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Report of the Significant Case Review carried out by Highland Child Protection Committee in association with Local Safeguarding Children Board – Child T

Executive Summary:
March 2018

Reviewers:
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Executive Summary

Reason for Case Review

In April 2016 Child T was admitted to hospital with serious injuries, including a life threatening head injury. He required urgent specialist medical intervention including surgery.

At the time he was living in a kinship placement in England with his maternal aunt (F) who had been approved as a kinship carer by the Kinship Panel in Highland in October 2015. He was subject to statutory measures of supervision following a Children's Hearing in December 2015.

T's mother (M) had been known to services throughout her childhood with this contact continuing into adulthood and to date. As a child she and her siblings spent periods of time looked after and were accommodated by the local authority. Departmental records suggest her parents had a tense and, on occasion, violent relationship. There were issues relating to substance misuse and this impacted on their ability to successfully care for their four girls. M's mother died when M was a teenager and she has continued over the years to have fractious relationships with her three sisters and her father. M's first child had successfully been placed with another maternal aunt from birth.

T was born in August 2014. He was accommodated with foster carers on release from hospital and his name placed on the child protection register. Due to M's lifestyle, poor choices and lack of consistent contact there was no opportunity to return him to his mother's care. In January 2015 it was agreed that alternative permanent arrangements should be sought for Child T.

In February 2015, F presented requesting to be assessed as a kinship carer. Following assessment and approval by the Kinship Panel in Highland, T moved to the North of England in December 2015 to live with F. Highland Council maintained all case management responsibility. The receiving authority were notified of his presence but were advised that no contact or assistance was required to be taken on Highland Council's behalf.

Following T's admission to hospital F and her partner were arrested and investigated in relation to physical abuse of the child. Their children were both accommodated immediately by the local authority in England.

Methodology

It was decided that the child's circumstances met the criteria for a significant case review (SCR) as set out in:' Criteria for establishing if a case is significant', National Guidance for Child Protection Committees Conducting a Significant Case Review (2015) (National Guidance).

Given that the injuries had occurred in their Local Authority, the English Safeguarding Children Board met to consider the need for a significant case review

(SCR). As Highland held case responsibility at the time of the injuries, and full knowledge of the history of the case, it was agreed that Highland Child Protection Committee (HCPC) would conduct the SCR with input from local professionals. Any learning would be shared between HCPC and the local Safeguarding Board.

The mandated sub-group considered that there was likely to be multi-agency learning in relation to the assessment and approval of kinship carers and in relation to cross border placements and communication.

The timeframe for the review was agreed by the CPC to be from T's birth in August 2014 until April 2016 when he was admitted to hospital.

It was agreed that the SCR would be undertaken using the Social Care Institute of Excellence Learning Together Model. Learning Together reviews take their focus from what a CPC wants to learn more about, using a review of the case as the vehicle for learning. Whatever the CPC agrees is then framed as a research question(s), which underpins the investigative work carried out by the review. The use of research questions in a *Learning Together* systems review is equivalent to Terms of Reference. The research questions identify the key lines of enquiry that the CPC wants the review to pursue and are framed in such a way that make them applicable to casework more generally, as is the nature of systems Findings.

Further information about the SCIE Model can be found at:
http://www.scie.org.uk/children/learningtogether/

Research questions and appraisal of practice examined in the review

The Child Protection Committee identified that this review held the potential to shed light on particular areas of practice and agreed the following research questions:

1. *What can we learn about the effectiveness of our approach to risk assessment, with particular reference to:*
    a. *The assessment of kinship carers, and*
    b. *The use we make of historical information to inform our work in the present*
2. *What helps or hinders the operation of effective Panels in the context of family placements?*
3. *What are the issues about working across borders in planning for children?*

Findings of Review and CPC Response

The review team prioritised 6 findings for the CPC to consider.

Finding 1

Are the various checks and balances within the kinship care system working well enough to routinely pick up when there is undue optimism about a potential kinship placement at the expense of critical thinking?

The checks and balances that existed to assure the safety and wellbeing of the child placed with a family member in this case failed. This Finding raises the need to test the functioning of the mechanisms for other children in a cautionary way, in order to reinforce the requirement to be constantly vigilant. Although this case was extreme in its outcome, if it is easy for optimism to outweigh the actual evidence presented to support it, then it places children at risk.

Questions for the CPC to consider:

- **How does CPC ensure that practitioners and their managers are competent and confident in both assessing and challenging information presented to them?**
- **Are CPC confident that members of Kinship Panel are adequately trained and supported to fulfil the functions of their role?**
- **Are CPC confident that the Children's Hearing System is clear about expectations for managing cross border Kinship Placements where the Local Authority retains case management responsibility?**

Finding 2

The focus on process in existing guidance is not helping staff to think in a child centred way about kinship placements and risks a default adherence to what should happen, sometimes at the expense of critical and creative thinking.

Assessment is used to collect and collate information about children and families. However, a good analysis of the information available is often lacking. Professionals need to use their professional knowledge and judgement to conduct a full assessment and analysis of the situation rather than relying on a Practice Guide to provide a step-by-step instruction, but if guidance exists it should be as helpful as possible in order to facilitate critical analysis of information gathered, not just the gathering of information. It is important to recognise that a 'one size fits all' approach is not effective in assessing children or carers and that tools will usually focus on the commonest denominator rather than how to assess each situation.

Questions for the CPC to consider

- **What value does the Committee place on practice guidance to support the assessment of kinship carers?**
- **If there is specific guidance, how different should it be to the kind of guidance that supports any risk assessment work?**

- **Is the Committee assured that the right kind of guidance exists in Highland to support all staff to lead and contribute to risk assessment, both generally and specifically in relation to kinship care?**
- **What kind of action does the CPC consider that it may be necessary to take to better support the professionals undertaking assessment work?**

FINDING 3

Are supervisory arrangements working well enough to support professionals to think through the complexities of assessment work, specifically in relation to the placement of children with kinship carers and more generally?

This Finding shows how easily supervision can move from being a mechanism of assurance to being complicit in, or even encouraging, non-critical thinking. There will be no quick solution to this, but in the first instance, raising awareness of the problem and its likely pervasiveness is a vital first step. The assessment sets the direction of travel for casework thereafter, notwithstanding the fact that it should be regularly reviewed. If the quality of an assessment is poor or overly optimistic then it is also likely that plans for children will be less robust, as in this case, where contact arrangements were minimal.

Questions for CPC:

- **Is the CPC aware that this is a common issue in child protection work?**
- **What kind of supervisory arrangements exist to support critical thinking in non-social work agencies?**
- **What value do organisations place upon reflective practice and to what degree does supervision demonstrate this?**
- **Is there the right balance between quality of work and timescales for the completion of assessments of kinship carers?**
- **What kind of support do practice supervisors receive and is this sufficient?**
- **Are the professionals who contribute information towards a kinship assessment sent a copy of that assessment when it is complete? If not, what avenues for challenge and/or escalation are there?**

Finding 4

Is there too much emphasis in Highland on retention of case responsibility for children placed at distance out-with the authority? Is this at the expense of on-going dialogue with an authority where a kinship carer is resident, and where necessary negotiating proxy responsibilities on Highland's behalf?

This Finding shows how quickly responsibility for a young child can turn into irresponsibility, just because of professional choices that are made about 'ownership' of that child. Negotiating proxy responsibilities with another area does not equate to a loss of control, but it makes it more likely that the viability of a placement will be well tested and therefore that children will thrive.

Questions for the CPC to consider

- **How can the CPC ensure practitioners from all agencies are clear about their roles, responsibilities and limitations when working with cases that cross borders**
- **How do CPCs and LSCBs ensure that authorities work together effectively in cross border cases?**

Finding 5

There are problems with the Disclosure/Vetting systems between England and Scotland that make criminal records and intelligence checks less easily available for potential kinship carers who are not resident in Scotland, risking key information not being available to support assessment and decision making.

The delay in the vetting process was a crucial matter in this case and could be in others. No actual written criminal conviction statement was ever received. Decisions not to move the child were made in the kinship panel then overruled with the absence of the information being well known – a separate issue around governance. It appears that professionals got 'fed up' waiting for information and decided to take the risk. The information that is now known and could have been known at the time illustrates all of the concerns that existed but that practitioners were not able to act on, including, for example, that F, like her sister, M, bore the consequences of a traumatic childhood. She clearly had issues around aggression and anger which culminated in assaults against others and undoubtedly contributed to whether by action or a failure to act in the assault and injury of T.

Questions for the CPC to consider

- **This is undoubtedly an issue which goes beyond Highland. Can this be represented and discussed at a national level with the Chairs of CPC's and Social Work Scotland?**
- **Are staff in CPCs/Safeguarding Children Boards clear about the processes for Criminal Records checks in England and what these might mean for children coming into their area?**
- **How can HCPC and the Safeguarding Children Board help practitioners understand the processes for carrying out Criminal Records checks in cross border cases?**

FINDING 6

There is a tendency for professionals in a child's network not to consider a foster carer to be part of that network, which not only makes it more difficult for foster carers to escalate any concerns that they have pre and post placement but also make it more likely that they will not be taken as seriously as other professionals if they do.

The foster carer in this case knew T better than anyone and yet her suggestions as to how best he might transition between her care and the care of F were dismissed at the time. The degree to which this is indicative of a deeper dismissal of foster carers as being less significant than others within a 'professional' network is for the CPC to determine by hearing the views of all parties. Certainly, in a case which highlights the lack of child-centred assessment work in other Findings, there is a need to better value the importance of a foster carer's contributions in this context.
Questions for CPC: • **What is the considered status of foster carers relative to other professionals contributing to the assessment and planning of children moving to kinship care?** • **Have the experiences of foster carers in Highland ever been canvassed relative to this Finding and if not, is this something the CPC would find of value?** • **Has there ever been any study in Highland or more widely of the impact of kinship placements on children in later life? Might this be something that the CPC considers of interest?**

Learning from Significant Case Review
Highland Child Protection Committee Chair Summary

This is undoubtedly a distressing case where a young child suffered serious injury, the Child Protection Committee membership is pleased that Child T continues to recover and appears to be doing well supported by agencies. Our thoughts at every stage of this process have been with him and others affected

As with all Significant Case Reviews (SCRs), this report has identified a number of areas of improvement where agencies involved can learn from what happened; the Highland Child Protection Committee will continue to seek assurances from those agencies affected that the necessary improvements to practice are achieved.

This review also involved cross-border working which resulted in learning for child protection colleagues in the North of England. The Reviewers suggested six key findings and a number of these are already being addressed by the Highland Child Protection Committee and all have been discussed with relevant English Safeguarding Board.

The Review discussed the requirement to ensure Social Work kinship assessments are of the best quality, with the right checks and balances in place throughout the process to support practitioners and ensure children are, and continue to be, safe in their placements.

Local kinship procedures will be reviewed and Highland Child Protection Committee has requested consideration of national kinship standards through the Care Inspectorate.

Highland Child Protection Committee training reviews have already been put in place to make sure practitioners and panels are able to recognise disguised compliance and over-optimistic thinking. The need for 'respectful uncertainty' by practitioners engaged in risk assessment is highlighted and opportunities for more reflective and critical thinking through supervision will be supported.

The Review also highlighted the difficulties in managing cases 'cross-border' and the need for good planning and communication to ensure this happens in all cases. In particular, the issue of organising criminal record checks which has been raised nationally with the Care Inspectorate.

Many children rely on the care provided by experienced foster carers and the final finding in this review discusses the role of carers in formal assessment and planning processes. The Highland Child Protection Committee will consider this finding further to ensure the voices of carers are heard and recorded effectively in child protection cases.

I am hopeful our Highland communities are reassured that through the work of the Highland Child Protection Committee and partners that learning points from this review are being addressed and implemented by child protection agencies in Highland.

The Highland Child Protection Committee is committed to continuous improvement, every child and young person in Highland should be protected from abuse, neglect and harm by others at home, at school and in the community. The Committee will continue to work with child protection partners in the public and 3rd sector across Highland to support a collaborative approach to improvement, promotion of good practice and quality assurance of child protection practice.

DCI Vince McLaughlin, Chair, Highland Child Protection Committee