Learning Themes from local Reviews

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Learning Themes from local cases

2 local cases for which I was lead reviewer:

- ‘Sarah’ DHR
- A local unpublished SCR

2 local cases I have read:

- ‘Child O’ SCR
- ‘Child P’ SCR

Learning Themes

- Risk – awareness, assessing and managing risk, closing the gap between known and actual risks, seeing children as 'protective factors'
- Think Family
- Voice of the Child/Adult Victim
- Transactional partnership working
- Leadership
- Addressing professional disagreements

Assessing and Managing Risk

- This was an important theme in **Sarah and the unpublished** cases.
- Level of risk appeared to be stable for quite some time and safeguarding adults plan was the vehicle for managing risk.
- But risk is **fluid**. It can increase **quickly** and **rapidly.**

Awareness of Risk

In **Sarah's** case a number of major risks were overlooked or downplayed. Research and experience tells us that there is:

- An increased risk to a person trying to end an abusive relationship
- An increased risk of homicide where the abusive partner is threatening suicide
- Increased risks where stalking & harassment are present
- And the perpetrator's similar behaviour towards a previous partner received insufficient attention

Discrepancy between known & actual risks

- In the local unpublished case, the family were perceived by practitioners to be a ‘universal’ family about whom there were no concerns
- However, risks were increasing as a result of a deterioration in the physical and mental health of father and his abuse of alcohol and drugs
- These risks were largely – but not completely - hidden from view.
- Limited opportunities to better understand family functioning presented themselves but were not taken.

Discrepancy between known & actual risks

How do we improve our ability to close the gap between what is known and what is knowable?

Unpublished Case learnings:

- Safeguarding ‘whole system’ only as strong as weakest point - Ambulance service gained key insights which were not shared.
- Needed to ’think family’
- Needed to avoid looking at incidents in isolation

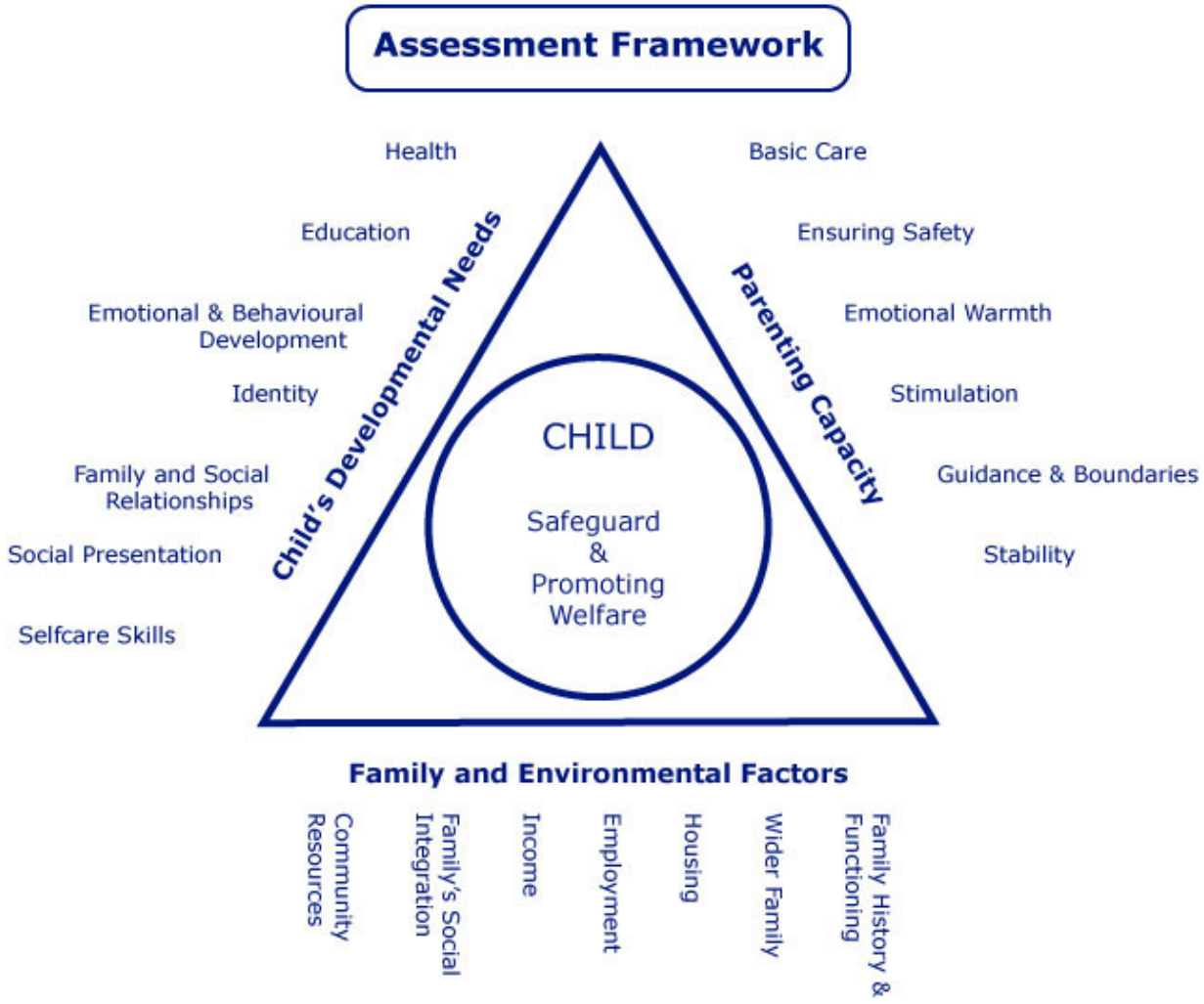
Risk of child seen as ‘protective factor’

- **Child O** was perceived to be a protective factor for the resident parent’s mental health.
- Previous SCRs have shown that considering child to be protective factor for an adult increases the risk to that child.

Think Family

In the local unpublished case more consideration was needed of how this family was functioning given:

- Language and cultural barriers
- Isolation from extended family support
- Very cramped accommodation
- Financial insecurity
- Growing family
- Father’s deteriorating physical and mental health


Assessment Framework
Health
Education
Emotional & Behavioural Development
Identity
Family and Social Relationships
Social Presentation
Selfcare Skills
Child's Developmental Needs
Basic Care
Ensuring Safety
Emotional Warmth
Stimulation
Guidance & Boundaries
Stability
Parenting Capacity
CHILD
Safeguard & Promoting Welfare
Family and Environmental Factors
Community Resources
Family's Social Integration
Income
Employment
Housing
Wider Family
Family History & Functioning

Think Family

- In **Child O's** case, when responsibilities to safeguard adults and children are given to family carers, their capacity to do so needed to be assessed and recorded.
- Families should not be left to deal with acute, complex mental health situations without clear planning and intervention by professionals.
- Practitioners needed support to fully embed the 'Think Family' approach so that they are aware of the well-being of all members of a service user's family and able to act on this awareness. (How might this be achieved?)

Think Family

In **Sarah's** case the needs of the children of both Sarah and the perpetrator were not fully appreciated. The perpetrator:

- texted Sarah's daughter as a means of applying pressure on her mother to withdraw her complaint.
- used one of his children to send threatening texts to Sarah via her daughter.
- exploited the support of his wife to present a false picture to practitioners that he had left Sarah and was moving on with his life.

Voice of the Child/Victim

- In the local unpublished case, elder sibling made three disclosures to school
- first one not recognised as disclosing domestic abuse,
- all contact following the disclosures was with father despite each disclosure raising concerns about father's behaviour
- no contact made with mother at all
- All three disclosures largely dealt with in isolation and not linked to other concerns

Voice of the Child/Victim

- In **Sarah's** case, the perpetrator's allegations against her were given priority over her fears of the perpetrator.
- When she later rang 999 to report her fears she was told to ring back on the non-emergency number and declined to do so.
- She appeared to lose confidence in the police and it was her adult son who later reported the full scale of the stalking and harassment.
- She made disclosures to a mental health practitioner on the day prior to her murder which were recorded but not acted upon.

Voice of the Child/Victim

Listening to the voice of the child or adult victim – how can we improve?

Practitioners need to take into account the whole picture of a child's environment and consider *what it is like to be a child living in that family.* (**Child O**)

Any other thoughts?

‘Transactional’ partnership working

- In **Sarah’s** case practitioner responses to escalating risk of domestic abuse were sometimes quite passive.
- When domestic abuse policy was complied with, practitioners appeared to feel that they had discharged their responsibilities by complying with processes.
- Opportunities to engage with Sarah and her family to consider a wider range of options for safeguarding her were not taken.
- “Practitioners should never assume that someone else will take care of domestic abuse concerns”.

Leadership

Not seen enough evidence in SCRs of:

- leadership or managerial intervention or challenge.
- Escalation to management.
- Nurturing of practitioners (in some cases).

Frequently noticed a leadership vacuum in multi-agency working.

When practitioners disagree…..

- **Local unpublished case** – no challenge from GP who was surprised by consultant paediatric consultant's conclusion that injury to sibling was 'accidental'
- **Child O -** no evidence that other professionals challenged a diagnosis by a senior clinician when they had information which contradicted it.

When practitioners disagree…..

- Willingness to challenge decisions with which one disagrees is an important component of safeguarding whole systems.
- Disagreement between partner agencies not uncommon in cases I have reviewed.
- LSCBs have processes for resolving professional disagreements and many safeguarding adults boards also have them, but I have never seen them used in any cases I have reviewed.

Closing Thoughts

- Many of learning themes are linked to each other.
- Making progress in one area of learning can have a positive knock-on effect in other areas
- Reviewing cases always reveals examples of good practice and many examples of strong personal commitment where practitioners have gone “above and beyond”
- The way in which SCRs, SARs and DHRs are carried out could inform wider practice, particularly use of chronologies/timelines.