Moray Child Protection Committee

What is a Case Review?

It is a process to gather a better understanding of, and learn lessons from, a situation where a child has been significantly harmed or died. It provides us with a lens into the system to produce organisational learning that is vital to improving the quality of work with families and the ability of services to keep children safe.

Who was involved?

Using the SCIE learning together model, two independent lead reviewers conducted the review between March 2017 and July 2018. The family concerned chose not to be involved.

The in-depth review process involved conversations with 32 staff across services including the Police, Children & Families and Criminal Justice Social Work, Education, Health Visiting, Midwifery, Voluntary Organisations, the Children's Reporter, Housing, and Community Safety.

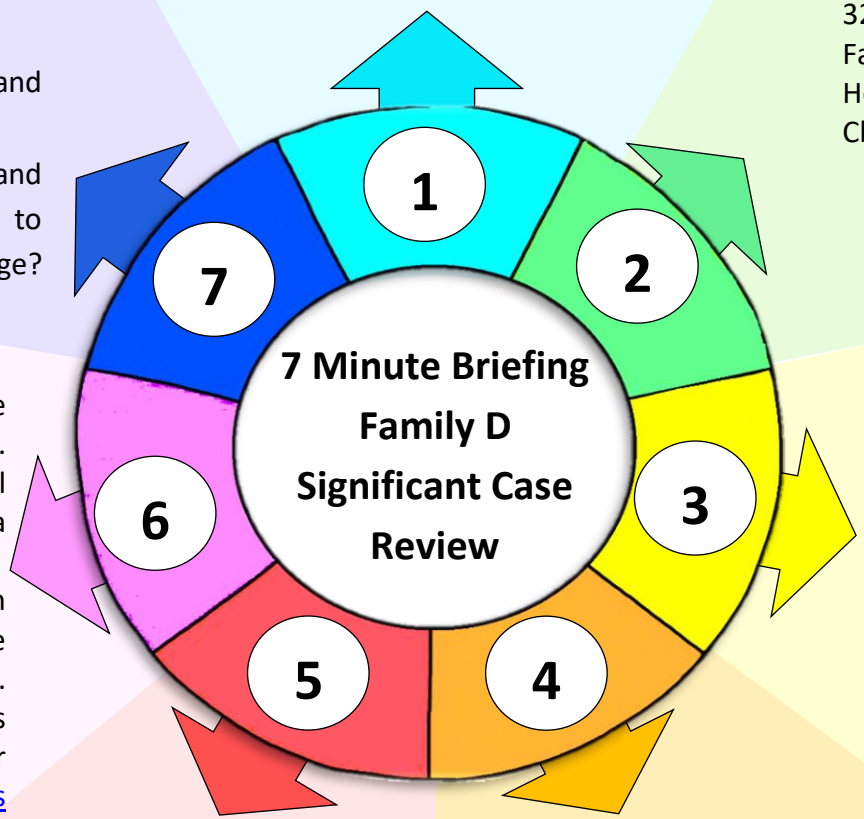
Questions for you to consider

- In your role, have you ever felt overwhelmed about a family situation that you struggled to make sense of?
- Who did you go to for guidance?
- Where did you go to seek the skills and support you needed?
- Would it have helped to press pause, and check in with the multiagency team to make sure you were all on the same page?

What will happen next?

Because the family were not involved in the case review we will not publish the full report. We will explore the learning points and detail the changes that we will be making, through a series of 7 minute briefs to the workforce.

The learning from this case has been incorporated into our action plans for service improvement and workforce development. We will submit the full report, and our plans for change, to the Care Inspectorate for evaluation and to inform future analysis reports.



About the case

The case refers to a child who was Looked After at Home, living with their parents and siblings. The child was known to use drugs and alcohol, was committing crimes such as shop lifting, vandalism, and assaulting others. The family were predictably unpredictable in how they chose to engage with services offered. There was a high level of frustration between agencies when they were working together, with each expecting another agency to be doing more. Staff in these agencies felt intimidated by the family, and were at times fearful for their own safety and that of their families. Concerns peaked when the child was admitted to hospital having ingested medication not prescribed for them. This life-threatening event raised questions about multi-agency working for the child and family.

Learning Together: what was agreed?

We need to support practitioners to better **understand the impact of domestic violence** within the family

We need to **work in partnership** to overcome very challenging cases, through shared reflection and strategic planning.

This is particularly important where **staff are concerned for their own safety** as well as that of the family.

We need to improve the **consistency** of professional risk assessment, analysis and reporting, and the **involvement of all agencies** in this process.

We should have a **relational approach** to effectively engage with children, young people and their families