



Learning from Case L Key Lessons & Action Points

FOR DISSEMINATION WITHIN AGENCIES

WORKING WITH NORFOLK CHILDREN

Nov 2014

SERIOUS CASE REVIEW: CASE L INTRODUCTION



- Serious Case Review of family where two of the children identified as having suffered permanent harm as a result of neglectful parenting.
- Review was published on the NSCB website 29 Oct 2014: www.nscb.norfolk.gov.uk
- Critically important that all agencies disseminate learning from this review in order to improve services and outcomes for children.

KEY FEATURES OF THE CASE

- Children's ages from baby to teenager
- Mother was main carer
- Father not part of the household but spent regular time with the children
- Mother reported a history of periodic domestic abuse and spent time in a refuge.

KEY FEATURES OF THE CASE, cont.



- Two of the children in school caused concern. Both had emotional and behavioural difficulties and were delayed in learning and development
- Various universal services provided
- Occasional involvement from Children's Services, but not deemed to meet threshold for social care intervention
- CAF in place for more than one year

KEY FEATURES OF THE CASE, cont.



- Extent of the neglect of the children largely unrecognised.
- Mother's voice and framing of what was wrong was predominant
- Second referral by 'new' practitioner led to Initial Assessment and recognition of level of neglect.
- All children subsequently subject to Care proceedings.

The NSCB's response

- Report resulted in 8 key findings
- The Board crafted its response to each finding and developed a SMART action plan, published alongside the SCR
- Actions incorporated into SCR/MAR Composite Action Plan, and reviewed regularly as part of continuous monitoring cycle

Finding 1: Early Help & drift

Despite the expectation in Norfolk that the CAF(FSP) should operate as a formal 'early help' process for children with additional needs, it lacks any of the inbuilt mechanisms for pro-active review and challenge that are present at higher thresholds (Child in Need, CP), leaving cases that are in the system for any length of time susceptible to collusion and drift.

Finding 1: NSCB Strategic Response

- The Norfolk Early Help offer has been substantially revised and now clearly sits within a more comprehensive approach to thresholds and the ‘step-up’ and ‘step-down’ of cases.
- The new approach is based on principles agreed by NCC Cabinet in April 2014 and detailed in the Early Help Improvement Plan , the Pathways to Support, How to Tackle the Challenge of Early Help (a District Based Model) and the Early Help Outcomes Framework.
- The adoption of Signs of Safety as a fundamental approach to risk assessment and planning also ensures that there will be clear mechanisms to eliminate drift in cases.

Finding 2: Losing sight of the child



The CAF (FSP) process in Norfolk risks being parent – rather than child – focused as a consequence of its being voluntary and consent-led, with the result that the individual needs of children are not adequately addressed.

Finding 2: NSCB Strategic Response



The Board recognises that this finding reinforces lessons from previous reviews and inspections, reflecting the concentration of Norfolk practice and procedures on processes rather than outcomes, based on a priority for the voice of the child.

- Lead Professional trained to ensure that parents are challenged appropriately
- Children's wishes and feelings are central to the FSP process and parents'/carers' response to this piece of work monitored and challenged as appropriate

Finding 3: Identifying Neglect

There is evidence that some professionals most readily recognise neglect in terms of poor home conditions, rather than more general deficits in child-parent relationships and care. This can leave children at greater risk (and parents unsupported) from a range of neglectful behaviours that go unnoticed.

Finding 3: NSCB Strategic Response



- The NSCB agreed that neglect would be one of three priority areas for 2013-14 in its Business Plan.
- A Neglect Strategy has been developed and approved by the Board and the Board has also considered a baseline assessment of the impact and prevalence of neglect across the county.
- Champions for the implementation of the strategy have been identified within all NCSB partners and training provided to support the identification and response to neglect as a core practice issue.

Finding 4: Missed appointments

There is no system to track/recognise patterns of missed appointments, within and especially across agencies, making it harder for professionals to share a critical sign of neglectful parenting.

Finding 4: NSCB Strategic Response



- Interagency information sharing has been identified as a high priority for the whole systems leadership for improving Children's Services.
- Implementation of the Digital Norfolk initiative will enable some of the technical difficulties to be overcome.

Finding 5: Tolerating poor parenting



There is a tendency for professionals to make allowances for struggling parents, which militates against a recognition of neglectful behaviour and child-focussed practice, leaving children at risk of long-term harm. making it harder for professionals to share a critical sign of neglectful parenting.

Finding 5: NSCB Strategic Response



This issue has been recognised within the NSCB Neglect Strategy and is also addressed through the establishment of a new model for social work intervention using Signs of Safety. This will:

- minimise bureaucracy and maximise direct intervention with families
- support change through recognition of family strengths, giving frontline social workers and other practitioners the skills and tools to work more directly with families and ensuring the management, supervision and support to support this.

Finding 6: Use of medical labels



There is a pattern whereby routine attribution of a label such as ADHD to a child distracts attention from what may be the result of poor parental care, resulting in a range of the child's particular needs not being recognised and not met.

Finding 6: NSCB Strategic Response



This finding presents an important challenge to the NSCB and will be addressed through continuing dialogue with clinicians working across the County. The appointment of a new designated doctor for the Board will enable this to be taken forward and will be a high priority for their attention.

- Practice focuses on the child not their diagnosis and ensures that plans are put in place that define strategies to test behaviours against parenting skills
- Improved understanding of ADHD as a clinical condition and how parenting is assessed and supported as part of the diagnosis, including access to services and interventions
- Engagement with clinicians in hospital and community settings to prepare revised protocols for multi-agency input to diagnostic discussions and planning of treatment and support plans

Finding 7: Engaging with fathers



Professionals involved in the CAF process are not commonly seeking the active participation of the less visible parent (usually the father), making them less visible to the professional process as well, and risking the loss of valuable information about parenting and children.

Finding 7: NSCB Strategic Response

This is a common and frequent finding from Serious Case Reviews and the steps identified below will ensure that the NSCB has a better understanding of the barriers and opportunities for the involvement of all parents and carers.

- Early Help Practice Standards document to include guidance on involving both parents and wider family members who may be protective factors. To be underpinned with guidance about men who pose a risk and directions on how to assess that risk.
- Consent is a guiding principle for FSP and is sought from both parents where applicable
- Engage with UEA research project on involving men to improve practice

Finding 8: Thresholds



Multi-agency partners tend to perceive CSC thresholds as either inconsistent or too high, resulting in uncertainty about how referrals will meet the criteria for acceptance. As a result, some children may not receive appropriate and timely referrals for intervention

Finding 8: NSCB Strategic Response



- The Early Help Strategy and the development of Signs of Safety as a model for assessment and intervention across all levels of need will provide a consistent and common approach to thresholds.
- It will be key priority for the NSCB to monitor that the introduction of these new ways of working result in appropriate and timely referrals for intervention and the appropriate direction of referrals to the relevant service.

Discussion Questions

- Do these findings resonate with you?
- What do these findings tell us about the response to Neglect in Norfolk?
- Is there anything else that the strategy needs to consider in relation to the findings?
- Any actions for your services?

Any questions?



**If you have any questions, comments
and/or would like more information
about Serious Case Reviews &
systems learning you can contact the
NSCB Board Manager, Abigail McGarry:**

abigail.mcgarry@norfolk.gov.uk

Thank you