Lessons Learnt Research Digest

Issue 3, July 2017

Welcome to the third 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 2016 and 2017 (all cases published after issue 2 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/

Local Learning

CASE	LEARNING
No cases to be shared at this current time	

Regional Learning

CASE	Report
October 2016 – Durham – Child M Child M was found unresponsive in a bath full of water by father. Child M was taken to Hospital, where she remained for over three months. As a result of her ordeal Child M has profound disabilities. **Background:** Child M was one of twins and prior to their birth there had been agency involvement with parents regarding complaints of anti-social behaviour, domestic abuse, alleged drug taking and welfare concerns around Sibling 1. Concerns around the home conditions and the lifestyle choices of parents emerged almost immediately upon Child M and Sibling 2 returning home from Hospital. Child M, Sibling 1 and Sibling 2 were made subject of Child Protection Plans (CPP), under the category of Neglect.	Full report and executive summary on DSCB website. **http://www.durham-lscb.org.uk/professionals/serious-case-reviewchild-death-reviews/**
August 2016 – Durham – Child Ava Sexual abuse of child aged 8 by her half brother **Background**: Disclosure made by Ava's older brother to the effect that he had filmed, on his iPad, a sexual assault by their half-brother Sam upon Ava, aged 8. Following criminal investigation, Sam was charged with a number of counts of rape and sexual assault and remanded in custody. Child Ava and Siblings 4 and 5 were subsequently made subject to Care Orders and removed from the family home. MAPPA serious Case Review also undertaken.	Full report and executive summary on DSCB website. **http://www.durham-lscb.org.uk/professionals/serious-case-reviewchild-death-reviews/**
March 2017 – Hartlepool – Olivia and Jasmine (two serious case reviews undertaken) Carol, a vulnerable adult was killed in December 2014 by Olivia and Yasmine – then aged 13 and 14 – both were found guilty of her murder and in April 2016 were sentenced to 15 years in custody.	Full report and executive summary on HSCB website. http://www.lscbhartlepool.org/professionals/page/101
2016 – Newcastle – Child J Death of a 15-week-old baby girl, J, in May 2014. A post-mortem confirmed she died of a head injury and further tests concluded this was likely to have been as a result of shaking. J's mother and her partner were convicted of causing or allowing her death and given custodial sentences.	Full report and executive summary on HSCB website **https://www.nscb.org.uk/Serious%20Case%20Review**
September 2016 – Sunderland – Baby O Non-accidental injuries to a 6-month-old baby girl in August 2013 who was admitted to hospital a fractured femur and bruises. **Background:** mother became seriously ill following the birth and Baby O and her older sister	Full report and executive summary on HSCB website http://www.sunderlandscb.com/pr_scr_cms.html

spent a brief period living with their paternal grandmother. Following the mother's hospital admission, Baby O and her sister became the subject of care proceedings and were removed into the care of their paternal grandmother. Following the injury of Baby O in August 2013, paternal grandmother was convicted of child cruelty and neglect in 2015	
September 2016 – Sunderland – Baby W and Child Z Non-accidental head injury to 11-week-old baby boy admitted to hospital in November 2012. Baby W and his 3-year-old brother Child Z were taken in to care, and later adopted, following the incident**.** **Background:** mother was 17-years-old when she first became a parent and living with her grandparents but moved into her own accommodation following the birth of Baby W. Child Z had previously been identified as a Child in Need due to concerns about neglect. Maternal history of concealment of pregnancies, lack of engagement with professionals and neglectful parenting.	Full report and executive summary on HSCB website http://www.sunderlandscb.com/pr_scr_cms.html
September 2016 – Sunderland – Baby E Death of a 4-month-old girl in September 2013 whilst sleeping in her parents' bed. The inquest concluded there was no evidence that drugs caused or contributed to the death and the medical cause was recorded as unascertained. Parents were convicted of Child cruelty and received a 6 month custodial sentence suspended for 2 years**.** **Background:** mother had a history of non-engagement with professionals, substance misuse and a violent relationship with the father of her first 3 children. The role the mother's new partner, the father of Baby E, played in her children's lives had not been assessed by professionals	Full report and executive summary on HSCB website http://www.sunderlandscb.com/pr_scr_cms.html

National Learning

<table>
<tr><th colspan="3">PHYSICAL AND EMOTIONAL ABUSE</th></tr>
<tr><th>CASE</th><th>KEY ISSUES</th><th>LEARNING & RECOMMENDATIONS</th></tr>
<tr><td>2016 – Anonymous – Child BS
Death of a 2-year-1-month-old girl in 2016 in hospital as the result of multiple injuries. Child died from a serious brain injury sustained whilst in the sole care of mother's new partner. The partner was charged with murder and was sentenced to 9 years' imprisonment. The mother was placed on police bail.
Background: family were known to universal services only. Child had a bruise to the face the week before the incident which was recorded by the nursery.</td><td>• the significant impact of the change in the mother's relationship on her children's safety,
• a lack of robust recording by the nursery following an injury to Child BS
• lack of robust evidence behind Ofsted's positive rating of the nursery's safeguarding provision leading to a misplaced confidence in their procedures.</td><td>Recommendations:
• develop common guidance and supporting documentation for local nursery providers;
• develop public awareness of domestic abuse and the risks to children at the points of parental separation and newly formed relationships</td></tr>
<tr><td>2016 – Birmingham – BSCB 2011-12/1
Death of a 21-month-old boy from serious injuries in June 2011. Following the child's death, the mother's boyfriend was sentenced to 8 years for manslaughter and the mother to 15 months for child cruelty.
Background: mother had recently moved out of maternal grandmother's home into her own tenancy and her new partner spent significant amounts of time there. Mother had a history of: mental health problems, childhood sexual abuse and abusive relationships. Partner had a history of substance misuse.</td><td>• GPs didn't consider safeguarding issues when treating parents of vulnerable children
• inadequate screening of referrals of concern to children's social care</td><td>Recommendations:
• the Safeguarding Board should routinely evaluate measures taken by Children's Social Care to improve the screening of referrals;
• the Mental Health Trust should promote guidance on protecting children and young people for doctors who treat adult patients</td></tr>
<tr><td>2016 - Devon - 'Thomas'
Admission to hospital emergency department of a 7-week-old baby with an unexplained head injury</td><td>• Thomas was subject to a child protection plan set up pre-birth on 3 September 2014, due to a high risk of neglect.</td><td>Learning
• professionals and agencies had an over-optimistic approach to the</td></tr>
</table>

on 25 December 2014..	• A schedule of expectations was in place triggered by risk factors including: mother's previous child with another partner removed for adoption in 2014; • mother's and father's history of drug and alcohol misuse; • personal neglect	management of the family. **Recommendations:** • putting the child as the focus of the child protection process; • review of the Core Group structure to include formal terms of reference, core membership and standardised agenda; • review of communication systems between agencies; • training offered to professional agencies involved in safeguarding very young children to help them recognise disguised co-operation
2016 - Surrey - Child AA Serious, non-accidental head injuries to a 10-week-old baby, Child AA, whilst in the care of parents. The parents were arrested and bailed pending further investigation and Child AA and an older sibling were taken into care. **Background:** sibling was subject to a Child in Need plan which continued following Child AA's birth. Team around the child and professionals meetings were convened following Child AA's birth. Concerns about the family included: young age and immaturity of parents; lack of support from family or friends; dependence on professionals for money, food and equipment for the children; poor living conditions. Mother was a young carer for her mother, was subject to a Child in Need plan and received services from Child and Adolescent Mental Health Services (CAMHS).	• there were differences of opinion between children's social care and the community health services; • this was compounded by a lack of clear and current assessment and co-ordinated planning.	**Recommendations:** • guidance for social workers on assessment should include joint visiting with other professionals to share perceptions and views; • risks to new born babies should be fully understood with the expertise of community health professionals in this area acknowledged; • inclusion criteria for the Family Nurse Partnership should be revised to include young parents who have a second or subsequent child.

June 2016 – Gloucestershire – Ben Death of a 9-month-old baby boy from brain damage assessed to be a non-accidental head injury. At the time of review inquiries were ongoing. **Background:** Ben's half-sister was living permanently with her grandmother due to concerns around the mother's neglectful parenting. Ben was born prematurely and remained in hospital for the first 6 weeks of his life. Following his discharge home, the family received regular home visits. Mother had a history of: emotional abuse in childhood, substance misuse, parental neglect and homelessness. Little was known about the father.	• lack of professional knowledge of or focus on the father, • lack of a pre-birth risk assessment and lack of consideration of the potential impact of the past on present or future parental care.	**Learning:** • the need for evidence-based multi-agency pre-birth or at-birth assessments; • the importance of involving fathers in the antenatal and postnatal period; • the need for a Lead Professional to support parents whilst their baby is in neonatal care; • the need to take into account the additional vulnerabilities of premature babies; • and the importance of all agencies, not just children's social care, seeing themselves as having a responsibility for safeguarding children.
April 2016 - Wiltshire - Baby J Suspected non-accidental injuries to a 6-week-old baby boy whilst in the care of his parents in September 2014. Baby J recovered and was placed with foster carers. No one was charged with any criminal offence. **Background:** during the mother's pregnancy the family were subject to the Common Assessment Framework (CAF) pathway because of the mother's young age (17-years-old) and a Team around the Child (TAC) meeting. Mother's history included: parental neglect; exposure to parental substance misuse and children's services interventions. Baby J's father had a history of substance misuse and had witnessed domestic abuse as a child. Services working with the family included: midwives, health visitors, children's centre outreach and substance misuse support. .	**Key issues:** there were 2 referrals to children's social care. Concerns included: homelessness, reliance on a food bank and J's faltering weight gain. The second referral, shortly after Baby J's birth, met thresholds for a single assessment.	**Learning:** practitioners should: • remember that assessment is a dynamic process and new information or changes to family circumstances may affect the nature and degree of risk; • make more use of the Multi-Agency Pre-Birth Protocol to Safeguard Unborn Babies - this is a valuable tool for all practitioners assessing risk and protective factors and making or deciding the outcome of referrals. **Recommendations:** • local safeguarding children board (LSCB) should investigate ways of embedding, improving and sustaining the CAF process without resorting to further guidance and more onerous expectations

March 2016 – Cheshire West and Chester – Child A Serious head injury of a primary-school-aged child in October 2014**.** **Background:** family had significant contact with a wide range of agencies and were receiving support from a Team Around the Family (TAF) due to concerns about home conditions and the children's failure to thrive. Mother had a history of childhood sexual abuse, a lack of emotional warmth towards her children and suspicion of services and professional involvement with her family. Father had a history of alcohol misuse, domestic violence and controlling behaviour.	**Key issues:** • parents were able to dominate and manipulate TAF meetings by disputing points, creating diversions and feigned compliance with recommendations; • no formal parenting assessment was made of parenting capability or motivation to change; • professionals struggled to distinguish between parental neglect and emotional abuse; • assessment tools were not always used effectively; • the escalation policy was not used by professionals to challenge decision making following referrals	
2017 – Anonymous - Child AB Life threatening attempted strangulation and suffocation of child by mother, followed by mother's suicide attempt, in 2014 and 2015. Child AB became subject to child protection investigation and child in need plan. **Background:** no indication of child abuse prior to the first event. Maternal history of mental illness, self-harm, disclosed attempts to harm husband and attempted suicide.	**Key issues:** include: • management of screening for maternal mental health and domestic abuse not fully embedded in practice; • lack of direct questioning regarding thoughts to harm others; • professional decision-making impacted by affluence and status of family.	**Recommendations:** include: • strengthen professionals' understanding of the negative impact of professional biases and beliefs in safeguarding practice; • review procedures to improve understanding of the child as a protective factor, risk of filicide and harm to others in cases of parent mental illness
2017 – Birmingham – Shi-Anne Downer [birth name]: AKA Keegan Downer Death of an 18 month-old-girl from a white British and black African background in September 2015. The post mortem revealed over 150 internal and external injuries that had been caused over a	**Key issues:** • the pre-birth decisions made about Shi-Anne's care followed the same approach as decisions made for her older sibling, without considering whether this was also appropriate for Shi-Anne 5 years later;	**Learning:** • all relevant checks should be carried out and the need for a period of monitoring should be considered before a special guardianship order is finalised.

number of months. Shi-Anne's guardian was subsequently convicted of murder. **Background:** mother had a history of drug abuse, mental health issues, reluctance to engage with services and time in prison; father was in prison at the time of her birth; 5 older siblings had previously been taken into care. Shi-Anne was made the subject of a child protection plan before her birth and was placed in foster care after birth. In January 2015, Shi-Anne became the subject of a special guardianship order (SGO).	• the assessments for the special guardianship order (SGO) were flawed and incomplete; • professionals had little or no contact with Shi-Anne after the SGO; • risk factors for the guardian's reduced parental capacity, such as becoming pregnant and the breakdown of her relationship, were not recognised and acted upon.	
2017 Merton - Child B Serious physical assault in September 2015 of a 16-year-old girl whilst she slept. B's mother pleaded guilty to grievous bodily harm and was sentenced to a Hospital Treatment Order under the Mental Health Act, 1983. Child B became a looked after child. **Background:** long history of mother's poor mental health, reports of excessive alcohol consumption and tensions in the parental relationship resulting in disputes which sometimes escalated to possible domestic abuse. B was subject to a child protection plan for emotional abuse, later becoming a child in need and finally a vulnerable child, supported by universal services. She was also a young carer for her mother.		**Learning:** • a holistic 'Think family' approach had not been embedded across multi-agency children's and adults' services; • young carers were not always recognised as such and their needs were not always understood or attended to by the whole multi-agency system; • recognition of trends or patterns of risk, or changes in risk and when to 'step up' or 'step down' a case were not robust with a lack of confidence in escalating concern. **Recommendations:** • review how the principles of the holistic 'Think Child, Think Parents, Think Family' approach are operating and how they are embedded in commissioning and leadership of frontline practice and its management, with joint working and understanding of mental ill-health and parenting.
2017 – Surrey – Child BB Death of a 23-month old child in May 2014 due to		**Learning:** • better interagency work and closer

non-accidental injuries. **Key issues:** Child BB was taken to hospital in a state of extreme physical collapse, with bruises and burn marks, and died the following day. Criminal charges were brought against the mother and her partner in March 2015, but the partner committed suicide before the trial. Mother was found not guilty.		communication between police, probation services and children's services could have resulted in a better understanding of the behaviour of the mother's partner; • safety messages on dating websites focus on the users' personal safety but not on potential risks after a relationship is established. **Recommendations:** include: • police, probation service and children's services to review processes for liaison about incidents and call-outs in relation to domestic violence; • national consideration be given to how mothers can be alerted to the need for caution when engaging in new relationships with previously unknown men, potentially with an emphasis on relationships made through internet dating sites and social media.

<table>
<tr><th colspan="3">NEGLECT</th></tr>
<tr><th>CASE</th><th>KEY ISSUES</th><th>LEARNING & RECOMMENDATIONS</th></tr>
<tr><td>December 2016 - Herefordshire – Family HJ
Concerns of neglect and possible physical abuse of a period of 5 years of a minority community sibling group, with mobility, sight and learning difficulties and health challenges.</td><td>• children known to children’s social care and the police.
• Concerns around missed or cancelled appointments for weight checks and immunisations, sight and delayed development checks and lack of cooperation by the parents.
• The youngest child was briefly taken into foster care following concerns of possible sexual abuse</td><td>Learning:
• identification of neglect and children with disabilities;
• lack of cooperation by family; consideration of each child individually; internal and external escalation and professional disagreements;
• specialist social work provision and legal processes.
Recommendations:
• to provide an effective multi-agency childhood neglect strategy;
• to request that NHS England reviews its commissioning arrangements for child sexual abuse medicals in the local area;
• provision of training in culturally competent practice.</td></tr>
<tr><td>November 2016– Anonymous – Child G
Death of a 3½-year-old African boy in November 2015. There were indications that there might have been some degree of force feeding causing ingestion of food into the lungs.
Background: the father was found guilty of manslaughter and child cruelty. Family was known to children’s services and children had previously been subject to child protection plans for neglect, physical and emotional abuse and children in need plans.</td><td>• lack of recognition of the impact of the mother’s ill health on her parenting capacity;
• insufficient awareness of father’s lifestyle and the reliance placed on Child G’s step-sister to provide family care;
• parental inhibition of their children’s voices;
• problems in information sharing following the family relocation;
• professionals overlooking the needs of the children</td><td>Recommendations:
• amending the neglect toolkit to include feeding issues and dental health;
• practice tool to be used by the health visiting service to ensure systematic and robust information capture for new families.</td></tr>
<tr><td>July 2016 – Mid and West Wales - CYSUR 2/2015
Death of an 8-year-old boy in December 2011.</td><td></td><td>Learning
• always consider children’s needs</td></tr>
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Post-mortem found he had been suffering from gross anaemia, dental abnormalities and soft tissue haemorrhage in the lower legs. He had not received medical treatment. The Crown Prosecution Service (CPS) decided not to prosecute the parents and an inquest reached a verdict of open conclusion. **Background:** the child had no direct contact with health, education or child care after being immunised aged 13-months. His parents declined his 3 year developmental check and were home educating both their children. Family had a history of: mother's deteriorating mental health; father's poor health and combined role as a home educator and carer for his wife and children; longstanding litigation claims against mother's former employer; reclusive lifestyle; and lack of engagement with agencies.		when a parent has a mental health problem; • share knowledge and experience with other agencies as part of a holistic family assessment. **Recommendations:** • Welsh government to consider changing legislation to require parents to register children receiving home education with the local authority on an annual basis and to ensure the children are seen and spoken to and their wishes recorded annually.
February 2016 - Luton - Child F Death of an 8-week-old child in October 2013. The cause of death was unascertained but neglect was a strong feature in the family.	**Key issues:** • the family of 6 children aged between 8 weeks and 13 years had been known to universal agencies since 2001 for: late booking appointments for pregnancies; failure to attend health appointments/school; house fires; domestic violence; inadequate housing/frequent moves; poor child supervision; and low level neglect.	**Learning:** • variable information sharing from agencies to children's social services (CSC); • inconsistent and idiosyncratic thresholds were applied within CSC; • lack of escalation between or within agencies; • poor recording practice within social care; • delay was a recurring factor **Recommendations:** include: • improve local arrangements and responses to domestic violence; • provide a robust system for reviewing and recording information within the health

		visiting service; • provide IT systems that support professionals to accurately record and share information; • ensure the tools for assessing risk and neglect are available for all professionals to use.
2017 - Bedford - Baby Sama Death of a baby girl under 2 months old of white British/Pakistan origin, in October 2015 as a result of fatal injuries received after falling from her car seat. The Coroner's Inquiry found her death was a tragic accident that could not have been predicted.	**Key issues:** • mother was 20 and father 28 when Sama was born. • Mother spent time in foster care and had had witnessed domestic abuse against her mother when she was a child. • Mother was looked after for 4 months when she was 15 when concerns were raised that she was involved with a 23 year old male (Sama's father) who was known to be violent. • Father had convictions for domestic violence, assault, drug dealing and breeding dogs for fighting. • Concerns identified about father being involved in the sexual exploitation of two looked after children. • In July 2015 Salma was made subject to a Child Protection Plan under the category of neglect.	**Learning:** issues identified include: • recognising and addressing the impact of child sexual exploitation (CSE) in assessments and plans to safeguard children; • understanding the dynamics of domestic abuse including perpetrator behaviour; • recognising the links between animal abuse and child abuse/domestic abuse. **Recommendations:** • makes recommendations relating to the safeguarding of babies from domestic abuse.
2017 – Blackpool - Child BW Death of 3-month old child in 2015 due to medical causes**.** **Background:** Child BW lived with mother and two siblings. A child protection plan had been in place for all children 1 year before the death due to concerns of neglect.	**Key issues:** include: • views on a good enough home environment can be subjective and complicated by working in a deprived area; • mother's disguised compliance may have added to the optimistic view of her	**Recommendations:** include: • wider promotion and clarification for staff of neglect assessment tool; • audit on how expected outcomes are recorded on Children's Services' documentation; • audit of pre-birth child protection

	intentions and capacity to change. **Good practice** identified: • robust information sharing processes and good local professional relationships.	processes to ensure that when siblings are on a child protection plan the needs of an unborn baby in the family are considered separately; • review progress of earlier recommendations of safe sleep assessment
2017 – Halton – Young Person Life-threatening asthma attack experienced by a teenaged boy in December 2014; at the time he was visiting relatives who did not seek medical help for around 18 hours. After being treated in hospital he was taken into care due to concerns about his health and the cumulative effects of neglect.	**Key issues:** • Young Person lived with his mother and her partner, and did not know his father. • He suffered from long-term asthma and severe eczema which was being treated at a satellite dermatology clinic. • He and his mother had Common Assessment Framework (CAF) support between 2009-2012.	**Learning:** • from early age, professionals held information about Young Person which was not shared; • professionals had limited understanding of the young person's lived experiences; • treatment for the young person's eczema was provided by a medical team that primarily worked with adults, and had limited knowledge of how chronic conditions can affect a child's life and age appropriate pathways for support. **Recommendations**: identifies findings for the local safeguarding children board (LSCB), which can be used as a basis to make the local safeguarding system safer. These include: • professionals need to be confident to raise questions about family or household members who could pose a risk of harm to a child
2017 – Swindon - Child S Death of an 8 week old girl in October 2015 whilst sleeping with her mother on the sofa. Child S was taken to hospital following a cardiac arrest and life support was withdrawn after three days. **Background:** Child S was subject to an interim	**Key issues:** • neglect, the impact of time spent in hospital on ability to care for children, communication gaps between organisations, health visit delays.	**Learning:** • The impact of time spent in hospital on ability to care for children. **Recommendations:** include: • make training available to Children and Families staff regarding the effects of long

supervision order and a child protection plan at the time of her death. The family was known to Swindon Borough Council Children, Families and Health; Great Western Hospitals NHS Foundation Trust; CAFCASS.		term drug use on the brain and to consider the impacts on patient's ability to care for their family after a discharge from intensive care.

SUDDEN UNEXPECTED DEATHS IN INFANTS AND CHILDREN		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2016 – Bournemouth and Poole – Baby N Death of a 17-week-old boy in summer 2015 from sudden unexplained death in infancy (SUDI). Baby N died whilst co-sleeping with his mother. The coroner's report indicated overheating through being over wrapped as a contributory factor. **Background:** mother had been in care during her childhood and became pregnant at 16-years-old. Father had Attention Deficit Hyperactivity Disorder (ADHD), a history of drug abuse and violent behaviour and was known to the Youth Offending Service (YOS). Maternal grandmother had a history of hoarding behaviour, leading to cluttered home conditions in which Baby N slept. Baby N had been subject to a child protection plan due to neglect at the time of his death.		**Recommendations:** • The LSCB should satisfy itself that all agencies share information; • protocols for the protection of the unborn child need to be fully understood by practitioners; • the LSCB should consider including risk of SUDI in child protection planning for under ones at risk for neglect; • the LSCB should ensure clarity about health visitor's role in safeguarding babies with regard to sleeping arrangements

2016 - Suffolk - Baby D
Death of a 12-week-old baby boy whilst co-sleeping with his mother. Police arrested the parents, following anonymous allegations of heavy drinking and drug taking in the family home, but there was insufficient evidence and no further action was taken.
Background: no concerns were identified about the care of Baby D before or after his death. A range of agencies had been working with the family due to the increasingly challenging behaviour of Baby D's half-sibling Child P. Mother had reported feeling overwhelmed by Child P's behaviour and a social work assessment had taken place the day before Baby D's death.
	• need for some improvement in agencies' delivery, recording and coordination of advice about safe sleeping
	• need for improved public and professional awareness of the issue of safe sleep
		Recommendations:
		• recommendations for the local safeguarding children board (LSCB) include:
		  ○ consider introducing consistent safe sleep assessment and recording arrangements for health professionals;
		  ○ carry out regular audits to evaluate the delivery and recording of safe sleeping advice.

SEXUAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2016 - Anonymous – Child N The harmful sexual behaviour of a 16-year-old child, who was briefly made subject to a children in need plan following 2 allegations of child sexual abuse. The second allegation led to conviction and imprisonment for sexual assault of an under 13-year-old. **Background:** history of disrupted education due to difficulties in concentration and attainment; diagnosis of Attention Deficit Disorder (ADHD); statement of Special Educational Needs; concerns about inappropriate sexual behaviour; and going missing from home.	• lack of supervision for vulnerable children using shared school transport; • lack of policy and procedures to guide children's social care professionals; • limited professional understanding of sexually harmful behaviour.	**Learning:** • identifies significant learning about responding to children at risk of sexually harmful behaviour. **Recommendations:** • makes various recommendations including ensuring that multi-agency practitioners are better equipped to work as part of a multi-agency approach in cases of harmful sexual behaviour and review the risk and safety for children who use local authority school transport.
2016 – Bristol - Operation Brooke Sexual exploitation of children between 2011 and 2014. The police investigations, known as Brooke 1 and Brooke 2, resulted in the successful prosecution of 15 offenders for crimes including rape, paying for the sexual services of a child and trafficking for sexual purposes **Background:** investigation Brooke 1 involved the sexual exploitation of a 16-year-old looked after child and a further 3 children aged between 14 and 15-years-old. Brooke 2 involved the sexual exploitation of 6 children. The perpetrators, who were all in their early 20s, used drugs, alcohol, money and the children themselves to attract and groom new victims.	• the multi-agency system was not set up to respond quickly and flexibly to adolescents with complex needs; • professionals struggled to distinguish between sexual abuse, sexual exploitation and/or underage sexual activity; • working methods and recording systems did not reliably identify patterns in individual and group behaviour which made it harder to detect victims and perpetrators of CSE.	
June 2016 – Peterborough - Operation Erle	**Key issues:** issues identified include: lack of robust	**Learning:**

The sexual exploitation of young people in Peterborough over the period 2010-2016. **Background:** focuses on learning from Operation Erle, a multi-agency investigation which resulted in ten male defendants being found guilty of 59 offences against 15 girls. .	response to disclosures of sexual activity at a young age; lack of robust response to the assessment and safety planning of missing episodes; difficulties in transitions between children's and adult's services and a tendency to see young people as adults capable of choosing to be in abusive relationships. Also identifies examples of good practice, including close co-ordination and joint working between children's social care and the police.	• the need to produce and share victim contact strategies with all members of a joint enquiry; • the importance of considering the needs of the family as a whole and the need for young people to talk to an independent person when returning home after a missing from home episode. **Recommendations:** • local safeguarding children board (LSCB) to undertake an audit of provision of child sexual exploitation interventions within educational establishments; • all agencies should ensure that the voice of the child is central to all child sexual exploitation work and the safeguarding board to use multi-agency data to map and evaluate high risk areas for child sexual exploitation to inform early identification of perpetrators and victims
2017 - Anonymous - Child F and Family Harmful sexual behaviour and death of 17-year-old boy in 2015 as the result of stab wounds. **Background:** Child F was assessed as a Child in Need in 2011. Behaviour and attendance at school erratic, and several incidences of involvement with others in minor and serious offences, including rape of a 12-year-old and 14-year old. Decision made that prosecution relating to first rape was not in public interest.	**Key issues:** include: • when cases are not pursued in the public interest it is still necessary for the young person to be given a full understanding of the implications of their actions; • lack of support for mental health needs due to referrals to and from between agencies; • good chronologies of key events would help spot risks; • agencies should take great care when describing sex as consensual when in law it cannot be; • young teenagers are often unclear about	**Recommendations:** include: • review safeguarding approach to young people with harmful sexual behaviour; • encourage education providers to ensure law around consent is explained clearly; • ensure that a young person’s concern about violent risks to them is taken seriously by agencies.

	consent.	
2017 – Anonymous - Considering child sexual exploitation Child sexual exploitation of 3 girls by a young adult female who was involved in sexual activity with them and recruited them in abusive sexual behaviours by a number of older adult males between January 2013 and August 2015.	**Key issues:** • all girls had complex needs and missing from home episodes. • The alleged perpetrator was part of a wider network of predominantly male operatives.	**Learning:** • difficulty in identifying the alleged perpetrator as a risk to children; • the need for services to work with parents to strengthen parental confidence as perpetrators set out to deliberately drive a wedge between child and family; • importance of early intervention in responding to sexual exploitation; • the need to understand children as victims without choice or informed consent. **Recommendations:** • introduce a process for responding to vulnerable children/young people which incorporates child sexual exploitation and: • identifies and minimises the risk from a non-familial source; • builds on factors that increase resilience; • facilitates a multi-agency team around the child; • and facilitates partnership with key people in the life of the young person.
2017 - Croydon - Claire Review of the responses of agencies between 1 January 2012 and 31 January 2014 to a young girl who was found to have contracted two sexually transmitted infections whilst in local authority foster care. **Background:** Claire was known to multi-agency services from the age of 5 months and had previously been the subject of a child protection plan. At 6-years-old she was sexually abused by a	**Key issues:** • lack of assessment, support and guidance for kinship foster carers; • absence of scrutiny and challenge when assessing and approving new foster carers; • lack of collaboration between social workers representing different teams within the looked after child service; • the importance placed on performance	**Recommendations:** • strengthen the contribution of family members in looked after child reviews and child protection conferences; • review how agencies are kept informed of planned changes for a child and consider adapting processes to facilitate the involvement of partner agencies; • put processes in place to embed challenge as an accepted responsibility in

member of the household and became a looked after child in the care of her paternal grandmother. This placement broke down and Claire was placed in foster care. Claire was removed from the placement after 15 months when she was diagnosed with chlamydia and gonorrhoea.	indicators compromised the role of the Independent Reviewing Officer.	safeguarding children

BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2016 – Cheshire West and Chester - Bryony Death of an adolescent girl from an overdose in February 2015. There were no suspicious circumstances surrounding Bryony's death and she left a note expressing her distress and desire to take her own life. **Background:** Bryony was subject to a Child in Need plan and spent time in foster care placements under Section 20 arrangements. Before she died, Bryony had returned to live with her mother under a care order. Family history included: domestic abuse and mother's disability resulting in Bryony spending a lot of time caring for her. Bryony faced difficulties including: severe emotional distress; self-harm; offending behaviour; school refusal; going missing; and risks around child sexual exploitation and harmful sexual behaviour. A number of services supported the family including: children's services and Child and Adolescent Mental Health Services (CAMHS).	• the mindset of some professionals was skewed towards risk, resulting in them viewing Bryony as a perpetrator rather than a vulnerable child; • there was a lack of focus on working with the whole family (including father and grandparents); Bryony's views were not sought consistently enough.	**Recommendations:** • LSCB to undertake focused work on bringing risk assessment, risk management and safeguarding practice together across children's and adults' social care.

December 2016 – Thurrock - James Death of a 17-year-old boy of Ghanaian heritage in July 2015 in North London. James was found collapsed with a sheet tied around his neck. The Coroner recorded an Open Verdict on his death. **Background:** James was a looked after child in semi-independent accommodation, following a breakdown in relationships with his family. He was known to the police and children's services in a number of local authorities.	• James had a history of: running away; violent and criminal behaviour; sporadic school attendance; non-engagement with services; drug misuse; self-reported mental health issues; and suspected involvement in gangs.	**Learning:** • looked after child placements situated too close to areas where gangs operate; • incomplete mental health assessments; insufficient work by professionals on understanding family dynamics and rebuilding family relationships; • the absence of a positive action plans in response to concerns raised in looked after child reviews. **Recommendations:** • review safeguarding arrangements for children in custody and young people presenting as homeless; • widen the remit of looked after children inspections nationally to include semi independent placements; • embed a more robust record keeping and follow-up process for health assessments; • assess the risk posed by any condition disclosed by a child or young person in custody to a forensic medical examiner and develop a matrix for identifying and escalating concerns about children in care.
September 2016 - Brighton and Hove - Child E Death of a 17-year-old boy from injuries sustained by hanging in December 2014. Coroner returned an open conclusion on whether E's death had been an accident or suicide. **Background:** the local authority looked after E from when he was 3-years-old in a 'Family and		**Learning** • there was a tension between the roles of the local authority as corporate parent and 'Family and Friends' carers who can be seen as 'parents', this can result in blurred boundaries and difficulties asserting

Friends' placement with his maternal aunt and her partner. He spent time in respite foster care and before his death moved to the same area as his birth father. Family history includes: mother's mental health and substance misuse difficulties; mother's death from an overdose when E was 8-years old and absence of E's birth father for much of his childhood. E faced difficulties including: emotional distress; challenging behaviour at home; being known to the police and alcohol and substance misuse.		the local authority's statutory responsibility for a child when this is needed. • Due to inconsistent standards in transfer summaries and chronologies, new social workers did not always receive enough background information to gain an holistic understanding of the needs and risks facing young people and their carers.

HOMICIDE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2016 - City and Hackney - Ms AB and Child D Death of 22-month-old Child D and her mother, Ms AB, in March 2014. Child D's father and Ms AB's ex-partner, Mr YZ, was convicted of their murder and sentenced to life imprisonment. Combined domestic homicide review and serious case review. **Background:** in February 2014 Ms AB reported serious domestic abuse to the police. Prior to this, there were no records of Ms AB and Child D having contact with any agencies other than universal health services. Father had a previous conviction for drug offences and was known to drug and alcohol services and the Probation Service.	• Ms AB's disclosure to the police of Mr YZ's threat to kill her and her 3 children did not result in a thorough investigation and action to protect them; • there were missed opportunities to refer the case to children's services who could have made their own risk assessment.	**Recommendations:** • the Metropolitan Police Service should review its electronic crime reporting system to ensure that: any threat to life in a domestic abuse case is reviewed by an inspector who will be responsible for implementing and directing actions; • when children are named as victims or witnesses in a domestic abuse case, a pre-assessment checklist is shared with children's services. • The College of Policing should commission research to identify a model of safe exit planning for victims of domestic abuse.

September 2016 - Hammersmith and Fulham - Rose Death of "Rose", a 9-week-old baby girl, in January 2015. Rose's mother pleaded guilty to manslaughter by diminished responsibility. The plea was accepted following psychiatric reports and she was sentenced to remain in a mental health facility with an unlimited restriction order. **Background:** mother received antenatal services from her GP and Chelsea and Westminster Hospital (C&WH) maternity services until the 29th week of her pregnancy. GP also referred mother to the perinatal psychiatry service but she returned to her home country to give birth before they could see her. Mother came back to the UK with Rose shortly before her death. Risks identified include: mother's anxiety and low mood related to her pregnancy; previous request to terminate the pregnancy; isolation from her family; low income; and separation from Rose's father.	• communication across and between health services and professionals was fragmented. • Professionals did not fully understand procedures for making referrals and the geographical areas covered by the C&WH midwifery service.	**Recommendations:** • perinatal and maternity services must audit referrals to ensure the new system is robust and vulnerable women are identified and followed up. • Health services should work together to develop a communication pathway locally to improve outcomes for service users
June 2016 - Gloucestershire - Lucy Death of a 16-year-old girl and her unborn child in 2014. Lucy died as a result of an assault by her partner Daniel, who was found guilty of her murder and given a life sentence. **Background:** Lucy was made subject to a Child in Need plan but social care decided to close her case when her unborn child was made subject to a child protection plan under the category of physical and emotional abuse. Lucy became homeless at 15 after relationships with her family deteriorated. After a brief period staying with her		**Learning:** • when safeguarding teenagers, there was a tension between respecting their autonomy and keeping them safe; • the Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) form did not capture all critical information for under-18s; • there was a lack of understanding of how to recognise key features of

partner Daniel, the couple separated and Lucy returned to live with her mother. Lucy presented with multiple risks including: emotional difficulties; self-harming; challenging and risky behaviour; school refusal; estrangement from family members; homelessness; pregnancy and being in an abusive and violent relationship. Services supporting Lucy and her family included: child and adolescent mental health services (CAMHs), family support services and a voluntary sector organisation specialising in young people's mental health.		domestic abuse between young people, leaving child victims and child perpetrators without the necessary support and protection.
June 2016 – Sutton – Child D Death of a 6-year-old girl in October 2013 from a head injury. Father was charged with her murder and child cruelty. Mother was charged with intending to pervert the course of justice and child cruelty. **Background:** Child D had previously been on the child protection register under the category of physical abuse, after being hospitalised with head injuries in February 2007. Child D's father was convicted and Child D was placed in the care of her maternal grandparents. Following new medical evidence, father's conviction was quashed and a high court judge ruled the parents were not culpable. The judge appointed an independent social work agency to work with the family and Child D returned to live with her parents in November 2012.		**Learning:** advises professionals to: • focus on the child's needs and experiences at all times, regardless of how demanding the parents are; • when working with independent social work agencies, consider issues around quality assurance of practice, accountability, how they are selected and how they work in a multi-agency context. **Recommendations:** • clarify the courts' responsibility to LSCBs in respect of serious case reviews; • following an unexpected court judgment, which has the potential to raise concerns for children, convene a multi-agency meeting to discuss future actions, roles and responsibilities and establish the means by which agencies can share information about and respond to any escalation of concern.

March 2016 - Lancashire - Child O Death of 22-month-old Child O in August 2014 at the hands of their mother who then killed herself. A post-mortem concluded mother and child died of carbon monoxide poisoning. **Background:** parents were separated and mother and Child O had moved to a number of places around the country. At the time of their death in Lancashire, they were not known to any statutory or other agencies within the county. Father had made an application for contact with Child O and a Cafcass children's guardian was working with the family. Mother had made unsubstantiated allegations to Devon and Cornwall police of domestic violence and sexual abuse against Child O's father. The coroner's inquest concluded there was no substance to the mother's belief that she was being pursued by Child O's father and he had acted appropriately throughout. Mother had a history of possible post-natal depression and personality problems and giving misleading information to statutory services to conceal the whereabouts of herself and Child O.		**Learning:** • there were organisational weaknesses in the approach to working constructively and proactively with fathers; • professionals needed to be encouraged to balance respect for women who talk about domestic abuse with appropriate scepticism and curiosity where allegations are denied. **Recommendations:** • made multi-agency recommendations including developing knowledge and awareness of the nature of homicide in the context of parental conflict