Significant Case Review Learning Brief

Falkirk Child Protection Committee

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Aims

- Create a space to help you understand the learning
- Outline the review approach and family background
- Share 4 findings
- Enable services to discuss and plan changes and improvements

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The starting point.
One case provides a 'window on the system'

We moved from the specifics of the individual case to its general significance to ask what it tells us about:

- The safety and resilience of our system?
- The reliability of our arrangements to keep children safe?
- Any underlying weaknesses and vulnerabilities?
- Which are the most pressing now and in the near future?

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Child F- Research questions

1. What can we learn about the quality of our risk assessments, decision making forums and planning across agencies including pre-birth planning?
2. Across services, what helps and what hinders effective collective decision making?
3. How well do practitioners understand and work with families where there are key risk factors including domestic abuse, parental mental health and non-engagement?

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Child F- Family Background

- Child F's parents had been known to a range of agencies since childhood
- The mother's first child was removed at birth, her second child had been on the child protection register due to concerns about parental mental health, substance use and non-engagement
- During pregnancy and subsequently to child F's birth, several agencies were concerned about the mother's ability to care , including observed bruising to the baby and frequent contact with the father who was in breach of his bail conditions
- Child F was placed on the CP register at 8 weeks old
- 11 days after registration, medical staff found a significant number of injuries- they were non accidental injuries
- Mother later pled guilty to assault of Child F and was sentenced to 6 years imprisonment

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Finding 1- The impact of risk factors adversely affecting a parent's ability to safely look after their children is not consistently recognised

Why does it matter ?

- Risk is the central component, found in daily practice
- It's crucial that all risk factors impacting on how a parent provides safe care are recognised and assessed
- Without developing clear or integrated assessments including chronologies which are regularly updated rapidly changing situations remain unclear

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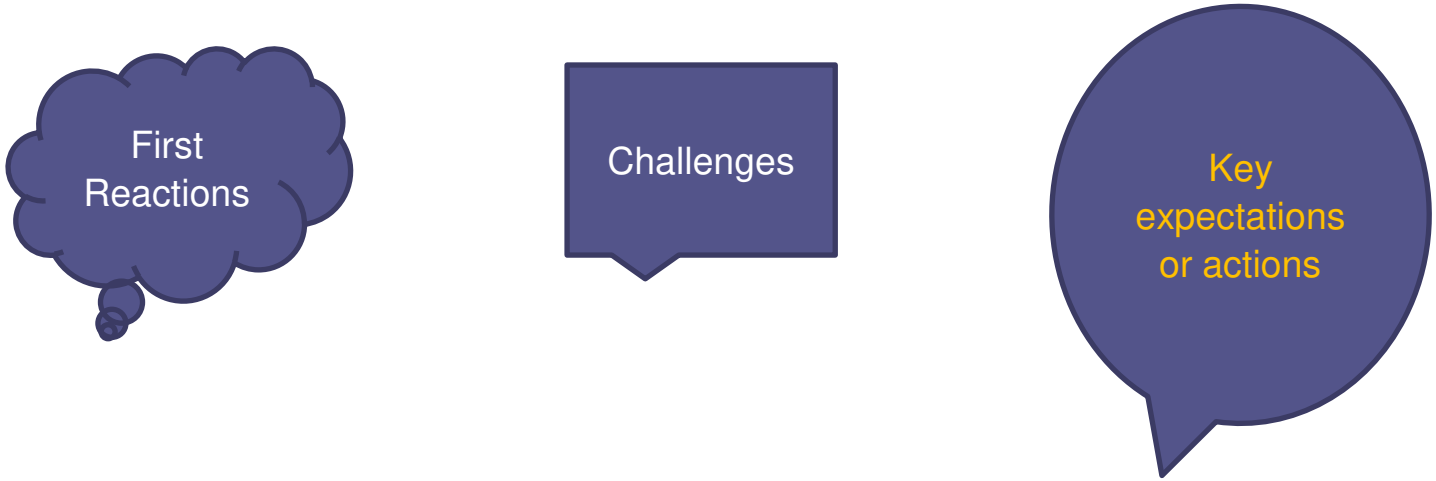
Recognising risk factors is essential



- **How do we ensure that an assessment is routinely taking place pre-birth, and beyond for children considered to be at risk of harm?**
- **How do we ensure parents understand what risky behaviour requires to change?**

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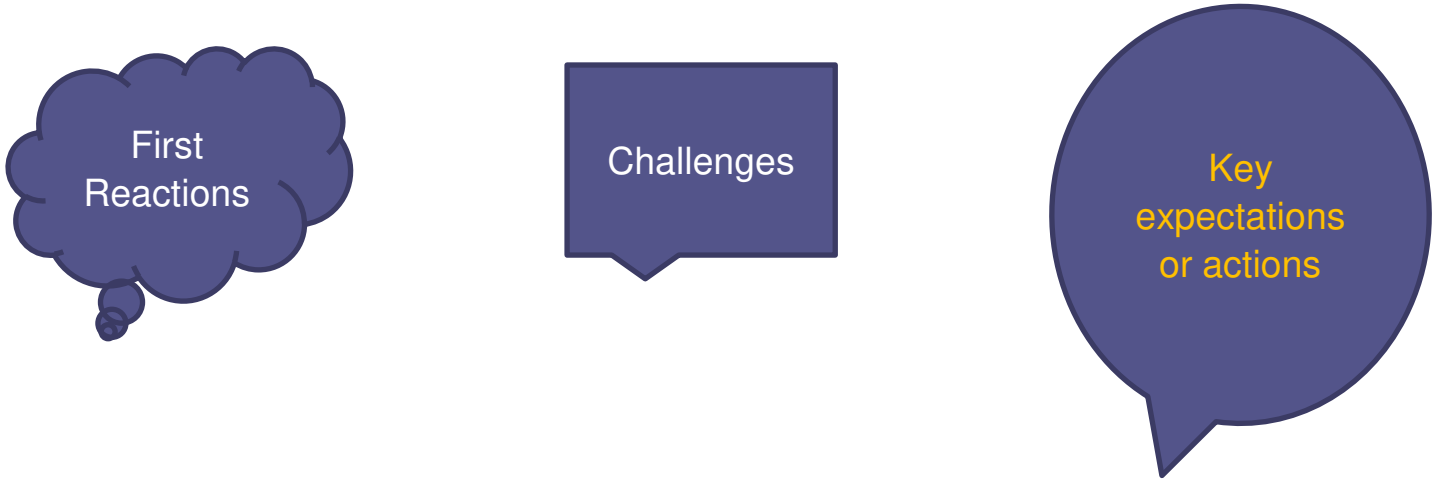
Finding 2- There is variable understanding of our collective responsibility in assessing and addressing risk

Why does it matter?

- GIRFEC relies on all involved coming together and making a plan.
- Risks and anxieties about a family need collective discussion/decision making or there's drift
- If the call is made not to use child protection procedures in a situation meriting them, it can give a false reassurance the risk is low.

Assessing and addressing risk is a collective responsibility



- **How do we ensure our assessments are truly integrated and informed by all relevant multi agency information?**
- **Are our standards and expectations in relation to using tools and frameworks clear and understood?**

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Finding 3- The lack of a strategic mechanism to mitigate resource and demand gaps impacts on practice and professional resilience

Why does it matter?

- Gaps between the demand and the availability of resources need to be measured and managed
- Pressures impact on staff morale and confidence
- Pressures in one place inevitably impact on another, across organisational boundaries

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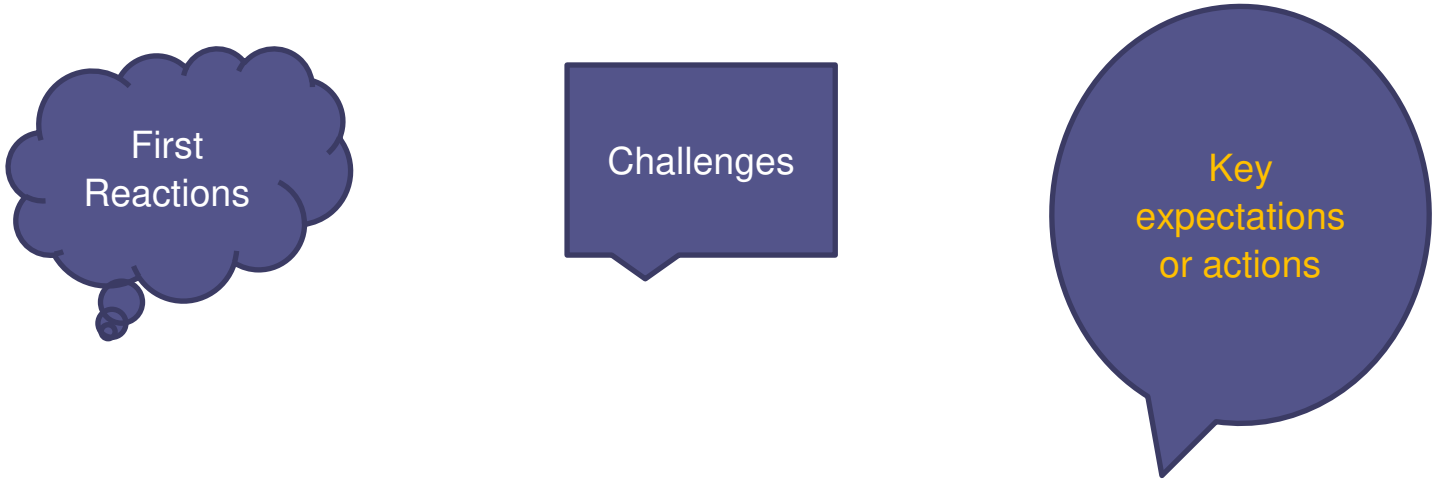
Pressures through lack of capacity and resource gaps need to be understood



- **What thoughts do you have about how we flag and address gaps that might have implications across the child protection partnership?**

Finding 4- There is no formal standardised process for timely case transfer between neighbouring local authorities including processes for escalation

Why does it matter?

- It's common for families to move between local authorities. Where children still have a multi-agency plan or have had high levels of planning, it's important that information moves with the family and it's clear at all times who is responsible for the family

- Service transfers should be timely and seamless.

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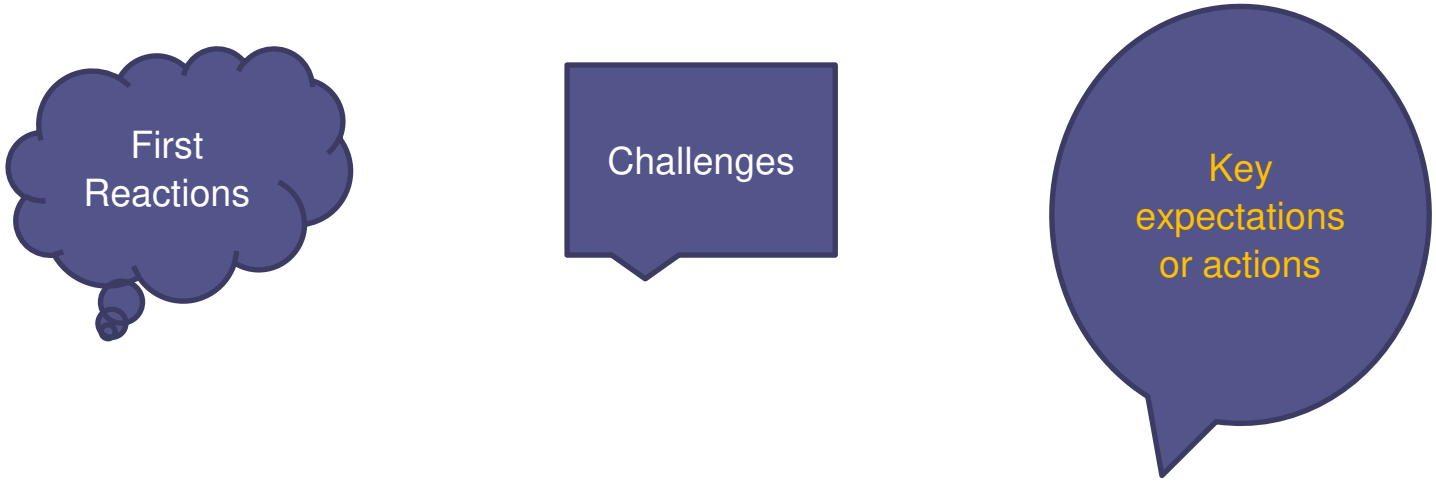
Ensuring a standard process for case transfers is essential



- When families who are known to services move across local authority boundaries what information do you share?
- If there are identified barriers, what are the escalation steps?

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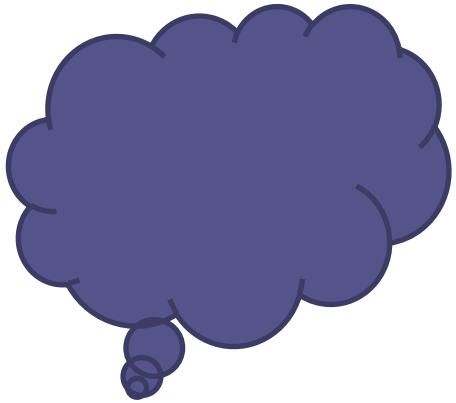
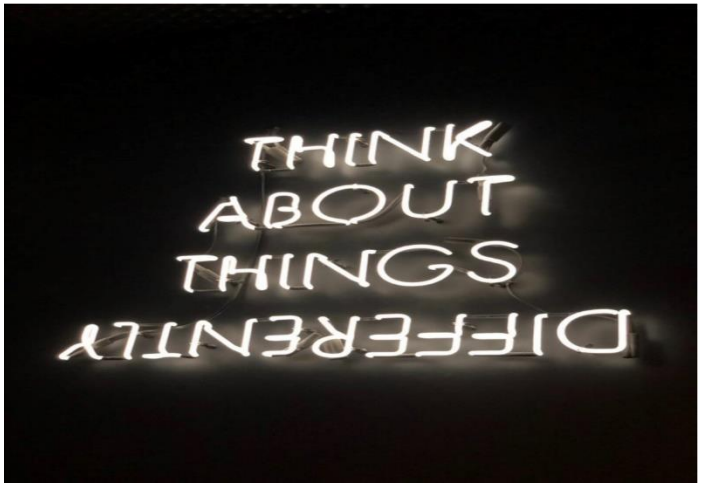
Thank you

Reflections

Take Aways

Asks





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