Lessons Learnt Research Digest

Issue 4, April 2018

Welcome to the fourth 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 3 of the digest).

https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2017/
https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2016/

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
2017 – Durham – Baby Bailey Death of a 7-week-old boy in November 2015. Baby Bailey had been co-sleeping on the couch before being found in the Moses basket. The post-mortem gave the cause of death as "unascertained".	Full report and executive summary on DSCB website. http://www.durham-lscb.org.uk/professionals/serious-case-reviewchild-death-reviews/

National Learning

PHYSICAL AND EMOTIONAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2016 – Camden – Child B Serious injury of a 9-week-old girl resulting in permanent disability in November 2014. **Background:** injuries to Child B were caused by a single episode of shaking and impact to the head perpetrated by one of Child B's parents. Both parents had been known to a number of services in Camden, including mental health services and a young parents' support service.		**Learning:** • Child B's parents received a number of services for short periods of time leading to a lack of continuity and fragmented service provision. **Recommendations:** • Camden LSCB should seek evidence as to how information on the dangers of shaking small babies is delivered in antenatal settings; • Camden LSCB should seek evidence that providers of antenatal services in Camden are asking women about domestic abuse; • the LSCB to ensure perinatal services are consistent and accept post-natal as well as antenatal referrals; • the LSCB look at effectiveness of risk assessments of children affected by domestic abuse.
2016 – Haringey – Child R Death of a 6-month-old child due to traumatic head injury in January 2015. Father was found guilty of murder in December 2015.	• On 23 January 2015 Child R was taken to hospital following cardiac arrest at home whilst in the care of the father. The child died on 26 January from injuries caused by physical abuse.	**Learning:** • key issues identified includes failure of agencies to undertake a risk assessment once the criminal background of the mother was known. Identifies learning for the police, the courts and the

	• The family had limited contact with services. • Maternal history of: conviction of murder in her country of origin and served with a European Arrest Warrant whilst pregnant with child R. • Father had a history of drugs and alcohol misuse.	probation service. Good practice identified include: the actions of the safeguarding midwifery team in attempting to find out whether the mother presented any risk. **Recommendations:** • when police is asked to undertake a welfare check on a family by health agencies or children's services there is an understanding of what this means; • ensure that the judiciary is made aware of the importance of considering any safeguarding risks to the children of foreign nationals convicted of serious and violent offences.
2016 - Hertfordshire - Sophie Death of a four-year-old girl, "Sophie", killed by her father in March 2014. He was convicted of her murder in May 2015 and sentenced to life imprisonment. **Background:** Sophie was removed from her mother's care by Bedford Borough Council and placed with foster carers. Four months before her death, Luton County Court granted Sophie's father a Residence Order and she moved to Hertfordshire to live with him. A Supervision Order was made by the Court to Hertfordshire County Council. Father's son "Joe", Sophie's half-brother, and his siblings had been subject to a child protection plan under the category of neglect. Father and Joe's mother were involved in a child custody dispute. Concerns included: Sophie's mother's chaotic lifestyle and substance misuse; father's violence towards partners and his mental health problems; foster carers'		**Learning:** • assumptions about the rights of the birth family in court proceedings contributed to acceptance of a limited assessment which did not focus on the needs of the child; • there were shortcomings in the response to suspicions of child protection risks which left Sophie at risk of harm. **Recommendations:** • assessments of friends and family as carers should be conducted with the same rigour as assessments of foster carers and adopters; • establish a clear framework for the consideration of independent assessments conducted as part of legal proceedings – agencies should be

reports of Sophie's fearful reaction to contact with her father.		prepared to challenge conclusions when necessary.
November 2016 - Hertfordshire – Child A Discovery of multiple injuries resulting from the severe physical abuse of Child A, aged 8, in March 2013. Mother and step-father were arrested and bailed. A member of the extended family was convicted of offences arising from Child A's physical abuse in 2016. **Background:** Child A was born prematurely when his mother was in her teens. He suffers from cerebral palsy and is profoundly deaf. Due to his disability he had been a child in need since birth, receiving services from children's social care, occupational therapy, speech and language services and he attended a specialist school. Step-father had a history of domestic abuse, drug and alcohol problems and criminal behaviour; mother had physical health problems and was arrested for assault. The police, step-father's probation officer and his drug and alcohol service made referrals to children's social care. Concerns were substantiated following child protection enquiries but Child A and his siblings were not judged to be at continued risk.		**Learning:** • multi-agency confusion about the child in need processes for disabled children meant there were no effective outcome-focussed plans or multi-agency reviews; • there was an unwillingness to label the early signs of poor quality care provided to disabled children as neglect, leaving children's needs unaddressed. **Recommendations:** • the LSCB should explore how embedded the "think family" agenda is and take remedial action as appropriate.
2017-Anonymous-Child Y Serious health and developmental impairment of a teenage boy due to fabricated or induced illness (FII) over a number of years.	• the difficulties faced by professionals in working with a family when FII is suspected.	**Recommendations:** • development and implementation of pathways for the early identification and management of perplexing presentations, including suspected cases of FII, and for the management of identified cases of FII, including those who are subject to child protection plans;

		• The Department of Health and the Department for Education should be asked to commission national research to establish the prevalence, incidence and case characteristics and outcomes for children who have perplexing presentations or FII.
2017 – Birmingham - Child D Death of a 5 month old child of Lithuanian parentage from a brain injury in March 2015. Father was found guilty of murder of Child D in February 2016 and also found guilty of injuries caused to siblings DD and LD.	• Child D was a twin who was born prematurely and spent 2 months in hospital after their birth. Child D's sibling had further health complications that required hospital appointments. The family were not known to children's social services until the death of Child D. The family were under financial pressures and away from the main support system of their extended families. There was contact with health visitors, GPs and hospitals before the birth of the twins.	**Learning** • Considering all children in a family, fathers must be included in assessments and plans for children, highlights the importance of interpreters. **Recommendations:** • Improved arrangements would not have prevented the death of Child D but there are opportunities for services to make some changes to develop their services.
2017 – Birmingham – Child S Death of a 15-month-old child in January 2015 as a result of multiple non-accidental injuries	• Child S had been brought to live in the UK by his mother from the Czech Republic who left him in the care of his adult half-sister and her partner. He was not known to any services. During the 3 months that he was in their care he sustained significant injuries that led to his death. A number of friends and relatives were aware of the injuries to Child S but did not report it.	**Learning:** • the importance of using interpreters when working with families whose first language is not English, need for information in a number of languages, challenges of international migration for safeguarding children, work needed to address the lack of knowledge or trust of professionals and services within migrant communities. **Recommendations:** • number of recommendations related to working with migrant families.
2017 – Brighton and Hove - 'A'		**Learning:**

Death by suicide of a 17-year-old boy in January 2016. 'A's' mother had mental health problems and 'A' had been exposed to physical and emotional abuse and witnessed domestic violence from an early age.		• identifies learning under three headings: choice and initiation of placement; • issues arising during placement, such as identifying the need for additional therapeutic support; • transition towards greater independence including help with coping with change and his move from therapeutic care. **Recommendations:** • the need for training around the vulnerability of care leavers for Brighton and Hove Children's Social Care; • all care and placement plans should include a contingency position; • and the therapeutic unit should review organisational capacity to challenge care plans if they deem it necessary.
2017 – Brighton and Hove – Siblings W and X Reported deaths of 2 brothers in Syria in 2014; it is understood they went with a friend to join their elder brother fighting for the Al-Nusra Front. Child W died soon after his 18th birthday (but travelled when he was under 18) and Child X died aged 17. **Background:** the children had several siblings and grew up in Brighton but spent considerable periods in their parents' North African/Middle Eastern country of origin. It is understood that the family came to the UK because they opposed the regime in their country and at least 1 family member was killed for his political beliefs. The family left the UK for several years and experienced racism when they returned. The children disclosed physical and domestic abuse		**Learning:** • professionals do not have effective ways to intervene in families who have suffered long standing trauma: this can increase the risk of young people being vulnerable to exploitation; • efforts to support children so they are less likely to become vulnerable to radicalisation do not seem to address all the core issues. **Recommendations:** • practitioners need to have a greater understanding of, and curiosity about, the role and potential impact of culture, identity, gender, religion and beliefs on children

by their father and became subject to child protection plans; the mother separated from the father who spent long periods overseas. Child W and his sibling Q began behaving antisocially and became involved with Youth Offending Services. Siblings W and X left the UK in January 2014.		
2017 - Central Bedfordshire – Nolan Death of a 1-year-old boy, Nolan, in 2015 as a result of serious head injuries with the explanation inconsistent with the injuries sustained. **Background:** Mother's childhood included exposure to domestic abuse and neglectful care and she was on the Special Educational Needs register at school. She lived with her mother and partner. Her first child was born when she was 16 and Nolan was born when she was 17. Both infants were born prematurely and had medical problems. Nolan's father had mental health issues, a permanent movement disorder and lived in supported housing. Reluctance by mother to engage with services, including late booking for pregnancies and missed medical appointments for the children. 5 referrals were made to Children's Social Care, the last 8 days before Nolan's injuries.	• lack of curiosity about late booked pregnancy; • no recognition of the impact of prematurity, unexpected home birth and illness on the parents' ability to cope and implications of any rejection of help; • challenges to parenting capacity should be communicated; • the need to follow up referrals with checks and a visit.	**Recommendations:** • make the reporting of bruising to non-mobile babies mandatory; • ask member agencies to report on how they ensure the role of fathers and wider family members in the household are properly assessed; • ask the police to review its internal handover processes; • the LSCB should demonstrate the essential value of professional curiosity.
2017 - Croydon and Lewisham - Children R, S and W Life-threatening injuries of a 6-month-old girl, Child W, in April 2015. The injuries remain unexplained but were suspected to be non-accidental. Mother and her partner were arrested on suspicion of grievous bodily harm but not charged. Child W and her siblings, aged 1 and 4, were placed in foster care.		**Learning:** • responses from children's social care were incident-led. Opportunities were missed to assess the children's needs over time to assist in measuring the impact of the help already offered. Local authorities needed to have clear 'step up / step down' procedures for families who reject Early Help services.

Background: all 3 siblings were subject to child protection plans for neglect. During this process they moved from one local authority area to another. The case transferred between local authorities but the family were reported as missing. Mother was vulnerable, her own mother had suffered serious mental illness and she had spent much of her childhood in the care of her grandmother. There were concerns about domestic abuse, lack of engagement with services, mother's young age and her mental health problems associated with childhood trauma.		**Recommendations:** • make sure multi-agency training ensures the voice of the child is central to any contact or assessment. Develop a range of resources for practitioners to use when assessing children's needs, including very young, pre-verbal children.
2017 - Derbyshire - Polly Death of a 21-month-old girl, Polly, in May 2014 after attempts of resuscitation in hospital failed. Polly's mother was convicted of murder and child cruelty, and her boyfriend of allowing the death of a child.	• Polly was subject to a child protection plan at birth due to pre-birth concerns about possible neglect. Polly was in foster care for a period in 2013 following a reported incident of domestic violence at home. Polly was returned to her mother's care in October 2013 with a supervision order which included regular contact with her birth father. Between January and April 2014 Polly was involved in a number of medical incidents. Reports of domestic abuse referred to agencies and the family moved from supported living arrangements to rented accommodation in a neighbouring county.	**Learning:** • the child protection plan did not assess the implications of the mothers mental health needs on her capacity to parent; • lack of authoritative professional practice that saw Polly as the primary client; lack of understanding by some professionals about their role and responsibility when Polly was subject to a supervision order; • little recognition of the role the boyfriend and father were playing in Polly's life; • and medical staff did not consider the possibility of child abuse or neglect when Polly presented with medical issues.
2017 – Hertfordshire – Child G Death of a boy aged less than 1 year from unknown causes. A post mortem examination identified seven fractures which predated the death.		**Learning:** • reluctance to name neglect by professionals involved with the family;

		• the crucial importance of the assessment process to ensure appropriate intervention; • the need to review the types of cases that are discussed in supervision. **Recommendations:** • the need to challenge agencies to demonstrate they are working in line with its strategic approach to neglect; • to ensure that those families and children managed under Children in Need are the correct ones and are properly reviewed; • the need to deliver safe and effective services for children within its traveller communities and to use this learning to enhance services to other minority communities.
2017 – Hull – Baby J Death of Baby J aged 4 weeks in summer 2014 owing to head injuries associated with being shaken. Baby J's father, FJ, was later convicted of manslaughter.	• Baby J's parents had both received support from mental health services prior to and after Baby J's birth. FJ had a history of domestic abuse with a previous partner and increasingly with Baby J's mother. Both parents were homeless and living in separate hostels throughout the pregnancy although Baby J's mother moved to her parents after the birth. An initial assessment was carried out in November 2012. Although recommended, a pre-birth risk assessment was not carried out.	**Learning:** • no single agency had a full picture of the parent's history of mental health issues and drug and alcohol misuse; • the risks posed by domestic abuse and coercive control by perpetrators were not understood; • written agreements with families need to be monitored. **Recommendations:** • improving information sharing, communication and record keeping in relation to domestic abuse and mental health issues and involving fathers in risk assessments.

2017 - Liverpool - Chris Subdural haematoma suffered by Chris, a baby under 6 months old, in September 2015. Further examination revealed recent and old injuries including rib and leg fractures. Chris's injuries will have a life-long impact. **Background:** Chris's mother is a migrant to the UK. Her husband, MH, is also a migrant. MF is the birth father of Chris and sibling CS. Both MH and MF had access to the children. Family had contact with services including the GP, health visitors, midwifery and maternity services and the police. Police attended incidents involving the family on 5 separate occasions and notified children's services each time. Referrals were also made by maternity services and the health visitor following Chris's birth. Concerns included domestic abuse, the family being victims of anti-social behaviour and mother's rough handling of CS during a medical appointment	• safeguarding children in migrant families could be improved by addressing cultural competence in understanding family dynamics and more effective use of interpreters; services are too reliant on self-report information from migrants due to a lack of robust historical health, social care and criminal records.	**Recommendations:** • the LSCB should ensure that professional interpreter services are always used by agencies - the use of family members or others is not acceptable; • LSCB should contact the relevant government department to highlight poor availability of historic health and social care records for migrants to the UK.
2017 - Luton - Child J Death of a 13-month old boy in November 2015 from non-accidental head injuries inflicted on the day of his death.	• Child J lived with his parents for the first weeks of his life. Parents had a history of domestic abuse and separated in Spring 2015. They were known to children's social care services. Mother became involved with a new partner and moved to a new area where children's social services were informed about the family. Child J died of non-accidental head injuries and a post-mortem found several fractures. Mother and her partner were imprisoned for offences connected with his death.	**Learning:** • transfer arrangements within health visiting and between Family Nurse Partnership and health visiting assume a degree of cooperation from families, which may leave children of avoidant parents at risk of harm when families move; professionals may underestimate the risk of physical harm to children in domestic abuse situations involving physical violence. **Recommendations:** • effective transfer arrangements between local authorities to avoid losing sight of vulnerable children when families move;

		• and transfer of information between health visitors where families are transient.
2017 - North East Lincolnshire - Child T Death of a 4-year-1-month-old girl as a result of non-accidental head injuries and ingestion of a range of illegal drugs. **Background:** Child T was subject to a Child in Need plan for 13 months following her birth. For at least 6 months before her death, she was exposed to and ingested heroin, methadone, ketamine and various benzodiazepines. Mother and partner were charged with neglect, child cruelty and drugs offences. First child was taken into care before the birth of Child T as a result of domestic abuse and drug misuse by both parents; father was in prison at the time of death.	• the need for robust assessment to understand family functioning and assessing parental capacity to change; where siblings are born to children subject to a Child Protection Plan, a proactive decision is needed about the unborn or newborn baby; all contacts from family members raising concerns about the welfare of a child should automatically be treated as a referral; the need for multi-agency professionals to develop tools and skills to combat disguised compliance, particularly where parental substance misuse or domestic abuse are key causes of concern.	**Recommendations:** • all children identified as a Child in Need should have a multi-agency plan with a level of management oversight equal to children subject to a Child Protection Plan; • multi-agency professional meetings should ensure attendees understand the status and range of kinship care arrangements and their implications for the child; • practitioners should develop increased skills in analytical thinking to apply at points of assessment and decision making.
2017 – Nottingham – Child J Death of a 7-year-old girl in July 2014. Her aunt, who she lived with under Special Guardianship Order (SGO), and paternal grandmother were both sentenced to imprisonment for child cruelty.	• Child J was born with mild learning disabilities and a kidney condition. Her mother was a single parent and had poor mental wellbeing; her father had several other children and had spent time in prison. Mother disclosed having thoughts of harming Child J and made allegations of abuse against the paternal grandmother, father and father's new partner. Child J became a Child in Need. She was placed with a foster family at 4-years-old and received support from child and adolescent mental health services (CAMHS) after showing signs of having experienced significant early trauma. She was placed permanently	**Learning:** • there was a lack of understanding about the impact of early emotional abuse and neglect on young children and the likely manifestation of this in their behaviour; • a full assessment which brought together all the available information on Child J in the context of possible physical abuse was needed; • the importance placed on engagement with parents/carers can mistakenly leave children at risk. **Recommendations:** • professionals should not accept the term self-harm in children under 10 without a consideration of potential wellbeing or

	with her aunt (her father's sister) under an SGO, with support under a Family Assistance Order (FAO). During this time the aunt stated Child J was self-harming and deliberately misbehaving. Several concerns were raised about the aunt's punitive parenting style, including a referral to the NSPCC helpline.	safeguarding concerns.
2017 – Nottingham - Baby ON16 Non-accidental injuries of 16-week-old baby which resulted in admission to accident and emergency.	• the need for practitioners to be aware of the significance of early life experiences, drug use and mental health problems in parents and their impact on the children; the need to understand normal child development which would have improved the quality of decision making; inter-agency cooperation; the need for effective supervision and managerial oversight. Examples of good practice were noted by the GP, the housing support worker and the health visiting service.	**Recommendations:** • reviewing procedures for children cared for by extended family members and undertaking a learning exercise to improve responses to injuries and bruises in young babies.
2017 - Somerset - Child L and Child J Non-accidental injuries to 6-week-old Child J, sustained on at least two separate occasions. Child L, aged 5-months, half-sister to Child J, had a mouth injury and bruising 10 months earlier and had been subject to a Child Protection enquiry but after a Child and Family assessment the case was closed.		**Learning:** • the need for practitioners to be aware of the significance of early life experiences, drug use and mental health problems in parents and their impact on the children; • the need to understand normal child development which would have improved the quality of decision making; inter-agency cooperation; • the need for effective supervision and managerial oversight. Examples of good practice were noted by the GP, the

		housing support worker and the health visiting service. **Recommendations:** • the strengthening of interagency procedures for the police, children's social care, housing providers and the NHS Foundation Trust.
2017 - Somerset - Child Sam Severe and irreversible brain damage caused to a 6-month-old boy as a result of non-accidental injury.		**Learning:** • importance of professionals working with families to recognise the increasing risk factors within the family and the impact these might have on the parents' ability to care; • importance of information sharing. **Recommendations:** • ensuring that agencies identify and respond to risks and vulnerabilities within families where domestic abuse is a concern; • appropriate training given about the importance of measuring and recording growth measurements; • and training for health care professionals to highlight the signs and symptoms of brain injuries in young babies.
2017 – Trafford – Child N Circumstances around Child N becoming a looked after child at the age of 7. Following placement in foster care after the father's physical assault of an older sibling, Child N and siblings disclosed physical, sexual, emotional and psychological abuse.		**Learning:** • identifies learning lessons in relation to multi agency working maintaining the child as the focus. **Recommendations:** • focused outcomes and plans for children; • the value of multi-agency working; • undertaking a thematic audit on working with violence and aggression;

		• and developing a strategy to hear the voice of a child for children subject to multi agency procedures
2017 – Warrington – Child 1 Child 1 witnessed mother's death in the family home in 2014 from multiple stab wounds caused by father. Child 1 sustained stab wounds including the partial amputation of finger during the incident.	• Child 1 was the eldest of 3 siblings, one of whom was also present in the home at the time of the incident. The children were not known to child protection agencies. They attended school and had no additional health needs. Father and mother were married for 16 years prior to the incident but were experiencing marriage difficulties and attending marriage counselling. Mother experienced domestic abuse and disclosed that she thought father bugged the house, her phone and computer and that she was frightened for her safety and that of her children. Both parents had been in contact with police with issues around domestic difficulties. The criminal investigation revealed that the family home was dominated by father's controlling behaviour.	**Learning:** • a point of separation represents increased risk of harm to a victim of domestic abuse as well as children within the relationship; • stalking behaviour in the context of domestic abuse is an indicator of high risk and is significantly associate with dangerous acts; • the sharing of information between professional agencies is critical. **Recommendations:** • development of early help initiatives to help children talk about domestic abuse; • publicising and promoting the role for independent domestic violence advocates; • the use of public information notices to maximise the impact of warnings in cases of stalking.
2017 - Warwickshire - Child J Non-accidental leg fracture of a 7-month-old baby who had been on a child protection plan since birth and had been living in a mother and baby foster placement with her mother until aged 5-and-a-half-months.	• Family were known to agencies for about 6 years due to concerns about the care of 2 older children where a number of probable non-accidental injuries occurred and family violence and substance misuse were present in the household. These children were subsequently taken into care and adopted. After the placement in foster care ended, the mother was housed in	**Learning:** • importance of assessing the accuracy of current or historical concerns reported by others; • the need to respond flexibly to requests to house families in other local authority areas; • to consider what formalised support is required following a move out of a baby and mother foster placement. **Recommendations:**

	her home town some distance from the foster carer.	• to make arrangements for appropriate medical and health advice to be available at strategy meetings; • to consider how new professionals working with a family are made aware of the case history and reasons for decision making.
2017 - Warwickshire – Child T Death of a 23-month-old infant due to non-accidental injuries whilst in foster care in June 2013.	• Child T was a looked after child who was placed with foster carers in March 2013 as a result of injuries sustained whilst in his mother's care. In June 2013 Child T died following admission to hospital with non-accidental injuries.	**Learning:** • fostering social workers should consider the needs and wellbeing of the children in foster care from a safeguarding perspective, regular and consistent supervision of foster placements is crucial, unrealistic expectations and views of foster carers due to lack of knowledge of child development must be challenged and addressed through training. **Recommendations:** • social workers should be made aware of the need to formally register any concerns about the care offered by foster carers as complaints to be investigated.

NEGLECT		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2016 – Central Bedfordshire - Bethany Death of a girl, Bethany, aged 19 months on 11 April 2015. Cause of death was inconclusive after an open verdict at the inquest. **Background:** both parents had learning		**Learning:** • the assessment of parental capacity is essential; • vulnerability of the parents should not override the needs of the child;

difficulties and troubled childhoods. Concerns were expressed by professionals from pre-birth onwards as to the parenting capacity of both parents. Bethany had been the subject of a Child Protection Plan for Neglect from October 2013. A Care Order was put in place for Bethany to remain in her mother's care with the support of professionals and extended family. After key family members withdrew their support, the process to take Bethany into care was started. Bethany died before steps towards removal could be completed.		• family support was over-relied on in planning; • issues of professional bias. **Recommendations:** • the LSCB should examine parental assessment processes; • be able to identify and respond to neglect; • ensure multi-agency challenge processes are in place for child protection plans lasting longer than 9 months.
2016 – Swindon - Child D Death of a 2 week old baby boy, Child D who was found dead on the sofa after his mother fell asleep whilst breast feeding. **Background:** Child D was born prematurely and had been at home for 4 days at the time of his death. His mother was visited by midwives, his health visitor and his social worker in the days when he was bought home. Child S had sibling Child C living in the same home who was designated as a child in need. The mother also has 2 other children removed from her care. Child Ds mother spent much of her childhood in care and was known to misuse alcohol, took several overdoses and moved frequently to escape from domestic abuse	• include communication between agencies, professional standards, mothers impact on staff, safe sleeping, the impact of parental ill health and hospitalisation.	**Recommendations:** • training for staff about working with men, use of chronologies, identifying sexual exploitation and assessing parental capacity to change.
2017 – Anonymous – Alex Death of 11-year-old child with complex medical needs requiring a high level of input from a variety of practitioners and putting a high level of demand on those caring for the child, making it difficult to define the threshold for neglect.	Alex was diagnosed with cystic fibrosis (CF) at a year old. The parents separated when Alex was 5. There was evidence that the mother had experienced domestic abuse, coercion and control which continued with a partner who became Alex's stepfather. The stepfather had considerable influence in decision making and	**Learning:** • the importance of the child's wishes and feelings to influence their care; • practitioners had varying levels of knowledge in relation to the child's clinical needs;

	gave the impression of having parental responsibility. Alex's health deteriorated from age 6 and hospital admissions increased due to CF. Clinical staff were concerned about carers' capability to deliver the care needed.	• the cumulative nature and clinical implications of his illness were not fully understood by those working with the child; • the formal escalation procedure in place at the time was not used. **Recommendations:** • the importance of the voice of the child; • the importance of supervision in social work; • the need for formal processes and procedures to be in place to share information about children who meet the LSCB threshold level 3 criteria; • decision making in practice should include the history of the family dating back at least one year.
2017 – Dudley – Child P and Child H Death of a 2-year-4-month-old child (Child P) and a 7-month-old child (Child H) at home in unrelated incidents, with no specific cause of death identified.	• agencies had been involved with their families because of concerns about neglect and welfare of the children.	**Learning:** • inadequate and adult focussed assessments, failure to incorporate males in assessments, lack of professional curiosity and an over-optimistic view of parental ability to effect change, effects of substance misuse overlooked and poor information sharing. **Recommendations:** • requiring the preparation and consideration of an up to date genogram for all interagency meetings concerning a child's welfare. • Carry out an audit of cases to form a judgement on the impact of the Neglect Strategy.

		• Review arrangements for the timely completion of serious case reviews. • Ensure more effective consideration of mental health issue within assessments of the needs of children.
2017 – Kent – Child C Death of a girl aged 2 years-and-four-months in June 2015 caused by accidental ingestion of her mother's methadone.		**Learning:** • no documentary evidence about the views of the children or the ability of the mother to prioritise her children; • potential neglect not identified; • not every agency had a full picture of the children's needs and their reactive working was not conducive to identifying long term neglect; • there was lack of clarity about the safeguarding risk assessment process. **Recommendations:** • update training on resistant and hostile parents; • all agencies should use chronologies when carrying out risk assessments; • KSCB to review and update the training programme for working with substance misusing parents.
2017 – Rochdale – Child K Death of a baby girl, Child K, who drowned in a bath in the presence of her older brother and sister. The 3 young children were left alone in the bath while in the care of their mother. Child K was taken to hospital by ambulance where her death was confirmed. **Background:** history of domestic violence between Child K's parents, her brother was subject to a child protection plan in Bury because		**Learning:** • the police decision to interview Child K's brother shortly after the incident reflected poor communication between the police and children's services and poor judgement on the part of officers involved; • engagement with families who have additional need but who don't reach the threshold for extra help or reject it.

of this. The family had professional involvement from specialist services in Bury. Following their move to Rochdale the family lived in separate households with extensive contact and shared care. Child K was born in Rochdale where family accessed universal services. An offer of family support services was declined as Child K's mother was suspicious of social workers.		**Recommendations:** • the LSCB to conduct a multi-agency practice and service review on how agencies meet the needs of families who are reluctant to engage with services.
2017 – Staffordshire – Child B Death of a 14-month old girl in July 2014. Cause of death was not ascertained but there were concerns she had died while co-sleeping with her mother and maternal grandmother who were both believed to have been under the influence of alcohol.	• Child B and her siblings were on a child protection plan under the category of neglect. There were 5 critical incidents related to the mother's alcohol misuse	**Key findings:** • there were a number of missed opportunities to safeguard Child B and her siblings; • there was a tendency to parent-centred practice; • professionals did not listen to the views of Child B's siblings; • birth fathers were not involved in assessment and planning. **Recommendations**: • involving fathers and other significant men connected to a child in child protection cases; • listening to the voice of the child; • interagency communication.

SUDDEN UNEXPECTED DEATHS IN INFANTS AND CHILDREN		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**

SEXUAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2016 - Calderdale - Jeanette Sexual exploitation of a girl when she was aged between 13 and 15 by a large number of British Asian men of Pakistani heritage.	• Jeanette was her mother's carer from a young age; she was neglected and physically abused by her father; her mother died when she was 13 and she subsequently lived without parental supervision. She spent time outside the family home in the company of older men who gave her alcohol and drugs.	**Learning:** • the need to allocate a consistent children's social care worker; • the need for suitable forums to discuss children at risk; • the need for action to 'disrupt' the activities of the men who were abusing Jeanette; • the need for systems, practices and procedures in services to Children in Need and children at risk of sexual exploitation. **Recommendations:** • professionals working with children and young people are able to identify and act upon drug and/or alcohol use; • to ensure that perseverance is still a key component of any training on child exploitation; • to ensure that escalation procedures are fit for purpose, that all professionals are aware of their existence and are confident in using them; • a version of this report to be commissioned by the LSCB to use with young teenagers to make them more aware of the dangers of child sexual exploitation.
2016 - Devon - CN11 Bonnie	• child had been subject to a Child Protection Plan at birth and placed in the	**Learning:**

Sexual abuse of a girl aged 2-years-4-months in October 2014.	care of her maternal grandmother. The Special Guardianship Order (SGO) detailed the chaotic lifestyle and neglect by the mother and the risk of sexual abuse by the child's maternal grandfather. The grandparents had divorced over 12 years earlier but the grandmother subsequently allowed him access into the family home.	• predictive analysis of risk must include the history of family relationships and events to identify unresolved risks rather than submit to a rule of optimism; • the need for vigilance against the potential for disguised compliance; • ongoing monitoring with regular review of risk and need in kinship placements with a history of abuse in the family; • agencies engaged in child protection must ensure clear guidelines and advice to practitioners on the procedure for a forensic examination where there are concerns of sexual abuse. **Recommendations:** • include a series of questions offered as considerations to form the basis of an Action Plan in the light of findings of the review including: is there evidence of a good level of understanding of the signs and symptoms of domestic abuse and child sexual abuse amongst practitioners working in key agencies; • is there a culture of optimism in relation to domestic abuse; • and is there clarity across partner agencies for the process of referral into the Sexual Abuse Referral Centre (SARC).
2016 - Knowsley - Child Q and Child S Two independent cases involving two 12-year-olds at risk of child sexual exploitation (CSE).	• both children were victims of long term neglect and abuse and had developed very challenging behaviours. Child Q was placed separately from her siblings and had 12 documented placements. Child S was subject to monitoring and	**Learning:** • the importance in child sexual exploitation work to support the workforce. **Recommendations:**

	intervention by various agencies and at least 11 referrals were made before she was taken into care. Child Q was given alcohol and cocaine by the offender; Child S does not perceive herself to have been a victim of CSE.	• to evaluate the learning needs of multi-agency practitioners in relation to changing national guidance on what constitutes child sexual exploitation and reflect this in updated strategy and to encourage full participation of all relevant multi-agency partners in safeguarding work.
2016 – Norfolk – Child P Sexual abuse of a 15-year-old girl by her step-father. Child P disclosed two incidents of sexual abuse in 2014. Step-father pleaded guilty and received custodial sentence and mother imprisoned for her knowledge of and failure to prevent the offences.	step-father was a known sex offender - previous conviction for indecent assault on his 14-year-old sister and placed on the sex offenders' register. Child P's mother had a blood disorder (which Child P believed to be life threatening) and was taking medication for depression, learning difficulties noted. Child P was known to children's services and had frequent visits to A&E and GP during her childhood and referral to CAMHS. History of poor attendance at school and evidence she was being bullied. Evidence of physical abuse by mother.	**Learning:** • insufficient knowledge on the part of children's social care about the behaviour of sex offenders and fragmentation of available intelligence within or across agencies. **Recommendations:** • developing guidance for managing school absences reported by parents as health-related; • mandatory training for social workers about working with adults known to pose a risk to children; • training on the impact of domestic abuse for school nurses.
2016 – Wigan – Child F and Child G Sexual and physical abuse of Child F and Child G (sister and younger brother) by their stepfather over several years.	Child F made multiple disclosures to different professionals which were subsequently retracted. Mother was sexually abused as a child and had consecutive relationships with four men who posed a risk to herself and her children; the stepfather was previously implicated in causing serious injuries to a 6-month-old child. Both children were the subject of child protection plans. Following allegations of abuse by Child F in 2013 the stepfather was arrested; the investigation was closed because Child F was not	**Learning:** • professionals had limited understanding of how and why victims of abuse disclose and withdraw allegations; • the mother's parenting capacity was not formally assessed and no long term support plan was put in place; • the voices of Child F and Child G were ignored or disbelieved on some occasions. **Recommendations:**

	deemed a credible witness. She was removed from home during the investigation and informally fostered afterwards. Child G had denied previous allegations, but disclosed abuse in February 2014.	• family history and genealogy should be used to identify and assess patterns of risk; • the police should review evidence gathering practices in cases where a child has alleged abuse.
2017 – Bradford – Jack A teenage boy, Jack, was sexually abused over several years from the age of 13, by multiple adult males. He was visiting adult chat rooms, being groomed and meeting individuals who posed a severe risk to him.	• there was significant multi-agency support for Jack but services were not effective in keeping him safe from abuse. Good practice identified by the school and GPs.	**Learning:** • lack of understanding of technology-assisted abuse and its effects; • restricting a young person's access to technology will not keep them safe, we must educate children, young people, carers and parents in how to keep safe whilst online; • child protection procedures were inconsistently applied; • a lack of coordinated support for families and young people; • absence of leadership and planning **Recommendation:** • the need to investigate technology-assisted abuse and consider local responses to protect children and young people; • to seek assurance from police and children's social care that child protection processes are fit for purpose and that issues relating to practice identified by this case are being dealt with.
2017 – Buckinghamshire – Child sexual exploitation 1998-2016 Discusses all the cases of child sexual exploitation (CSE) in Buckinghamshire from	• looks at the chronology of events starting in 1998 and the operations and reviews since then. Outlines reviews carried out by Thames Valley Police, Children's Social	**Learning:** • identifies what needs to change in order to improve agencies' response to

1998-2016. Since 1998 there have been more than 10 Thames Valley Police operations across the county involving up to 100 children and young people. In 2013 a serious case review was undertaken to examine the response to 1 young person (J), but the impact of CSE on the other young people has not been reviewed.	Care and Buckinghamshire Safeguarding Children Board and the Misunderstood audit of peer-on-peer sexual exploitation. Explores the voice of those affected including interviews with 16 young people and 2 parents.	children, young people and adults facing CSE. **Recommendations:** • makes 14 recommendations including Buckinghamshire Safeguarding Children Board and Children's Social Care should facilitate discussions with organisations such as Young Carers, Youth Clubs and the Youth Service to ascertain how they can better engage with statutory agencies to safeguard young people at risk of CSE; • Buckinghamshire Safeguarding Adults Board should bring agencies together to ensure there is an appropriate, effective and coordinated response available to victims of CSE as they become adults.
2017 – Surrey - Child GG Concerns about child sexual exploitation (CSE) of a 16-year-old girl.	**Key issues:**	**Learning:** • lack of recognition among professionals of the risk of CSE as well as 'drift'; • lack of coordination of services; • the importance of relationship-based practice with children who have been involved in CSE; • the need to avoid blaming or holding children responsible for the abuse and CSE; • the importance of information sharing. **Recommendations**: • audit the extent to which children involved in or at risk of CSE are no longer blamed or held responsible and that records are respectful about the child and their family;

		• raise awareness of CSE with taxi drivers, hotels, after school clubs, youth groups, park wardens and sports clubs.
2017 – Trafford – Child PB Alleged sexual abuse of an adolescent boy by foster carers in 2 separate placements between 2013 and 2015. A criminal investigation was initiated but neither foster carer was charged with criminal offences.	**Key issues:** include: • Child PB became looked after aged 12 due to behavioural problems. His first long-term foster carer (FC1) requested that the placement be ended, citing ill health. PB was placed in a residential educational setting, living with a second foster carer (FC2) during weekends and holidays. His behaviour deteriorated and he was moved to a permanent residential placement. PB went missing several times, returning to FC2 although this was not always reported. On one occasion FC2 told police he hadn't seen PB, but PB was found hiding undressed at FC2's home. Despite FC2 being suspended as a foster carer, PB was persistently found at FC2's home. Weeks later, following therapeutic support, PB disclosed sexual abuse by both foster carers.	**Learning:** • although these disclosures have not led to prosecutions, the actions and behaviours of both foster carers should have led professionals to consider at a much earlier stage whether they could keep children in their care safe and whether they posed a risk to children placed with them. **Recommendations:** • ensure foster carer assessments and reviews are robust, thorough and appropriately challenging; • ensure supervision files have carefully maintained chronologies to support supervision and review so that any emerging concerns or issues can be addressed; • ensure all practitioners have a sound understanding of the range of characteristics, motivations and behaviours of people who seek to sexually abuse children.

BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**

2016 - East Sussex - Child M Death of a 17-year-old girl in March 2013 from a drug overdose. **Background:** Child M had had a relationship with an older man Mr C and had used drugs from the age of 13. She had gone missing and overdosed a number of times from 2008-2013. Child M was known to CAMHS, psychiatric and community drug services and social services in 6 local authorities. At the time of her death she was a looked after child under a Care Order to East Sussex County Council living in bed and breakfast accommodation in Hampshire. Thames Valley police issued Mr C with a Child abduction warning notice.		**Learning:** • draws attention to Child M's relationship with the older man Mr C. Although recognised as an exploitative relationship Mr C was referred to as Child M's 'boyfriend'; • recognises the vulnerability of young people going missing; • a lack of coordination in the early stages between Child M's school, substance misuse and mental health services and children's social care provision. **Recommendations:** • Surrey LSCB should ensure early help is better coordinated; • commissioners of substance misuse services should ensure coordinated prescribing arrangements and information sharing between GPs and mental health services; • East Sussex LSCB and member agencies should consider how it can improve health care for looked after children.
2016 - Nottinghamshire - NN15 Death of a 15-year-old girl in spring 2014 by hanging.	Alex lived with her mother and step-father and was only known to universal services. Six months before her death three of her friends had told school staff that Alex had been self-harming. Police investigations following her death found that she had been abused by a distant family member who was a convicted sex offender. He was arrested and committed suicide whilst on police bail.	**Learning:** • professionals need to be equipped with knowledge to recognise self-harm and take appropriate action according to their role; • students should be supported to know how to respond when they become aware of friends who self-harm or have suicidal thoughts; • police services need to be intrusive in their management of registered sex

		offenders and make use of dynamic risk assessment tools available to them. **Recommendations:** • the local authority should develop model guidance on self-harm for its schools; • the effectiveness of police management of registered sex offenders should be reviewed.
2017 – Anonymous - Martin Death of a 14-year-old boy in February 2016 initially thought to be due to suicide but, before the review was completed, an inquest determined the cause to be misadventure.	• Martin was an adolescent with mental health needs. His parents separated following domestic abuse by the father. Although there were concerns about his emotional wellbeing at home and school in December 2015, a referral to children's social care was not made.	**Learning:** • the challenge for professionals working with families where members have a range of complex needs; • need for coordination in provision of services across local authority boundaries; • specific practice issues were found which highlight the dilemmas faced by front-line practitioners when exercising professional judgement in their safeguarding practice. **Recommendations:** • to strengthen the sharing of information to ensure a whole family approach when working with children in blended families; • to re-launch the CAMHS pathways within the borough; • for the London Safeguarding Children Board to work with organisations across London to mitigate the risk to children where there is a lack of clarity associated with localised commissioning arrangements;

		• partner agencies should be asked that contracts with service providers include an expectation that they should fully participate in any serious case review process.
2017 – Enfield – Child YT Death of 17-year-old boy after his arrest for illegal entry into the UK and subsequent placement in foster care the day before.		**Recommendations:** • reviewing out of hours emergency child protection to record all aspects of vulnerability; • ensure the voice of the child is heard.
2017 – Rochdale – Child L Death of Child L aged 14 in 2016. A coroner's verdict found the cause of death to be 'death by misadventure'. **Background:** Child L was found hanging in her home in February 2016. Child L had attempted suicide in the previous 2 years by overdose and had a history of self-harming from the age of 7. She had witnessed persistent domestic abuse from an early age. Child L had contact with Child and Adolescent Mental Health Services (CAMHS) and Children's Social Care (CSC). A common assessment framework (CAF) and a Child in Need assessment were completed.		**Learning:** • keeping the focus on the child at risk when dealing with resistant parents or assessing parental capacity; • critical thinking skills are necessary when assessing families with complex dysfunction; • remaining attuned to the presence of unknown men. **Recommendations:** • all children assessed as medium to high risk through self-harm or suicide are referred directly to CSC to coordinate multi-agency working.
2017 - Thurrock – Harry Death of a 16-year-old Black British boy of West African parentage in a young offender institution (YOI). He had a history of epilepsy and a post-mortem examination confirmed death from natural causes.	A formal diagnosis of epilepsy was made at age 7. The diagnosis was not recorded by either primary or secondary school and prescribed medication may not have always been ingested. His aggressive behaviour caused concern from age 13; he was excluded from school on several occasions and 2 separate assaults of railway ticket inspectors led to his detention in the YOI.	**Learning:** • possible side effects of medication (aggression, impulsivity, violence) should have been explored; • annual reviews by the GP practice of medication should follow practice policy; • response times to medical emergencies in the YOI should be reviewed;

		• internal information sharing within the YOI should be improved. **Recommendations:** • the YOI should strengthen procedures around medical risk factors of under-18-year-olds; • the health provider at the YOI should undertake an audit of the ordering of medical tests to ensure procedural compliance; • school nurses should alert teaching staff if a pupil has a diagnosis of epilepsy; • NHS England should ensure that GP practices have policies in place with respect to regular medication reviews for children with epilepsy.

HOMICIDE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2016 – Lincolnshire - Alex Death of a 9-year-old boy in 2014. His grandfather was later convicted of his murder. **Background:** Alex had had little involvement with agencies. Alex's maternal grandfather lived with or near the family for the duration of Alex's life and had significant mental health problems. Adult mental health services provided constant contact with the grandfather and his family over a long period of time. Alex was drowned in the		**Learning:** • lack of robust risk assessment and care planning to protect family, carers and the public at the point of discharge from the inpatient facility. **Recommendations:** • mental health management teams in acute wards must ensure processes for risk assessment at all stages of treatment

bath in December 2014. His grandfather murdered Alex to draw attention to his desire to return to hospital care, following discharge from an acute inpatient mental health hospital ward.		and discharge to take account of carers and their families; • improvements to care pathway/treatment plans so that all patients are clinically assessed prior to transfer; • there should be a named consultant responsible for each patient's care and discharge; • adequate safeguarding children training to be embedded in all practices.
2017 - Isle of Wight – Child G Death of a 6-year-old girl, Child G, in summer 2016. It appears that her father killed her and her 2 dogs before killing himself	• Child G had never had any direct contact with children's social care. Some professionals described the father as having a learning disability although this was not formally diagnosed. He had regular periods of depression and had been referred for psychotherapy following 3 bereavements and the loss of his job. Child G and her mother were also referred for mental health support. The parents separated and mother had twice reported to the police that the father had gone missing because she was concerned about the risk of suicide. He was assessed by a psychological therapist as being at moderate risk of causing himself harm.	**Learning:** • professionals working with the father needed to consider how his mental health problems might affect Child G and what her needs might be. Risk assessments need to be continually updated as circumstances change. Having a child should not in itself be seen as a factor which can reduce a parent's risk level. **Recommendations:** • the safeguarding adults board and the safeguarding children board should develop a shared strategic approach to "Think Family". The joint working protocol for safeguarding children and young people whose parents/carers have problems with mental health, substance misuse, learning disability and emotional or psychological distress should be reviewed and made more accessible to practitioners from the multi-agency partnership.