Gloucestershire Safeguarding Children Board

GSCB

Executive Summary

0508

Kevin

(d.o.b. Aged 9)

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The Serious Case Review Process

The decision to review the case

Gloucestershire Safeguarding Children Board made the decision to complete a Serious Case Review in July 2008 following concerns that there had been a breakdown in multi agency working to safeguard Kevin who is 9 years old. As a result of this breakdown, Kevin and his family may not have received the level of services that were required to meet his needs including the need to be protected from harm. In such circumstances, the Gloucestershire Safeguarding Children Board (GSCB) must conduct a Serious Case Review in order to consider whether there are lessons to be learnt which would improve multi agency working and services to vulnerable children. GSCB must then make sure that all organisations providing a service to children and families put these lessons into practice. A Serious Case Review Panel made up of senior staff representing organisations providing services to children and families, was responsible for drawing up the terms of reference for the review and making sure it was completed.

Please note that we have changed the subject's name to ensure he can not be identified.

Context

Kevin lived with his mother, stepfather and sisters until he was four years old. He did not know his birth father and considered his stepfather as his 'Dad'. His mother had been the victim of abuse and there were reports from the police that she suffered domestic abuse from Kevin's father His health visitor and other health staff had concerns about Kevin's welfare from an early age as he did not put on weight as expected and suffered from seizures. His mother found it difficult to cope with his behaviour and he went to live with his grandmother when he was four years old. His behaviour continued to cause concern when he went to school. Although many services were provided for Kevin and his family, his behaviour deteriorated. There were signs that Kevin may have been emotionally, physically and sexually abused. There were also allegations that he had been neglected.

How the case was reviewed

The review was completed using the procedure in 'Working Together to Safeguard Children', chapter 8. This can be found on the DCSF website.

All organisations providing a service to Kevin and his family were asked to provide a report on their work from when the first concern about Kevin was

logged with the Gloucestershire Safeguarding Children Service in April 2001 when he was 22 months old. Information in the reports had to cover the period up to July 2008 when the decision to complete a Serious Case Review was taken. These reports from organisations, called Individual Management Reviews or IMRs, had to provide a chronology of all their contact with Kevin and his family. IMR authors had to analyse decisions made and actions taken by their organisations. The IMR authors were asked to address specific questions:

- Was communication within the organisation and between the organisations, timely and effective?
- Did the organisation make appropriate and timely assessments of the parents/ child, in line with internal organisational procedures?
- Was action taken in a timely manner and in accordance with agreed policy and procedures?

Each IMR author identified good practice as well as lessons to be learnt. They made recommendations and action plans to achieve them.

Individual Management Reviews (IMRs) were provided by the following organisations:

- Gloucestershire County Council Children and Young People's Directorate - Social Care.
- Gloucestershire County Council Children and Young People's Directorate - Educational Settings
- Gloucestershire NHS Primary Care Trust
- 2gether NHS Foundation Trust.
- Gloucestershire Hospitals NHS Foundation Trust.
- Gloucestershire Probation Area
- Gloucestershire Constabulary Child Protection Unit
- CAFCASS

Kevin and his grandmother were asked for their views which were then reported to the Serious Case Review Panel.

An independent overview report author met with the panel and the IMR authors to analyse the findings and draft recommendations for action. The Overview Report was presented to the Gloucestershire Safeguarding Children Board to approve the recommendations and action plan.

Practice issues arising from the case

Good practice identified.

The service provided by Kevin's school was commended by the IMR author. Kevin's grandmother thought that the level of support provided to Kevin and his family by the school was very good. The one to one work with Kevin prevented

his exclusion and support was provided for Kevin at week ends. The work undertaken by the family centre and the Behavioural Support Team was also seen as good by Kevin's grandmother. The IMR author identified the service offered by the Children and Adolescent Mental Health (CAMHS) service as good. Kevin's grandmother felt that the school, police and CAMHS worked well together. She was happy with the current service provided by the social worker in contrast to the service provided previously. Kevin is happy with the new arrangements for his care and education.

There were no racial, cultural, linguistic or religious identity issues to be considered in the service provided.

Lessons learnt and recommendations for action

Lesson 1
It was not clear whether the GP's role is to assess the significance of the information and decide any child protection action needed.

As a toddler, Kevin suffered from seizures and weight loss. He was also treated for a head injury. Staff from different health organisations working with the family, were aware that his mother was a victim of abuse as a child and suffered from domestic abuse as an adult. Kevin's symptoms were not identified as possible indicators of abuse or neglect. The one place where all the information was available was the GP record.

Recommendation 1 The Gloucestershire Safeguarding Children Board Health Sub Committee will consider this lesson and recommend what action can be taken

Lesson 2.
There was confusion about when a multi agency meeting was appropriate and when a strategy discussion as part of child protection procedures should be held.

Staff from different organisations working with Kevin and his family were very aware of the indicators of physical and sexual abuse and neglect. Child Protection procedures were used to log concerns from April 2001 onwards. There was also evidence of good communication between agencies to ensure that information was shared and concerns raised. Although there were multi agency meetings held which brought staff together from different organisations to discuss concerns, these were not always in line with child protection procedures. There were times when a multi agency meeting was held when a strategy discussion was needed. Some of the concerns were serious enough to prompt a child protection investigation but this did not always happen.

Recommendation 2a
The GSCB must hold to account social care teams to ensure it is satisfied that those teams are applying child protection procedures appropriately and at the correct threshold.

Recommendation 2b
Where the child protection threshold is not met, following the completion of a social care core assessment, the GSCB must satisfy itself that there is an appropriate multi agency response, and that professionals and families have an understanding of who the lead professional is in each case.

Lesson 3
Because the Social Care case file did not have a complete chronology, staff did not take into account all that was known about the case when making the assessment. There was a tendency to look at each new concern in the current context.

Several initial assessments were completed between 2001 and 2007 when new concerns were received. Every time Kevin's case was allocated to a social worker, a new initial assessment was completed. Because a full case chronology was not in Kevin's case file, the social worker completing each assessment was not aware of the history or complexity of the concerns which had been raised each time. There was insufficient knowledge of who was caring for Kevin and the impact on his behaviour. CAFCASS were working with the family over a four year period and had substantial relevant knowledge but were not involved in assessments made. Other organisations also noted that their case files did not have a complete chronology. This was a lesson from previous Serious Case Reviews.

Recommendation 3a
The lessons learnt from previous Serious Case Reviews held in Gloucestershire should be raised again with all staff and included in case audits in all agencies.

Recommendation 3b
When the contents of a clinical record are such that it necessitates a second file to be opened on a child, a chronology of risk sheet from the first file should be photocopied and remain in that file and the original removed into the second file.

Recommendation 3c
All social care assessments must include a history of involvement with social workers and an analysis of the success or otherwise of previous interventions.

Lesson 4
Kevin was not seen on his own by staff in Social Care to find out why he had run away or to get more details of the disclosures he made.

Kevin was listened to by the psychotherapist at CAMHS and was able to disclose abuse. He was not seen on his own by the social worker after he had run away or had disclosed abuse. This partly explains the tension between organisations whose concerns were based on what Kevin had disclosed, and Social Care who had not spoken to Kevin on his own.

Recommendation 4
All Social Care assessments must clearly represent the 'voice of the child'; their view of their current circumstances as well as their view of what needs to happen.

Lesson 5
It was not clear whether staff in organisations working with Kevin and his family should log a welfare concern, make a new referral or contact the social worker directly where one was allocated. Information continued to be passed to the social worker when the case was closed because organisations had not been informed of the decision to close the case.

Staff referred new concerns to the social worker believing that the case was open. Kevin's sisters who lived with their mother had a separate social worker which also caused confusion.

Recommendation 5a
Practice in logging welfare concerns with the Safeguarding Children Service and making referrals need to be clarified through child protection training, including how concerns are logged on cases that are open to Social Care. This clarification needs to include how to respond to welfare concerns where siblings do not reside at the same address

Recommendation 5b.
Case open to Social Care should not be closed without multi agency consultation. All agencies involved in working with the child/young person should be consulted and told in writing when the case has been closed

Lesson 6.
Staff in organisations working with Kevin and his family were not satisfied with decisions made by Social Care and found it difficult to challenge these effectively.

Concerns about Kevin's behaviour, which included running away, cruelty to animals and setting fire to his bedroom, did not prompt the action requested by

Kevin's school and CAMHS. There was a great deal of communication from the school and CAMHS to Social Care but this did not result in a shared understanding of the degree of concern about Kevin's welfare nor of each other's roles to achieve the action needed.

Recommendation 6 a
Social Care must ensure that they achieve a shared understanding with referrers about the degree of concern for the welfare of the child at the point of referral.

Recommendation 6b
Procedures should be written for agencies to follow, in the form of a multi agency escalations policy, if professionals are not satisfied with decisions made by any agency with responsibility for safeguarding children.

Recommendation 6c.
The Gloucestershire Safeguarding Children Service Manager to convene a meeting between professionals involved in the case from CAMHS and Social Care and appropriate 'named' professionals to facilitate a common understanding of each other's roles and responsibilities with regard to safeguarding

Lesson 7
There was no clear multi agency response to Kevin's increasing tendency to run away from home.
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Kevin ran away from home nine times between March and April 2008. There was always a quick response from the police to find Kevin and take him home. However it was not clear what further action other agencies should take in response to this behaviour**.**

Recommendation 7
Gloucestershire Safeguarding Children Board to prepare a multi agency protocol to agree interagency response to children who run away or go missing as recommended in the report 'Stepping Up: The Future of Runaways Services' published by the Children's Society in 2007.

Lesson 8.
CAFCASS was not sufficiently involved in information sharing and the completion of assessments.

CAFCASS worked with Kevin and his family for over four years and had substantial knowledge of his care and family relationships. This knowledge would have helped services understand the causes of Kevin's behaviour. However, information was not always shared with other services and CAFCASS was not

always invited to multi agency meetings. Social Care did not involve CAFCASS in undertaking assessments and did not appear to understand the importance and value of CAFCASS's role. CAFCASS were not asked to provide an IMR until later in the Serious Case Review process.

Recommendation 8
Gloucestershire Safeguarding Children Board and CAFCASS Head of Safeguarding to improve agency awareness of CAFCASS role in safeguarding processes.

What happens next?

Gloucestershire Safeguarding Children Board have accepted this recommendations and have agreed an action plan. The implementation of this plan will be monitored by the GSCB.