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Northamptonshire Safeguarding Children Board

Learning Summary Template

Date Learning Summary completed	25th September 2015
Type of review conducted and overall purpose	**Case Mapping Exercise for Child O** Half day workshop facilitated by Named Doctor for Safeguarding Children, Nene and Corby Clinical Commissioning Groups.
Precis of case and month/year of incident	On 14th December 2014, the baby was brought into Accident & Emergency fitting. The baby sustained non accidental injuries that resulted in multiple bleeds to the brain. The family has a long and complex history of severe domestic abuse and maternal mental health difficulties. The baby and four older siblings were supported by professionals through a CAF process at the time of the incident.
What you learnt about the case: key themes/early learning	(Specific issues or general areas of concern or good practice) * The police did not share information about the shoplifting incident; all agreed if this had been known the CAF would not have been stepped down. * CAF in place; however not working (mother stopped engaging, disguised compliance, unmet need) but did not reach the threshold for safeguarding – therefore, where could the case go? In this instance, Targeted Prevention Team where involved but due to non-engagement with the CAF and the Targeted Prevention Team, the CAF was closed. * Suggestion – the case could be escalated to Complex Case Discussion Process; however, those health colleagues present had not heard of a Complex Case Discussion Process before so this needs to be promoted. * All participants agreed that there were no indicators available to frontline that might have required escalation to a safeguarding process. the most critical information, about the baby's paternity and that the birth father was involved in his care, was not shared with professionals working with the family.
What you learnt about the review/methodology	(What worked/didn't?; Who was involved, how long did it take, chairs, authors etc) All agencies engaged well in the process; thoroughly completing the timeline of questions of and contributing to discussions at the workshop. All attendees contributed to discussion. Due to prior commitments Police Author was unable to attend, but provided a detailed report. Education

	representative attended, but the meeting felt it would have been benefical to have a School representative as well. The workshop was facilitated by Named Doctor for Safeguarding Children, Nene and Corby Clinical Commissioning Groups; it was due to be co-led with a Service Manager from Safeguarding Children's Services, but she had to give apologies due to illness. Difficulties – Scheduling Workshop to suit all attendee's requirements. Attendees informal feedback at end of meeting – found process informative. Some reported having some anxieties about attending but felt it had been a positive experience. A Case Mapping Exercise is a quick learning process and is very effective.
Key learning points – single agency	(Indicate transferrable learning, not necessarily all recommendations) Health; promote Complex Case Discussion Process as an escalation to CAF's/Early Help Assessments not reaching the threshold for safeguarding intervention. Health to provide reassurance that awareness raising of the Complex Case Discussion Process has taken place. Police; when dealing with a criminal incident, need to consider the wider safeguarding agenda – it was noted three children were present with the parents when they stole from the supermarket and it was not reported anywhere. Police to provide reassurance of what processes are in place to ensure safeguarding and sharing of information is considered now.
Key learning points - Multi-agency	(As above, focus on transferrable learning) All agencies need to raised awareness of disguised compliance and non-engagement when undertaking a Early Help Assessment.
How do you intend to make changes? Who's doing what?	Trust Lead for Safeguarding & MASH, Northamptonshire Healthcare Foundation Trust to ensure staff are made aware of the Complex Case Discussion Process and provide reassurance raising awareness has taken place. Head of Protecting Vulnerable Persons, Northamptonshire

	Police, to review this case and provide reassurance of the processes in place and ensure when officers are attending a crime, they consider the wider safeguarding picture if children are present.
How will you audit the impact? i.e. how will you know anything has changed?	As above.
Any other comments, advice, suggestions – about the case, the method, embedding change or evidencing impact/ change	Due to this mother's ongoing vulnerabilities and anxieties and that four of her children have returned to her care, with plans for Child to return to her care, professionals attending this workshop requested that assurance be sought regarding current and planned multiagency monitoring and support. A Service Manager for Safeguarding Children's Services was present at the workshop and agreed to take this back to the team working with the family. 20.11.15 - Update received from Service Manager within Children, Families and Education: Child has returned to family care, supervision order in place for 1 year for child, which recognises mother's vulnerability especially in relation to contact with paternal family. Multiagency support plan in place for all 5 children, with all agencies having a clear shared view of family history.
For SCR's – please provide a set of PowerPoint slides setting out the learning for practitioners about the learning for a learning workshop	N/A