

# Swindon LSCB Serious Case Reviews (SCR's)

## Common Themes & Outcomes February 2009

This is the second report prepared by Swindon LSCB (previously ACPC) to provide agencies with the opportunity to reflect on the learning from SCR's. The previous report written in January 05 looked at 4 Serious Case Reviews and identified a number of common themes: Communication (e.g. record keeping, inter-agency co-ordination and information sharing); assessment (e.g. integration of available information, recognition of warning signs, basis of decision taking); resources (e.g. staffing levels, availability of supervision); and policies and procedures (e.g. compliance with them and how they are interpreted). It should aid reflection to again use these 'themes' to look at the further 3 SCR's conducted in Swindon.

### The cases

(A) was a 16 year old male found dead in September 2004 in his accommodation in Swindon. He was diabetic and had many hospital admissions prior to his death. (A) died of a diabetic coma which may or may not have been deliberately induced.

(B) was a baby of 11 months found dead in 2005 in the family home. The post mortem established that this child died from starvation and neglect.

(C) was found dead in May 2005, believed to have died as a result of a drugs overdose. She was 16 years old at the time of her death. (C) was the subject of a Care Order and on the Child Protection register under the category of neglect.

The *Executive Summaries* from all three cases are available on the Swindon LSCB Website, [www.swindonlscb.org.uk/lscb-index/lscb-workers-home/lscb-workers-casereviews.htm](http://www.swindonlscb.org.uk/lscb-index/lscb-workers-home/lscb-workers-casereviews.htm)

## Common Themes

It must be said that strengths were identified in multi agency working in each of the SCR's. There were however shortfalls in practice common to two or more of the reviews:

### Communication:

- Assumptions were made about who was acting as the key agency in a case.
- Information was not exchanged within agencies e.g. when a child moved schools, between Health Visitor and GP, hospital and community.
- Information was not exchanged across LSCB agencies e.g. YOT and Long Term Social Work team.
- There were situations where Managers communicating across agencies could have improved outcomes.

### Skills and System issues:

- Shortfalls in record keeping.
- Professionals working in isolation – not clarifying roles / making links with other parts of the professional network.
- Lack of systems that could identify and support young people through transitions.
- Records not transferring when the child transfers.
- Absence of discharge plans.
- Problems seen as string of events rather than bringing information together to get the 'bigger picture'.

### Assessment

- Failure to take into account previous history when completing assessments.
- Shortfalls in the assessment of risk.
- Lost opportunities by agencies in assessing the vulnerability of the young person.
- Lack of referral for assessment.
- Multiple referrals and frequent presentations to hospital or health professionals should have triggered lead professional involvement and multi disciplinary review with consideration of referral for an initial assessment.
- A view that permanent exclusion of children from school should have been a trigger point for referral for initial assessment.
- Assessment and planning was not used appropriately to identify risk.
- Missed opportunities to identify need/risk through completion of the core assessment.

### Resources:

- Staffing and skills and experience in a social work team.
- Shortfalls in providing adequate supervision of staff in relation to assessment and children in need.

### Policies and Procedures:

Each SCR identifies shortfalls in compliance with procedures:

- There was a lack of understanding about thresholds for triggering the need for a strategy meeting in older young people.
- Agencies failed to make enquiries to the Child Protection register – had they done so this could have triggered the need for an initial assessment.
- Older teenagers – the issue of 16+'s allowed a degree of self determination – without assessing vulnerability.
- The need to clarify the responsibilities of Children's Social Care to children over 16 within the Child Protection process and also those who are children in need.
- Lack of understanding around neglect led to failure to implement Child Protection procedures.
- Procedures did not encourage consideration for the undertaking of an initial assessment when there were Domestic Violence referrals.
- The need for a protocol about how to manage 'no access' visits.
- The need for the LSCB to review the 'missing' protocol to include the significance of repeated missing episodes.

### Training:

In all three reviews there were recommendations about the need for ongoing and additional training for staff around Child Protection issues.

- Training for managers and practitioners around neglect.
- The need for improved take up of multi-agency training available about substance misuse. Advanced training in the subject to be designed for staff that work with young people at risk from drugs and prostitution.
- Managers should receive training around supervision and Child Protection.
- Training across agencies in assessment.

### Outcomes of Swindon Serious Case Reviews:

The last Serious Case Review was completed in 2006. All agencies and the LSCB developed action plans to address the learning and recommendations made in the SCR's. Progress on these action plans have been kept under careful and regular review by the LSCB and there is clear evidence progress and change around agencies working together to safeguard children in Swindon.

Among the outcomes from recent Serious Case Reviews are:

- The development of a local substance misuse service (U Turn) supported by multi-agency practice guidance.

- New policies and training that enable staff to challenge other professionals more readily. (*Escalation Policy*, [www.swindonlscb.org.uk/lscb-index/lscb-workers-home/lscb-workers-guidance.htm](http://www.swindonlscb.org.uk/lscb-index/lscb-workers-home/lscb-workers-guidance.htm))
- Much developed LSCB multi-agency training programme which has incorporated the learning from SCR's. [www.swindonlscb.org.uk/lscb-index/lscb-workers-home/lscb-workers-training.htm](http://www.swindonlscb.org.uk/lscb-index/lscb-workers-home/lscb-workers-training.htm)
- New multi-agency training courses (*Working with Neglect* and *Supervising Staff and Managing Risks where there are Child Protection Concerns*).
- Heightened awareness throughout the local safeguarding community of the issues of neglect.
- A new *Unborn Baby Protocol* to help professionals identify risks and support for both families and professionals when considering unborn babies. [www.swcpp.org.uk](http://www.swcpp.org.uk) (under *Further Guidance on Child Protection*)
- *No Access Guidance* being developed to assist staff on what to do when having trouble seeing a child due to non attendance for appointments or lack of access for home visits. [www.swindonlscb.org.uk/lscb-index/lscb-workers-home/lscb-workers-guidance.htm](http://www.swindonlscb.org.uk/lscb-index/lscb-workers-home/lscb-workers-guidance.htm)
- An updated *See the Adult, See the Child* protocol, to be launched on Friday 13 March 2009. Through the implementation of this protocol, the LSCB is looking to develop stronger links between the work of adult and children's services in Swindon.
- Better links between hospital staff, U Turn and the 16+ team, backed up by a *substance misuse pathway*.
- An LSCB *Missing/Runaways working group* developing a multi-agency strategy to address the needs of this vulnerable group.
- A *transition process* is now in place for children/young people with chronic/dependent conditions moving to adult services.
- All agencies now have processes in place which record whether child/young person was seen and spoken to and who accompanied the child.
- The LSCB reviews the SCR process to ensure the process is robust and that there are opportunities to disseminate learning to staff.