Lessons Learnt Research Digest

Issue 2, September 2016

Welcome to the second edition of the Board's Research Digest bulletin. The bulletin has been produced to share messages from recently published Serious Case Reviews and any local lessons learnt. The cases identify lessons to be learnt to improve learning and develop practice across multi-agencies to safeguard children and young people.
The information for SCR's in this bulletin has been obtained from the NSPCC national repository for Case Reviews published in 2015 and 2016 (cases published after issue 1 of the digest).
www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2015
In addition the NSPCC provides a thematic briefing highlighting the learning from SCR's which focuses on the different topics.
https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/

Please cascade to staff within your settings.

Local Learning

Darlington Lessons Learnt Review

July 2016 – Child E – fourteen year old male with special educational needs and learning difficulties receiving support from CAMHS, Children's Services, School, School Nursing Service and Youth Offending Service.

Background: A case was considered by the Case Review and Learning from Practice Subgroup for a number of reasons including; concerns about parenting; child E's presentation at school; child E associating with older males; working late nights; attendance at school reducing and discharging a firearm at school. Child E did not engage well with practitioners.

Key Issues: no consistent workers and there was 'start again syndrome', history not considered, plans were not focused on child needs, missed opportunities for information sharing, agencies focused on needs of parents and gap in training on how to work with complex adolescents

Learning: Ensure plans are SMART and focused on the needs of the child. To ensure information sharing by all agencies and to where possible keep workers consistent to develop a positive relationship with the child.

Learning for the LSCB: Research training to work with complex adolescents, ensure all statutory partners attend multi-agency learning events hosted by the LSCB. To raise awareness of relevant risk assessment within multi-agency procedures.

Regional Serious Case Review's

Both Sunderland and Durham LSCB have published a number of SCR's in 2015/16, please find link below to the overview reports.

http://www.durham-lscb.org.uk/professionals/serious-case-reviewchild-death-reviews/

http://www.sunderlandscb.com/pr_scr_cms.html

National Serious Case Reviews

Physical and Emotional Abuse

2015

May 2015 - Bristol – T - **Death of a 3.5-month-old on 14 January 2013 from a non-accidental brain injury, consistent with shaking. Father was found guilty of manslaughter. Mother was acquitted of causing or allowing the death.**
Background**:** evidence of possible physical abuse of T's older sibling who was a 'Child in need'. Both parents had been known to professionals since childhood. Parents' relationship started when T's father was 20-years-old and mother was 13-years-old. Charges against the father for sexual activity with a child were dropped due to lack of evidence. Father was a prolific offender and a drug user with a known history of domestic abuse. T's mother had a history of violent behaviour.
Key issues: the case was never seen as a child protection issue and learning from previous case reviews was not embedded in practice.
Learning: regular multi-agency meetings to consider possible victims and perpetrators of child sexual exploitation; the introduction of integrated chronologies; training for safeguarding leads on learning from previous local case reviews; advanced domestic abuse training for frontline practitioners; and a new protocol for the use of parent partnership agreements to ensure they are realistic.

October 2015 – Brighton and Hove – Baby Liam - **Life-threatening injury to the head of a 7-week-old boy whilst in the care of his father. Father was sentenced to 12-years-and-6-months imprisonment for grievous bodily harm with intent.**
Background**:** Father was a care leaver and had a history of substance misuse, volatile mood swings, petty crime and violence towards peers. Both parents were young and their relationship involved a number of incidents of domestic abuse.
Key issues: **failure of care-leaving service to share father's childhood history with professionals working with Baby Liam; issues accessing care-leaving service records due to a change in IT systems; focus of information gathering by midwives on mother rather than both parents; delays by hospital staff in informing police that possible non-accidental injuries had been identified; and delays by police in arresting the parents due to an unwillingness to act before an updated medical report was written stating that the injuries could not have been caused accidentally.**

November 2015 – Essex – John - **Non-accidental head injury to a 10-week-old boy from a Gypsy, Roma, Traveller community, thought to be due to being shaken. Both parents were charged and care proceedings initiated.**
Background: John was the subject of a child protection plan under neglect. Both parents had a history of drug addiction and criminal behaviour. 4 of the mother's older children had been removed from her care by a neighbouring local authority, including 1 child who was born with drug withdrawal symptoms. Father's 2 older children had been subject to child protection plans, primarily because of his domestic violence.
Key issues: the significance of parental histories; the challenge of the family's frequent moves on effective information sharing; and the increasing focus of the father as the source of risk.
Learning: improve the sharing of historical information about parents; parenting capacity assessments to feature in all core and pre-birth assessments; GPs to be invited to attend all child protection conferences; and the strengthening of guidelines relating to missed appointments ("Did not attend" or DNAs).

2016

February 2016 - Bracknell - Child C (born 2013), Child C sibling (born 2010) - **Non-accidental injury to 14-week-old baby in October 2013, admitted to hospital with a fractured femur. Parents were charged with grievous bodily harm but no convictions resulted. Both children were subsequently permanently removed from their care.**
Background: Child C and Sibling were subject to child protection plans under emotional abuse. Sibling had previously been a Child in Need. Family issues including violence and domestic abuse; alcohol and drug misuse by parents and maternal grandmother; mental health; and unstable housing arrangements leading to frequent moves.
Key issues: discusses family history and its impact on parenting; parental alcohol misuse; the involvement of fathers and the extended family in assessments; and the role of staff supervision across agencies.
Learning: Local Safeguarding Children Board to: review the sharing of domestic abuse notifications between the police and partner agencies; promote the "Think family" approach; and ensure that multi-agency training covers the impact of domestic abuse, mental health and substance misuse on parenting.

April 2016 - City and Hackney - Child H - **Death of a 6-week-old baby in Spring 2014 caused by inflicted injuries.**
Background: Following a review of the evidence, parents were informed they would not be the subject of any further enquiries. Family had been referred to children's services but were not assessed as in need of intervention. Parents and Child H lived with the mother's adoptive parents. Mother had a history of: childhood abuse and neglect which resulted in her being taken in to care, anger management issues, mental health issues and special educational needs.
Key issues: failure to share information about bereavement and illness in mother's family, which should have led to a re-assessment of parenting capacity; confusion around whether the mother was eligible for support from the Learning Disability Service; over-estimation by social services of the role of the hospital's psychosocial meetings with mother in monitoring the family's support needs; and incomplete record keeping within children's services.
Learning for LSCB: to promote understanding of adult learning disability and eligibility for services and the Borough should ensure its quality assurance arrangements are sufficiently robust.

Neglect

2015

2015 – Essex – Child G - **Serious brain injury to a 3-month-old girl in May 2013. Mother pleaded guilty to child neglect. The mother's partner was convicted of causing the injuries. Both received custodial sentences.**
Background: prior to Child G's birth her half-sibling had been subject to a child protection plan under the category of neglect. In the months before and after Child G's birth, mother had attended hospital a number of times due to injuries to Child G's half-sibling. Child G's mother had diagnosed learning difficulties and "extremely low" IQ classification. She had a history of difficult family relationships and mental health issues. Mother's partner was known to the probation service and other local authorities due to a history of violence towards women and children.
Key issues: issues identified include the challenge of sharing information about vulnerable families across GP's, midwives and health visitors; the need to focus of the role of fathers/partners through pregnancy and early years; and the need for offender managers to report any safeguarding concerns when an offender starts a new relationship.

2015 - Sunderland – Baby Penny - **Death of a baby girl as a result of a drowning accident in May 2014. Mother found Baby Penny under water in the bath after she left her unattended to answer the door.**
Background: mother had experienced significant mental health problems during a previous pregnancy following which her children were subject to child protection plans. During her pregnancy with Baby Penny mother had regular contact with her GP, community psychiatric nurse, health visitor and midwife. A pre-birth core assessment concluded that Children's Services should close the case. Limited information about Baby Penny's father, now know to have a history of domestic abuse with his previous partner and convictions for violent crime.
Key issues: delays in children's services' response to referrals from other agencies; lack of full consideration of the parents' histories and the role of fathers; failure to escalate and challenge inaction by children's services; and missed opportunities for early intervention.
Learning for LSCB: to ensure there is a clear contingency procedure and process for when it has been agreed that there should be follow up if additional information is identified; to design and develop regular multi-agency workshops; and to review the effectiveness of early help services.

2015 – Tri-Borough (Hammersmith and Fulham, Kensington and Chelsea, Westminster) - Sofia
Death of a 1-year-old girl in October 2013 from asphyxiation due to choking on food. Autopsy findings found Sophia was significantly underweight and there were signs of historic untreated injuries. Parents may be charged with neglect.
Background: mother had no permanent address and received services from 7 local authorities. Sofia and her mother were known to medical staff, social workers, housing professionals and the police. There were no signs of physical injury or neglect and Sophia was not considered to be at continuing risk of significant harm. When Sophia was 3-months old they moved and were not seen by a professional until her death. Father was allegedly living overseas but was later found to be living with the family illegally on an expired visa.
Learning: findings include: complexity of legislation and lack of understanding around provision of housing and benefits for a European National; homelessness during pregnancy not being a trigger for assessment and not being considered a safeguarding issue after birth; assessments made on mother's intention rather than child's experience; strategy discussions conducted via telephone excluding some agencies; a focus on physical manifestations of neglect over more complex

indicators; and avoidant families becoming 'lost' to services.

November 2015 - Harrow – Baby F - **Death of an 11-month-old boy of Irish-traveller descent from a brain injury after being found submerged in water whilst unsupervised in a bath.**
Background**:** Baby F and 2 half-siblings were subject to child protection plans under neglect. Mother given a 6-year custodial sentence after pleading guilty to manslaughter. Mother had a history of: substance misuse, self-harm, domestic abuse, lack of engagement with services, regular changes of address and periods of homelessness.
Key issues: include: a failure by midwifery services to identify and refer pre-birth safeguarding concerns; difficulties in contacting and assessing the family because of their transient lifestyle; and a lack of investigation by children's services following referrals from the public.
Learning for LSCB: ensure the involvement of the public in safeguarding children is fully valued; ensure practitioners routinely consider families' histories of agency involvement; and raise staff awareness of the difference between Police Powers of Protection and Emergency Protection Orders.

November 2015 - Sunderland – Baby N - **Unexplained injuries to an 11-week-old baby in March 2014. Baby N was moved to a place of safety before being placed with the maternal grandmother. Father was charged with neglect/ill-treatment.**
Background: father had a history of domestic violence and involvement with children's services due to concerns about neglectful and abusive parenting.
Key issues: the failure of children's services to conduct a pre-birth assessment based on concerns reported by health visitors; significant delays in children's services conducting an initial assessment once Baby N was born; health professionals seeing their safeguarding role as primarily passing on or responding to information from children's services; and an over willingness amongst professionals to accept what they were told by the parents.
Learning: frontline practitioners should be reminded of Unborn Baby procedures and specifically told a pre-birth assessment is required if a previous child of either partner has been made subject to child protection procedures; where Initial Assessments are undertaken, referring agencies should be informed in writing of the outcome of referrals so there is clarity between agencies about the rationale for the decisions taken; and referral forms and guidance should make clear the expectation that referring agencies gather background information from their own records.

2016

January 2016 – Anonymous – Child U, B and V - **Death of a 6-week-3-day-old baby boy and neglect of his older half-siblings (13 and 15-years-old). Ambulance service was called by parents on 29 November 2015 as Baby V was not breathing. Parents had been drinking heavily. Both parents pleaded guilty to child neglect and received a custodial sentence.**
Background**:** all 3 children were subject to child protection plans for neglect and physical abuse. Parents of Baby V and father of half-siblings (U and B) all had histories of alcohol misuse, mental health problems and domestic abuse. U and B had poor school attendance.
Key issues: the needs of adults dominated the work undertaken; increasing concerns about the children's wellbeing failed to trigger intervention via the Common Assessment Framework (CAF); and adults' accounts were accepted without reference to other available information.
Learning for LSCB: to review and report on the effectiveness of early intervention; to ensure commissioning arrangements for assessing substance misusing parents are in place and a clear pathway to accessing services for families; and all agencies to consider information on fathers and

other significant males during assessments.

January 2016 - Greenwich - Child S - **Death of a 13-month-old girl of Somalian heritage in February 2013. Post-mortem found evidence of fractures, indicative of a non-accidental injury. Both parents convicted of neglect.**
Background**:** family known to universal services only. Mother arrived in UK seeking asylum while pregnant. Father and siblings joined them at a later date. All injuries to Child S occurred after family were reunited.
Key issues: limited knowledge of family's history in Somalia; family moved regularly between local authorities making it harder to share information and provide support; mother's family sometimes interpreted rather than an independent interpreter being provided.
Learning: a single system for London to ensure health visiting services are notified by GPs of new children who move into the area and a notification system to ensure that universal and children's services are informed about any housing moves of vulnerable families.

February 2016 – Manchester – B1 - **Death of 10-day-old baby of Black and Asian British descent in August 2013. Father had lain on top of B1 while in bed. He was convicted of neglect in 2015.**
Background: B1 and 2 older siblings were the subject of child protection plans under emotional abuse. Both siblings had been on a plan before and had been looked after in 2010. Family were well known to agencies because of parental alcohol misuse, domestic abuse, concerns about neglect and father's criminal behaviour.
Key issues: professional focus on domestic abuse as an anger management issue; parental fear of statutory intervention; manipulative and obstructive parental behaviour; delays in follow-up to incidents; lack of recognition of indicators of neglect such as dental cavities; the limited use of assessment tools or frameworks; and the impact of excessive workloads and reconfiguring of services on the capacity of professionals.
Learning for LSCB: promote more co-ordinated and effective response to managing the behaviour and risk from perpetrators of domestic abuse in households with children when using measures such as domestic violence prevention notices. Ensuring arrangements for pre-birth assessment of risk to unborn children are appropriate and fit for purpose.

February 2016 – Manchester – D1 - **Death of an 8-month-old baby of Black Caribbean and White British heritage on 5 July 2014. Child D1 was found lifeless on the floor after co-sleeping with mother who had consumed alcohol the previous night.**
Background: D1 was a 'Child in need', the subject of a Supervision order and had previously been the subject of child protection plans under neglect and emotional abuse. Mother was a looked after child with a history of alcohol and drug misuse, antisocial behaviour and going missing from care. Father had convictions for drugs offences and was suspected of gang links and domestic abuse.
Key issues: the risks presented by the father and the extent of parental substance misuse were not fully known.
Learning for LSCB: to conduct a thematic review of looked after girls focusing on teenage pregnancy; consideration to be given to the multi-agency response to looked after children and care leavers who have children removed from their care; and partner agencies to review their practice relating to fathers and significant males.

February 2016 – Thurrock – Megan - **Chronic neglect of a 17-year-old girl who was admitted to intensive care after collapsing at home on 27 November 2013.**
Background: Megan and her sibling spent periods subject to child protection plans because of physical abuse and neglect and as Children in Need. Family issues included: chronic neglect, domestic violence, housing eviction, poor home conditions and financial problems.
Key issues: lack of effective information sharing and analysis; lack of professional understanding of adolescent neglect; lack of professional consideration of Megan's lived experience; and professional focus on the level of service provided to the family as opposed to the impact of services.

Sudden Unexpected Deaths in Infants and Children

2015

2015 - Blackpool - Child BV - **Death of a 1-month-old infant in Winter 2014. Ambulance service found Child BV unresponsive in 2-year-old sibling's bedroom, lying between the bed and wall.**
Background: both parents had consumed large quantities of alcohol the previous day and could not remember how or why BV was not asleep in usual place. Family were known to universal services only. Father attended Accident and Emergency and visited GP prior to BV's birth and disclosed that he was a regular heavy drinker.
Key issues: alcohol use and the safe care of children; engaging with fathers; sharing of information about excessive parental alcohol use between professionals; safeguarding requirements for nursery providers; and safe sleep support.
Learning: safe sleep assessments by health professionals; campaigning to raise awareness of the risks of alcohol use when caring for young children; and engaging with new and expectant fathers.

2016

January 2016 – Milton Keynes - Child A - **Death of a 7-week-old baby boy of mixed parentage whilst co-sleeping with mother who had consumed alcohol and cocaine. Mother was arrested but no charges brought.**
Background**:** Child A's older sibling had died in 2007 when 2-weeks-old from sudden infant death syndrome. No concerns about the child's care were identified. Mother was known to police as both a perpetrator and victim of crime and was supported by domestic abuse services. Mother had issues related to: alcohol and drug misuse; housing; mental health problems; and lack of engagement with professionals.
Learning: professionals working with adults must understand parental behaviour in terms of the impact on the child; risky behaviour in pregnancy should be seen as a potential child protection issue; and threat of withdrawal from engagement should be seen as an indicator of risk.

Sexual Abuse

2015

December 2015 – City and Hackney - Children in a foster home - **Sexual abuse of 5 girls of primary school age in their foster home between 1999 and 2008. Most of the girls had special educational needs or a learning disability. The male foster carer and a male family member were convicted of child sexual offences. There was evidence that the female foster carer was aware of the risk of sexual abuse.**

Background: both foster carers had been abused and neglected as children. Male foster carer had sexually abused two young girls before fostering but this was not known until police investigations in 2012. Police received an anonymous allegation that the male foster carer had child abuse images on his computer in 1999. This information was kept on his record but was neither investigated nor shared. Some professionals expressed concerns about the quality of care provided but the foster carers manipulated professionals and presented themselves as "experts".
Learning: **issues identified include police non-disclose of unsubstantiated child abuse image allegations during checks on the foster carers; lack of professional curiosity about the reasons for a foster child's sexualised behaviour; and the unwillingness of the fostering service to respond to concerns due to the foster carers' reputation as a valued resource.**

Behavioural/Mental Health concerns

2015

2015 - Hull - Child W - **Death of a 16-year-old girl on 16 November 2013 at a hostel where she was living. Coroner recorded the cause of death as hanging but unclear whether Child W intended to take her own life.**
Background**:** Child W was removed from her birth family and adopted at 10-years-old with her younger brother. Adoptive parents struggled to cope with their behaviour. Prior to her death, there were concerns around self-harm, substance misuse and an alleged rape.
Learning: findings include: W was assessed as needing "intensive therapeutic support" but this support was not provided. Adoption support plans need to clearly detail how and by whom therapeutic needs will be met; attachment needs of adopted children should form part of specialist therapeutic services ; and local authorities should ensure that staff are clear about local guidance and support for homeless 16 and 17-year-olds.

2015 - Salford - Child N - **Overdose by a 17-year-old female leading to a profound brain injury. Review examines services provided to Child N between the ages of 14 and 17-years-old across two local authorities.**
Background: N was a 'child in need' but children's services lost contact after she left supported lodgings to move in with her boyfriend. He was 5-years her senior and they met in a sexual exploitation "hotspot". N had a troubled adolescence with issues of self-harm, substance misuse and going missing. Mother proactively sought professional help to cope with N's behaviour.
Learning: good practice highlighted includes the support provided by N's senior school. Missed opportunities include: social workers should have worked to repair family relationships and greater consideration should have been made relating to child sexual exploitation. Early help services must be proactive in working with families with adolescents; local authorities must exercise their legal duties relating to homeless adolescents; and that a clear pathway of mental health services for 16-18-year-olds is created and disseminated to all agencies.

October 2015 - Child O – Haringey - **Suicide by a 16-year-old girl in January 2014 while she was staying at a therapeutic residential unit.**
Background: Child O had a history of eating disorders, self harm and suicidal thoughts. She was in regular contact with health and social care services and spent time as a psychiatric in-patient. She spoke of sexual abuse/exploitation outside the family but agencies could not substantiate this nor persuade her to disclose details.
Key issues**:** delay in the local authority agreeing to the family's request that Child O be admitted into their care; no formal child protection investigation into O's situation; and opportunities missed to

assess whether thresholds for compulsory detention under the Mental Health Act were met.
Learning: Metropolitan Police Service to demonstrate that reports of child sexual exploitation are always followed up; local authority to demonstrate that child protection investigations and assessments are conducted and completed without delay and meet procedural and good practice requirements;
Learning for LSCB: to ensure guidance is available for partner agencies on dealing with safeguarding situations relating to social media use.

2016

February 2016 - Greenwich - Child T - **Suicide by hanging of a 15-year-old girl at her school in June 2013.**
Background: Child T and her siblings were the subject of child protection plans in Greenwich and Lewisham. Family had a history of: domestic violence, sexual abuse, parental neglect, regular house moves and changes of mother's partners. Child T disclosed self-harm to teachers and was supported by the school's pastoral and counselling services and later child and adolescent mental health services (CAMHS).
Learning for LSCB: to consider, including whether professionals are well equipped to understand and respond to self-harming behaviour in adolescents.

March 2016 - Lambeth with Islington and Kent - Child J - **Suicide of a 14-year-old Black British girl in the Summer of 2014 while living in foster care in Kent.**
Background: Child J had a history of suspected emotional, physical, sexual abuse and neglect and complex mental health needs including suicide ideation, self harm and an eating disorder. She suffered acute and chronic bereavement after her mother's death. Supported as a Child in Need before being looked after by the local authority. She also received adolescent acute and community mental health services.
Key issues: the significant impact of bereavement, transitions and loss; the need for J's history and the impact of her experiences to be taken into consideration in risk assessments and planning and treatment arrangements; the need for agencies to be clear about the legal concept of parental responsibility and when young people can make decisions; care planning for looked after children in receipt of mental health services. Also considers social media and pro-anorexia or 'Pro-Ana' websites.
Learning: improve transitional arrangements for children moving across geographic boundaries. Ensure there is a clear understanding from commissioners and providers of mental health services in relation to the range of therapeutic interventions for children with complex needs.
Learning for LSCB: be aware of what the current arrangements for supervision (reflective management) within agencies are and what the joint-arrangements are when a child is receiving services across agencies. What knowledge and training do staff in different services have about the use of the internet to access websites and their risks. How are LSCB e-safety policies and procedures being applied.

Homicide

2016

January 2016 – Enfield – AX - **Death of a 17-year-old boy of Afro-Caribbean heritage on 3 December 2013 following an altercation with three other adolescents. Courts later found that the three**

assailants were acting in self-defence.
Background**:** AX was homeless and had been provided with accommodation and emergency funds by his local authority in Barnet. AX had a history of: emotional and physical neglect, behavioural and emotional problems and involvement in criminal activity.
Key issues**:** professionals responding to discrete episodes of anti-social behaviour as opposed to addressing the broader concerns around an increasingly dangerous lifestyle; the failure of youth offending teams to update assessments as new information emerged; a lack of information sharing between schools and youth offending teams; and a failure to properly monitor and enforce attendance and curfew orders.
Learning: review mechanisms for sharing intelligence between agencies and put mechanisms in place to allow the prompt and effective transfer of oversight and supervision of young people on court orders who move between boroughs.

February 2016 - Oxfordshire - Child J - **Murder of a 17-year-old female by her ex-partner who received a life sentence in 2014. Child J had recently told her ex-partner she thought she was pregnant with his child, resulting in him threatening her.**
Background: Child J was a vulnerable adolescent who was known to children's services and other agencies, including a period with 'child in need' status. Professionals were aware that she had been in an abusive, controlling relationship with an adult male. He had been a looked after child and had a known history of violence. J had a history of mental health problems, suicide attempts and self-harm, non-engagement with services, drug misuse, going missing and a difficult relationship with her mother.
Key issues: Child J was often viewed as "difficult" and not as a child in need of safeguarding; processes and procedures for 16-18-year-old victims of domestic abuse were still under development; and the police response when she was reported missing failed to recognise the serious threat posed by her ex-partner.
Learning: schools to cover healthy relationships in the context of domestic abuse; and systems to be put in place to ensure that Multi Agency Risk Assessment Conference (MARAC) referrals are shared with all relevant frontline professionals.
Learning for LSCB: and Community Safety Partnership to act as a strategic lead on domestic abuse to ensure a unified approach to young victims and/or perpetrators;