Bolton Safeguarding Children

BOLTON SAFEGUARDING CHILDREN BOARD - LESSONS LEARNED BRIEFING - CHILD SB

Key Messages from the Serious Case Review

SB was a teenager who sadly took his own life. In the last two years of life he did not attend education, despite the efforts of services to address this issue.

This briefing summarises the key learning points from SB's Serious Case Review. All those who work with children and their families are encouraged to read this briefing and reflect on what the learning means for their practice

NB – read the briefing from left to right

THE FOCUS OF WORK WITH SB

Despite the family's concerning social history, poor school attendance was continually perceived as being the 'problem' rather than it being considered as a symptom of what was happening in SB's life. The sole focus on school attendance obscured and hid the effects of cumulative adversity, which SB experienced, and this left the child vulnerable.

This review has highlighted that when the 'child' is a young adolescent, the impact of these adversities can be overlooked or minimised and their vulnerability not considered within an assessment.

RESPONDING TO HOSTILE AND/OR RESISTANT PARENTS

On the occasions when contact was made with the family, parents and other family members were often, but not always, aggressive and hostile towards professionals. The failure to be able to meaningfully engage with the parents who were regarded as 'highly resistant' left professionals frustrated and resorting to legal measures.
This left SB in a vulnerable position.

MANAGING CHANGES AND TRANSITIONS

This review has highlighted that during times of transition, important information can be lost or misinterpreted. Frequent changes of practitioners can significantly impact on the ability of professionals to engage parents and gain the trust of children with whom they are working.

MULTI-AGENCY WORKING

Multi-agency working was not effective and the available information was not used effectively, agencies were working as single agencies and each to their own agenda.
There was a significant amount of information available but not fully accessed by those working with SB and his parents. Practitioners did not make best use of the multi-agency tools and processes available – early help, Day in the Life, chronology, supervision etc. Whilst this may not have changed what happened, using the tools would have supported practitioners to focus on SB, what was happening in his life and the impact of this.

SUPERVISION AND MANAGERIAL OVERSIGHT

The Review identified that good quality supervision did not take place routinely; this left workers with limited opportunities to reflect on their practice and consider other forms of intervention to secure the well-being of SB.

Good supervision can offer challenge within a safe space to review the current involvement and response to the child/family; it will also encourage critical reflection of a practitioners actions and assumptions of a child and their situation; it will explore with the practitioner the child's lived experiences and inform decision making

STRENGTHS IDENTIFIED FROM THE REVIEW

The work by EIT1 to support SB's mother to attend and manage the multi-agency meetings at school and the persistence in which the service tried to engage the parents
The efforts of School 1 to engage SB and through a variety of ways and means, encourage the child back into the school setting
The joint visits that took place with EIT workers and staff from school 1
The visit by the social worker to the family when they moved to a different area