

7 Minute Briefing

Carlos

Introduction

This briefing provides a concise overview of a case involving Carlos, highlighting key learning points and recommendations for improving multi-agency practice. The aim is to ensure that all safeguarding agencies are aware of the issues raised and can implement changes to enhance collaboration, communication, and decision-making in future cases.

Carlos, aged 15 at the time, lived with his mother and younger sibling. He had a history of involvement in criminal activity, including possession of a weapon, vehicle-related offences, and assault. On the day of the incident, Carlos was attacked by multiple individuals, sustaining a hand injury.

A strategy meeting was convened to address safety planning for Carlos and his family. It was agreed that Carlos, his mother, and his sibling would stay at his maternal grandmother's home, deemed a safe place. However, communication breakdowns and procedural gaps led to Carlos being discharged from hospital into police custody without his mother being informed or due consideration given to his post-surgery condition. He was subsequently interviewed within hours of undergoing general anaesthetic, contrary to medical advice, and with an appropriate adult provided through a scheme rather than a family member.

Key Lines of Inquiry

- Communication and Information Sharing
- Hospital Discharge and Safeguarding
- Police Procedures
- Perception of Carlos

Findings

Communication Gaps: Decisions from the strategy meeting were not shared promptly, leading to confusion and delayed actions.

Hospital Discharge: Carlos was discharged into police custody without informing his mother or considering his medical condition.

Police Interview: Carlos was interviewed within hours of surgery, with a scheme-allocated appropriate adult. However, a member of his family (his grandmother in this case) should have been asked first.

Perception of Carlos: Professionals predominantly viewed Carlos as a perpetrator, overlooking his victim status and the impact of adultification.

Referral Quality: Referrals were not of a high standard, failing to link Carlos to other young people involved in the incident.

Improving Practice

These questions are designed to prompt reflection and discussion among the multi-agency workforce. They encourage professionals to critically assess their current practices, identify gaps, and explore opportunities to enhance collaboration and decision-making in safeguarding cases. The focus is on developing actionable strategies to address systemic challenges, such as adultification, communication breakdowns, and inconsistent discharge planning—issues that were evident in Carlos's case.

Communication and Information Sharing:

- Are decisions from strategy meetings communicated to all relevant parties immediately after the meeting?
- How can we ensure clarity on roles and responsibilities, especially out of hours or during staff changeovers?

Hospital Discharge and Safeguarding:

- Are we considering all possible discharge options for children, particularly when they have medical needs or are involved in safeguarding concerns?
- How can we ensure that parents or guardians are always informed when a child is discharged, especially into police custody?

Police Procedures:

- Are police officers aware of medical advice regarding interviewing children, such as the 24-hour rule after general anaesthetic?
- How can we ensure that an appropriate adult is always present during interviews with children, particularly when family members are unavailable?

Perception of the Child:

- Are we fully considering the dual role of a child as both a victim and perpetrator in cases like Carlo's?

- How can we guard against adultification and ensure that children are treated as children, not as adults, in safeguarding and criminal justice processes?

Referral Quality and Multi-Agency Links:

- Are our referrals sufficient standard to support a joined-up approach across agencies?
- How can we improve the quality of referrals to ensure that all relevant information about linked individuals and incidents is included?

Discharge Planning and Follow-Up:

- Could discharge planning meetings be held sooner, particularly when a child is medically fit for discharge but safeguarding concerns remain?
- How can we ensure that the Emergency Duty Team (EDT) is informed and involved in out-of-hours decisions, such as discharge planning?

Multi-Agency Collaboration:

- How can we ensure that strategy meetings are conducted effectively, with clear actions and follow-up?
- What steps can we take to improve real-time communication between agencies during ongoing incidents?