provided by GP led agencies to view injuries as 'explained' and did not consider wider issues.
- No active involvement from Adult Social Care, Mental Health with mother.
- If a Strategy Meeting had been convened it may not have been as comprehensive as it could have been - as mother's mental health is unlikely to have been included / considered.
- Disguised compliance (mother) not considered by agencies. Over-reliance on Court decision that her parenting was judged to be 'good enough'; this should have been reviewed / challenged.
- False reassurance provided to agencies by Grandmother / weight being given Grandmother's support – which was not consistent.
- Support for mother was not available for the peaks and troughs in her mental health because she was not an open case.
- No formal discharge plan provided to Health Visiting Team when mother was discharged from the mother and baby unit – even though Child X was Looked After Child.
- Mother's presentation to A&E for Child X's incident in September 2015 was not in keeping with previous proportionate presentations. She attended A&E as she was 'told to', not because she had concerns.

- Child X seen by GP four days prior to presentation at A&E, but this did not result in a Child Protection referral to CSC. Query if all the bruises were seen at appointment with the GP, as they were very visible at presentation to A&E. Bruises ranged in approximate age – from faded, to just a few days old.
- Relevant recording of Child X's presentation in hospital – 'wolfing down food', 'frozen watchfulness', 'preferred strangers than parents' etc.
- Neglect was not considered by single agencies in a multi agency forum (e.g. Child in Need Meeting). Neglect Tool / Graded Care Profile not completed.
- Concerns from Social Worker regarding Mother's mental health, but deemed to be in a better place than previously - so did not escalate. The potential impact of mother's deteriorating mental health on Child X was not considered.
- Over-reliance on mother reporting on her deteriorating mental health to Adult Social Care Mental Health and Northamptonshire Healthcare Foundation Trust Mental Health to access services.
- Mother was agitated in hospital but referral not made to mental health - as consent is required from the individual to make referral to Adult Social Care Mental Health.
- No contingency plan in place for mother to manage her mental health.
- There was not sufficient consideration of father leaving prison and his new relationship with mother's best friend and how this might impact on mother & child. Health Visitor noted this, but it was not considered in wider scope.
- Concerns that Northamptonshire Healthcare Foundation Trust's recording of the voice of the child (positive report) was different to those recorded by other agency professionals.

<u>Good Practice</u>

- Mother engaged with the Health Visitor and Family Support Worker.
- Social Worker undertook announced and unannounced visits.
- Health Visitor did assess mother's mental health in January 2014, but it is not clear what assessment tool was used.
- Health Visitor was aware of father's new relationship with mother's best friend and considered the impacted on mother, along with father leaving prison.
- Social Worker implemented Written Agreement when unable to convene Strategy Meeting in a timeframe which was appropriate.
- Referral made by the Police officers who attended the home to arrest the two risky adults - regarding the condition of the home and mother's ability to parent.
- Duty Social Worker visited the home (unannounced) once telephone call from GP was received.

<u>Learning already taken</u>

- Very high percentages (currently 93.1%) of children have Child in Need Plan's. The remainder of cases that don't have Child in Need Plan's are less than 90 old or have a Child in Need Plan that requires update. Percentage of Child in Need cases with no plan is escalated weekly to Senior Managers.
- Safeguarding Supervision takes place for Health Visitors. If a Health Visitor does not have a Safeguarding Supervision within three months this is escalated to Senior Managers.
- Northamptonshire Police Intelligence System now has a flag system in place to identify when a child is in the property that is a looked after child, child in need or on a child protection plan.

What you learnt about the review/methodology	
(What worked/didn't?; Who was involved, how long did it take, chairs, authors etc) – The initial meeting identified key events that agencies needed to address and this worked well. – The request to agencies to complete and return information regarding the key events identified worked very well. – The half day workshop for the two Lead Reviewers, colleagues who had completed the return and any other people specifically identified worked very well. The meeting lasted two and half hours. All information discussed and robust discussions held. – Participants found the process helpful and instructive. – Spurgeon's Children's Centres not in attendance due to an accident over the weekend. Their absence was a significant gap within the Review / Workshop.	
Key learning points – Single-agency	
(Indicate transferrable learning, not necessarily all recommendations) – No single agency learning points were identified.	
Key learning points - Multi-agency	
(As above, focus on transferrable learning) – Agencies are required to support professionals when they are working outside their 'normal remit'. – Assurance that professional supervision is conducted and within a timely manner. – Recording of informal discussions needs to be consistent. – All children open to Children's Social Care have to have a recent & relevant plan (Child in Need / Child Protection / Looked After Child); if this is not in place, agencies need to challenge / escalate. – Convening non-urgent Strategy Meeting process needs to be more effective; there needs to be escalation to managers if there is not a timely response to requests for a Strategy Meeting. – Appropriate provision of services and support packages need to be in place for parents who have identified peaks and troughs in their mental health. – Sharing of information between Adult Social Care Mental Health and Northamptonshire Healthcare Foundation Trust Mental Health needs to be more effective. – Developing practitioners understanding of 'the voice of the child'.	
How do you intend to make changes? Who's doing what?	Actions as listed above.
How will you audit the impact? i.e. how will you know anything has changed?	Agencies contacted in (at 3 / 6 months) to assess progress of implementation of learning and changes.
Any other comments, advice, suggestions – about the case, the method, embedding change or evidencing impact/ change	Summary document of key events in Child X's life and actions taken to be placed alongside the Learning Summary once the criminal proceedings have been concluded.