

Welcome to the 2nd issue of the Leicestershire & Rutland Learning Review. The purpose of this newsletter is to give everyone concerned with safeguarding up to date information

Learning Lessons from local reviews.

As well as undertaking local Serious Case Reviews (SCRs) and Significant Incident Learning Processes (SILPs) Leicestershire and Rutland LSCB are also involved in other local authority SCR or Learning Reviews, e.g. if the child or parents have lived in this areas. Sometimes these reviews are not published on the LSCBs websites because of the detrimental impact this can have on surviving siblings so we decided that this Learning Bulletin would anonymise the case and present practitioners with the most up to date learning to enable them to revise or modify their practice.

The first case identifies the learning from a child sexual exploitation case. Barnardos, working closely with local authorities, have recently launched their 'Cut them Free' campaign to help reduce the number of children and young people experiencing the horror of child sexual exploitation. They highlight the need for: frontline staff to be able to recognise the warning signs and risk factors of child sexual exploitation and know how to respond using child protection procedures.

Case 1—Child Sexual Exploitation (CSE) Involving young women who were systemically groomed and sexually exploited by a group of males.

Recommendations for practice:

..That you can understand, meaningfully, how a young person defines their own ethnic, cultural and religious identity, and how they see themselves, positively or negatively.

..That you are clear about what you need to do when a child is reported missing and who you should share that information with.

..You ensure children who are being exploited are not criminalised unless exceptional circumstances exist.

..That the initial strategy discussion/meeting enables a systematic examination of a young persons needs so appropriate actions are put in place.

..That you have an understanding of the complex factors affecting a young person's capacity to make decisions and give informed consent and the impact upon the decisions to safeguard them.

..That you can identify CSE risks and take effective action to safeguard children and young people.

..That you have strategies and consequences in place to manage risks when working with families who do not engage with agencies to safeguard their children.

..Your feel confident to know how to resolve professional differences of opinion that impede safeguarding arrangements for a child or young person.

..That your supervision provides you with the opportunity to: **evaluate and reflect** on the effectiveness of the actions being taken in complex cases to safeguard the child in the short, medium and long term.

The next two cases highlight important learning for working with babies under 12 months.

A recent study of national SCRs has shown that whilst there is some

very good practice social workers and other professionals are not always quick enough in their response to concerns about children under a year old because they underestimate the fragility of babies.

Key messages for practitioners:

- Pre-birth assessments should begin swiftly
- Early action should be taken to minimise known risks to unborns
- Risk should not be minimised when reviewing child protection plans for babies



Case 2— Child physical abuse.

Very young baby died with significant injuries.

Recommendations for practice:

..That you continue rigorous enquiries and assessments regarding the surviving children following the death or critical injury of a child on your caseload to ensure appropriate safeguarding arrangements are in place

..Ensure strategy meetings are formally recorded, involve the relevant agencies (e.g. Health) including expert opinion when necessary (e.g. Forensic Pathology) and have an interim cp plan in place up until the time of the conference.

..Share information between different departments so all professionals are aware of crucial information, e.g. a history of depression.

Case 3—Child Physical Abuse

Very young baby died with significant injuries.

Recommendations for practice:

..When ending a cp plan for a child you ensure there is a lead person and an explicit transition plan (a step down process) so the family are clear what support they will continue to receive and what would trigger fresh concerns.

..Be aware that a recommendation has been made for a minimum duration of 9 months for a newborn on a cp plan before this is stepped down. The LSCB are considering this recommendation carefully and will give guidance shortly.

..When writing conference and assessment reports use a much stronger child centered focus with a child centered story that is specific to the needs and risks for each child.

..Improve information gathering and information sharing. **This message arises again and again**

..Independent Review Officers (as Chairs of cp initial and review conferences) must assess whether sufficient progress has been made, challenge any shortfalls and establish contingency or alternative strategies and actions to ensure these are achieved.

..When a child(ren) are subject to a cp plan for a second or subsequent time Chairs must record any previous issues of compliance by the family before agreeing the objectives of this cp plan.

..Risks known to a Multi Agency Risk Assessment Conference (MARAC) and child protection forums must be shared between the two processes ahead of decision making and plans for work.

The LSCB should develop a process to support staff when a child dies. their case—**N.B We have set up a working group to speak to staff about this and will let you know what is to be developed.**

The Munro Review & the Government Response

The previous Bulletin reported the completion of Eileen Munro's report. She had identified the need for changes to a system that has become too focussed on compliance, rules and procedures and has lost focus on the needs of and experiences of children.

Munro warned there is no quick fix but making specific changes will enable the removal of the bureaucracy that has impeded good practice. She recommends that Working Together (2010), some 55 times longer than its original format, is re-written to separate the guidance and the rules to enable the development of good professional judgement.

Munro highlighted the issues of **case recording** which have become huge details of description without any analysis because organisations tell practitioners to collect information but not how to understand what things mean or the risks they pose. Professionals need to know how to develop their expertise, knowledge and skills, through continued professional development (CPD), to develop intuitive, analytical and reasoning skills. Experience on its own is not enough, it needs to be allied to reflective practice to ensure better outcomes for children and young people.

In July 2011 the Government published its response and in essence agreed the system had become too focussed on compliance, rules and procedures rather than focussing upon the needs and experiences of children and young people. Work needs to be done to:

Reduce the amount of regulation and revise the statutory framework to focus on the value of direct work with children and families, and provide more evidence based practice.

Unannounced inspections will focus on the effectiveness of the help provided for children, families and their experiences.

Existing IT systems are to be used to improve information sharing in cp practice.

The Government will work with agencies to maximise existing resources and increase the number of preventive services offered.

Professionals will be better placed to act when they are concerned about a child because local arrangements will be more transparent.

Early intervention for teenagers will receive the same priority as young children.

Social Workers should be more concerned with the effectiveness of the help provided rather than compliance with procedures.

Work will be undertaken with the Social Work Reform Board (SWRB) to incorporate the development of specific capabilities.

Further information re Eileen Munro's report:

[A Child Centred System.](#)

Further information re the Government response:

http://www.trixonline.co.uk/website/news/news_index.html

Practitioners responsibilities to keep up to date with current research.

The NSPCC and Research in Practice highlight important new developments for frontline staff. This Learning Bulletin, with readers feedback, can be a useful forum to highlight new research, good reads etc....

The following is one reader's recommendation>

Series: Safeguarding Children across Services

The book is based on a large scale study, which has built upon earlier research undertaken at the University of York, which examines the care pathways of maltreated children in the care of seven local authorities. It compares the experiences and progress of children who remained in care or who were returned to their birth families up to four years after the decision was taken. The book traces the experiences of 149 children who had entered the care system, exploring the reasons for admission to care, types of maltreatment experienced and back-ground information. It compares the progress made by the children in relation to their safety, stability and emotional well-being. The authors effectively use case-study examples to illustrate the outcomes for the children and young people at each stage of assessment and planning along their care-pathway. Each chapter ends with a helpful summary of key points arising from the discussion and study findings. The book is a compelling read. An essential textbook for social workers and other professionals involved with safeguarding and looked after children.

Book Title: "Caring for Abused and Neglected Children : making the right decisions for reunification or long-term care"

Authors: Wade, J., Biehal, N., Farrelly, N. and Sinclair, I. (2011) *Caring for Abused and Neglected Children: Making the right decisions for reunification or long-term care*, Jessica Kingsley Publishers, London.

Publishers: Jessica Kingsley 2011

10 Pitfalls in practice and how to avoid them—re-visited.

This team of authors in 1998 produced the original version of *Ten pitfalls and how to avoid them* as part of *Assessing Risk in Child Protection*, an NSPCC Policy Practice Research Series report. Since the publication of the original booklet, there have been significant changes to processes of referral and response in local authority children's services that the authors felt necessitated this revision (2010).

The guidance will be very useful for newly qualified practitioners, but will also serve as an aide-mémoire for the more experienced.

What research tells us

1. An initial hypothesis is formulated on the basis of incomplete information, and is assessed and accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it.
2. Information taken at the first enquiry is not adequately recorded, facts are not checked and there is a failure to feedback the outcome to the referrer.
3. Attention is focused on the most visible or pressing problems; case history and less "obvious" details are

insufficiently explored.

4. Insufficient weight is given to information from family, friends and neighbours.
5. Insufficient attention is paid to what children say, how they look and how they behave.
6. There is insufficient full engagement with parents (mothers/fathers/other family carers) to assess risk.
7. Initial decisions that are overly focused on age categories of children can result in older children being left in situations of unacceptable risk.
8. There is insufficient support/supervision to enable practitioners to work effectively with service users who are uncooperative, ambivalent, confrontational, avoidant or aggressive.
9. Throughout the initial assessment process, professionals do not clearly check that others have understood their communication. There is an assumption that information shared is information understood.
10. Case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. The local authority may inappropriately signpost families to other agencies with no follow up.

If you have concerns about a child.....

For Children Living in **Leicestershire** contact:

01163050005 or email childrensduty@leics.gov.uk

For children living in **Rutland** contact

01572 758407 or email dutyteam@rutland.gcsx.gov.uk

For Children in Leicester City contact

0116 2527004 or email DAS.Team@leicester.gov.uk

Out of Office hours for all areas call 0116 2551606