Dissemination of Learning: Child F Serious Case Review

Introduction

In 2011 Child F was killed after he threw himself in front of a vehicle. In 2006 Child A's mother had died after a suicide attempt. Prior to her death there had been extensive involvement by children's services, police, health and mental health services as a consequence of a combination of domestic violence towards Ms A by her partner Mr. C, Ms A's previous suicide threats and concerns about Ms A's and Mr. C's substance use.

Following the death of Child, Havering LSCB carried out a serious case review and the findings of this review were disseminated to multi agency partners within Havering and neighboring boroughs on 3rd December 2012.

Two additional day long training workshops were arranged to explore lessons learned in depth. This report summarises the outputs from these workshops. Each workshop comprised a mix of multi agency partners who, during the course of the day reviewed the three key themes to come from the SCR and its recommendations. The three themes included working with:

- Families featuring co-morbidity Hard to reach families and individuals
- Older young people at risk of harm

Each workshop was divided into three sessions which looked at one of the above themes and asked participants to discuss the learning from the review, combined with their work experiences to identify three key single or multi agency recommendations that would improve practice, both in single and multi agency contexts

The outputs were not quite as ordered as the questions as groups tended to focus on issues pertinent to them. Whilst good practice was discussed in general terms in the groups, examples were not included in the presentations and have therefore not been recorded in this document. The majority of the outputs from the 2 days focused on what could be improved.

Key conclusions and recommendations from the sessions are summarised in the following sections. While some findings have more general applicability recommendations have been retained within the session in which they were discussed in order to convey a better flavour of the way discussions developed in the sessions.

An appendix lists some key quotations from research used in the SCR and dissemination.

CO-MORBIDITY OF DOMESTIC ABUSE, SUBSTANCE MISUSE AND PARENTAL MENTAL HEALTH

Referral process

1. Do not assume that others are taking action. There is a likelihood s47 referral necessary if all three toxic trio factors are identified
2. Early intervention with complex families through CAF may mitigate impact of co morbidity factors. All practitioners must understand the roles and responsibilities when using a CAF. This would be facilitated a more user friendly referral form (MARF)
3. There were concerns outcome of referrals to children's service were not always reported back to referrer. There should be continuing dialogue between referrer and recipient of referral to ensure appropriate action : referral is just the beginning – not the end of the process.
4. To facilitate the best response, referrers must consider how best to gather and present info when making referral
5. Referrers should consider escalation to management if action has not resulted

Info sharing

1. Consideration and understanding of who needs to know
2. Clarity of what, when, how to share info between agencies, who needs to know and which agency has lead role. Practitioners should have good understanding of how to use info sharing protocols (which should themselves be clear)
3. Is there scope for better sharing of IT systems (e.g. MASH)
4. Utilise information held by GP surgeries even if GPs cannot attend meetings

Multi agency working

1. Multi agency involvement must have a clear structure and be co-ordinated (e.g. through CP/CIN plan/MARAC)
5. Involved practitioners should have both shared case specific knowledge and understanding of relevant theory and research
2. Adult mental health and safeguarding services and youth offending services should be better involved in CYP multi agency meetings to ensure full multi agency involvement This should include understanding different agency risk assessment processes and how to balance therapeutic roles and statutory child protection processes.
3. Professionals must prioritise meetings where important info can be shared
4. The importance of home visiting to identify risk and assess progress is paramount

L&D

1. Training for staff on impact of substance abuse by parents
2. Understanding impact of parental co-morbidity factors on children
3. Understanding cultural attitudes to co morbidity factors e.g. use of specific substances, attitudes to women, response to mental illness

HARD TO ENGAGE FAMILIES

Practitioner skills

1. Be prepared to escalate and challenge; convene professionals meeting when necessary. Do not let senior titles intimidate you
2. Understand patterns- e.g. repeated behaviours need to be a trigger for further involvement
3. Don't become desensitised- seek support e.g. in supervision, practice groupings
4. Understand non engagement may be a consequence of families seeking to conceal co morbidity factors.
5. Be sensitive to ethnicity/culture e.g. use interpreter rather than ask a family member to interpret; consider how family values/norms may differ from mainstream within their culture (incl White UK)
6. Develop good communication skills:
7. Consider how to use research findings prior to visits
8. Have realistic outcomes (Including quick wins, SMART targets) and review if/how effective change has taken place
9. Understand the 'bigger picture' through effective multi agency working and info sharing

Improving management accountability/supervision

1. Supervision must be prioritised and mandated in time to avoid crisis
2. Avoid inexperienced social workers carrying the most difficult families;
3. Minimise frequent changes in allocated worker and when not possible ensure effective handover
4. Ensure workers have sufficient time allocated to complex families;
5. Ensure responsive and communicative team approach/positive info sharing to referrals/concerns
6. Utilise expertise of well qualified experienced workers to share best practice in L&D processes
7. Develop strategies for working with "scary families"

Client centered practice

1. Explain role of services to reduce the fear of the unknown
2. Avoid use of jargon/acronyms to improve understanding of offered service
3. Build trust through respectful practice: Deliver what you say you will and don't make promises you can't keep
4. Be clear about purpose of intervention, necessary outcome for intervention to cease and consequences of non engagement. Ensure both parties understand their obligations in a beneficial/motivational way using non judgmental attitudes.
5. Be aware family's own identified needs may not be a priority for agency. Sell the benefits of involvement e.g. smart targets, offers of specific help: e.g. a social worker arranged to have the locks changed for a client to give her peace of mind and this allowed her to build trust and engage more effectively.
6. Engage with all members of the family, including extended family, in a safe environment.
7. Identify any key professional(s) the family do engage with and consider how they may help facilitate improved engagement with the wider network
8. Utilise specific problem solving to encourage engagement e.g. venue, crèche, fares.

OLDER YOUNG PEOPLE

Risk assessment

1. Use timely assessment (incl. CAF) to identify risks (e.g. gang involvement, sexual exploitation) and protective factors (e.g. self esteem, supportive adults) to facilitate a robust early offer of help:
2. Consider how to develop trust and set boundaries
3. Above processes must be supported by regular supervision, risk management plan; multi agency approach; understanding of protocols and procedures.
4. Use accessible visible information e.g. injuries, marks, behaviour to help identify e.g. domestic violence, substance misuse, mental health/suicide concerns.

Multi agency approach

1. Each agency member may bring a different perspective: listening to young people and good networking will ensure connectivity and targeted support to reduce risks.
2. Use above approach to develop tailored approach, delegating tasks based on practitioners skills
3. Importance of information sharing (sexual exploitation – intimidation)
4. Importance of outreach work-e.g. visiting youth centres, colleges,
5. Personal responsibility for understanding what services available to meet need and how to access them- requires good info sharing across agencies.

Client centered practice

1. How young people behave isn't how they feel
2. Group work e.g. sexual health, gangs, drug use is an important tool in developing positive attitudes e.g. peer support
3. Ensure both parties understand the boundaries, what the intervention plan is to achieve, the behaviours necessary for change. Set goals that will lead to the CYP coming off the plan and smaller ones to help the client to achieve the bigger goals, e.g. getting to school each day. Agree realistic outcomes for both parties. Reward good behaviours.
4. Importance of staff attitudes e..g. consistency, honesty, confidentiality, listening in order to obtain and develop respect from young person
5. Therapeutic relationship
6. Consider gender related approaches
7. Be non judgemental but also clear about consequences e.g. Impact of criminality – explain consequences – make it real

Strategic

1. Services to develop youth engagement – youth led agendas; youth participation; empowerment
2. Use media to develop positive image and success stories.

APPENDIX: KEY RESEARCH QUOTATIONS UTILISED IN DISSEMINATION SESSIONS

Note a full bibliography is set out at the end of this appendix

Findings of the 2007-9 biennial review (Brandon et al 2010) noted : "*A quarter of the reviews concerned older young people who are likely to pose a risk to themselves and/or others, and whose needs are not always recognised, or met".*

The final Munro review (Munro 2011 p 96) identified a number of elements of authoritative practice of particular relevance in this case.

i. Critical analysis of evidence about what is happening in a child's life including recognition of child abuse and neglect
ii. Purposeful relationship building with children, carers and families
iii. Skills in adopting an authoritative but compassionate style of working
iv. Skills to assess family functioning, take a comprehensive family history and use this when making decisions about a child's safety and welfare
v. Knowledge of theoretical frameworks and relevant research findings and their effective application for the provision of therapeutic help
vi. Understanding the respective roles and responsibilities of other professionals
vii. Skills in communicating with children.

Brandon et al (2008 pp 63-70) note different patterns of dysfunctional parental co-operation ranging from a *"Pattern of high level of, possibly, panicky help seeking from many different agencies….needing constant reassurance"* to a *"Not co-operative, actively avoiding involvement / hostile refusal to engage with services or actively hostile / violent. ….actively avoiding or eluding agencies or moving frequently, going missing."*

This research cautions against seeing these patterns as a continuum but rather as "*fluid, overlapping categories which can change very quickly"* and noting how hostility can *"be modified by positive engagement skills of staff and should not be considered an inherent or unchangeable attribute"* (Brandon et al 2008 p 64).

Research has identified a high representation of older young people in serious case reviews. Brandon et al (2008 p 29) note *"The very high number of adolescents who died in both studies is a reflection of the many suicide cases in this age range".*

OFSTED's Ages of Concern notes *"Agencies had focused on the young person's challenging behaviour, seeing them as hard to reach or rebellious, rather than trying to understand the causes of the behaviour and the need for sustained support"* (Ofsted 2011 p 18).

Brandon et al (2008 p 80) noted in the SCRs studied *"the preponderance of domestic violence, mental health difficulties and substance misuse among parents and carers. The reviews revealed that it was much more common for these features to exist in combination than singly."*

The impact of living in a family where domestic violence, substance misuse and mental health had been factors were also not considered later in respect of Child F and Child K when their behaviour became challenging. Factors associated with experience of co-

morbidity for this age group included poor school performance, emotional disturbance, conduct disorders, fear of exposing family life to outside scrutiny, school exclusion, aggression and risk of suicidal behaviour (Cleaver et al 1999 p 97 quoted in Brandon 2008).

Brandon et al (2008 p82) note correlating factors for older young people subject to serious case reviews included

i. A history of rejection and loss (often including the death of a parent)
ii. Parents or carers with their own history of abuse and rejection, most of whom misused substances and had mental health difficulties
iii. Difficulties in containing these young people in school with challenging and threatening behaviour resulting in temporary or permanent exclusions
iv. Adolescence as a stage of development can mark the start of serious problems for some young people. Mental health problems are more likely to emerge and there is an increased risk of drug use, offending and running away (Biehal 2005 quoted in Brandon 2008).

H of C Education Cttee Children first: the child protection system in England

Local authorities have a statutory duty to "safeguard and promote the welfare of children in need" at all ages up to 18 years old. We heard many concerns that the child protection system is not meeting the needs of older children (aged 14-18). Our inquiry has revealed a worrying picture with regard to the protection and support of this group. This is characterised by a lack of services for adolescents, a failure to look beyond behavioural problems, a lack of recognition of the signs of neglect and abuse in teenagers, and a lack of understanding about the long-term impact on them. It is clear that the system as a whole is still failing this particular group in key ways. (Children First p3)

We recommend that the Government urgently review the support offered by the child protection system to older children and consult on proposals for re-shaping services to meet the needs of this very vulnerable group (Children First p4).

BIBLIOGRAPHY

Ages of concern: learning lessons from serious case reviews: a thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011

Analysing child deaths and serious Injury through abuse – What can we learn? A Biennial Analysis of Serious Case Reviews 2003-05, Brandon, Marion, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth and Jane Black: HM Government (2008)

Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009 Marian Brandon, Sue Bailey and Pippa Belderson (2010)

Cleaver H, Unell I, Aldgate J. Children's Needs – Parenting Capacity: The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development. (1999)

House of Commons Education Cttee Children first: the child protection system in England (2012)