South Gloucestershire Safeguarding Children Board News and Research

Quarter Four 2019

Domestic Abuse

Serious Case Reviews:

Serious Case Review: John *Author: Unnamed LSCB: Unnamed (January 2019)*

Multiple unexplained injuries to a disabled 2-year-6-month-old boy between October and December 2016. John suffered serious significant leg fractures more than once, with X-rays showing healing rib fractures; he was a child with disabilities who was not independently mobile and was pre-verbal. The case was subject to both Criminal Investigation and Family Court proceedings. Mother and partner initially arrested but the case was subsequently discontinued following evidence from doctors that a medical cause for the fractures could not be ruled out. John was known to health services for his developmental needs and social care as a Child in Need following incidents of domestic abuse. Maternal history of: child abuse, domestic violence and parental drug misuse. Father had a previous abusive relationship. Learning includes: John's disability needs were a distraction leading to a lack of focus on the vulnerabilities/risks to John following domestic abuse incidents; where there is suspicion of a potential non-accidental injury a formal Child Protection Medical should be undertaken to assess risk and inform decision-making; the response to the third incident of domestic abuse was not robust and left John and siblings at risk of harm; the Child in Need plan was not child focused. Recommendations to the LSCB: to seek assurance that the multi-agency response to domestic abuse is in line with its policies and procedures; to assure itself that the daily lived experience of children is central and captured in all the work partners undertake to promote their health and wellbeing

Full Overview Report available here

Serious Case Review: Child W8. *Author: Karen Perry LSCB: Walsall SCB (December 2018)*

Death of an 8-year-old child in January 2018. Child W8 was stabbed to death by her father. Child W8 lived with her mother and two siblings following her parents' separation in 2012. Mother and father were able to make arrangements for regular contact which took into account the children's needs. There had been two domestic abuse incidents in 2007 and 2012; police made a referral to children's social care after the second incident. In December 2017 Mother told Father about her new female partner, and following this there was a period of harassment. There were no concerns about Child W8 from when she started school in September 2013 until her death. Learning includes: sometimes very serious harm to children is not predictable; referrals and assessments should consider and record the dynamics of the domestic abuse as well as risks to children and ensure adequate support is provided; agencies made aware of domestic abuse incidents should proactively enquire about mother's and children's safety; mothers and children are better protected if midwives consistently use Routine Enquiry during pregnancy and the immediate postnatal period; entering a new relationship can be a risky time for families who have experienced domestic abuse. Recommendations include: evidence that practitioners show professional curiosity and are competent in working with families where domestic abuse is a feature; consider how to best raise awareness about the increased risks of violence at the point of leaving an abusive relationship and on discovery of a new relationship.

Full Overview Report available here

Linked Research & Resources:

Domestic Abuse Learning from Case Reviews This learning brief can be downloaded here

Domestic Violence and Abuse Training in South Gloucestershire: Multi Agency Training about Domestic Abuse is available at different levels. For more details and to book a place check here

South Gloucestershire Domestic Abuse Toolkit: Download a copy here

Mental Health/Substance Misuse

Serious Case Reviews:

Serious case review: Baby A *Author: Jane Carwardine/Melanie Hartley* *LSCB: St.Helens SCB (2018)*

Death of a 6-week-six-day-old girl found unresponsive on the couch next to her mother in November 2016. Baby A was born prematurely at 36-weeks' gestation. Mother sought help for her infant's feeding difficulties, vomiting and general unsettledness. At the time of her death, both parents had been drinking alcohol and were significantly intoxicated. Baby A's mother had a complex health and social history; substance misuse began when she was 12-years-old; her emotional and mental health challenges dated back to 2005 and in 2011 she was diagnosed with borderline personality disorder. Between 2009 and 2016 children's social care logged at least 13 contacts; a child protection referral was made by a consultant psychiatrist just before the birth of Baby A but the referral box was not ticked so was de-escalated to early help under midwifery and health visiting services. Learning: practitioners should be aware that pregnancy and post-delivery is a critical time for women to experience deterioration in their mental health; monitoring and assessing growth of new born, premature infants should be in line with expected practice standards; all relevant multi-agency professionals should be contacted for a core assessment; all agencies should contribute to effective information sharing. Recommendations: to ensure all early help guidance addresses the issues identified in this review; to seek assurance that 'Did Not Attend' policies contain clear guidance on the actions to be taken when adults with caring responsibilities fail to engage with services dealing with health issues that can adversely impact on parenting capacity.

Full Overview Report available here

Serious case review: Child BZ *Author: Nicki Walker-Hall* *LSCB: Blackpool SCB (2018)*

Death of a 13-week-old baby in March 2017 as the result of acute traumatic brain injury due to abusive head trauma. Father had called emergency services as baby BZ was unresponsive and not breathing. BZ admitted to hospital and injuries found to be consistent with abusive head trauma. BZ died two days later. Father was arrested for BZ's murder and was found guilty in March 2018. Mother had longstanding mental health problems, learning difficulties and a diagnosis of schizoaffective disorder. Father had a history of domestic abuse in a previous relationship. BZ was subject of a Child Protection plan at birth for emotional harm. Sibling had been the subject of Child Protection plan for neglect and physical abuse. Mother was detained under the Mental Health Act and Father became the sole carer for BZ. Key areas of learning include: historical information and understanding its importance and relevance to on-going work should be recognised to safeguard unborn and new-born babies; the practice of waiting until mothers are 30 weeks pregnant before a multi-agency approach is adopted in cases that meet the threshold for child protection may leave unborn babies and new-born babies at unnecessary risk. Recommendations to the Local Safeguarding Children Board include: review the arrangement around parenting assessments to ensure they are robust; seek assurance from Children's Social Care (CSC) that all assessments are subject to oversight, challenge and scrutiny by managers within CSC; seek assurance from CSC and adult mental health services that analysis of the effects of parents' behaviours on their children forms part of assessments and is evident within CP plans.

Linked Research & Resources:

SCIE - At a Glace Review: commissioned the University of York (Social Policy Research Unit) to carry out systematic reviews of research literature on parents with mental health problems (PMHPs). This is a summary of the findings, taking into account the quality of studies Find Review Here

NSPCC Learning from Case Reviews: Summary of Risk Factors and Learning

Non Accidental Head Injury

Serious Case Reviews:

Serious case review: Child V *Author: Jane Doherty* *LSCB: Greenwich SCB (2018)*

Death of a 3-month-old girl in November 2016 due to non-accidental head injury. Child V was in the care of her father whilst mother went shopping. Child V appeared lifeless and was taken to hospital. CT scans diagnosed a non-accidental head injury and rib fractures. Father was tried and acquitted of manslaughter and child cruelty. No charges were brought against the mother. Parents were known to children's social care, police and youth offending services and had a history of substance misuse and mental health problems. Mother failed to engage with health services on several occasions, particularly for antenatal care. Learning includes: lack of engagement with antenatal services poses a potential risk to the health and wellbeing of mothers and their babies; over-reliance on parental self-reporting can be susceptible to disguised compliance; professionals should be sufficiently curious about the father of the baby and extended family. Recommendations include: agencies to ensure that fathers are considered in assessments, this includes fathers, stepfathers and partners even when they do not reside with children; review

the multi agency pre-birth protocol to ensure it provides clarity on best practice in cases where women do not access antenatal care; review training programme to ensure that staff are aware of the risks associated with over reliance on self-reported information, lack of engagement and disguised compliance when working with families, including work with fathers.

Full Overview Report available here

Serious case review: Child BY *Author: Clare Hyde* *LSCB: Blackpool SCB (2018)*

Serious head injuries which were potentially non-accidental to a 3-month-old child in January 2017. Child BY is a twin, born prematurely at 35 weeks' gestation, discharged from hospital into a family with co-existing domestic abuse, mental illness and substance misuse and where father had just lost his brother. Family known to Child Protection Services for two older siblings; the twins were subject to Child Protection Plans at birth; various risk assessments were carried over a two year period. Family is White British. Issues identified include: the need to consider mother's full history and understand the impact of trauma, loss and ongoing abuse and coercion; severe risk of harm is most likely where there is an absence of protective factors; the need to consider male perpetrators in assessments and address or recognise their behaviour and accountability for it. Learning arising: to consider the approach to domestic abuse cases where the victim expresses a wish for the relationship to continue and how this impacts on the children; to ensure that practice and supervision are influenced by an understanding of the long term impact of unresolved childhood trauma, loss and abuse and serious and chronic domestic abuse and coercion on parenting capacity; to consider how agencies currently respond to families where neglect may co-exist with domestic abuse and that neglect is responded to as a safeguarding issue and not solely as a symptom of domestic abuse.

Full Overview Report available here

Linked Research & Resources:

Multi Agency Guidance for injuries to non-mobile babies: available here and Blue spots advice sheet available here

Neglect

Serious Case Reviews:

Serious case review report in respect of: Child G *Author: Sue Gregory* *LSCB: Lincolnshire LSCB (Dec 2018)*

Neglect of four siblings over a period of several years. Matthew admitted to hospital with a non-accidental head injury in November 2016, diagnosed as a fractured skull. Lincolnshire police investigated but case has now closed. Mother known to children's social care since 1997. Mother had a history of heroin use and offending behaviour. Several referrals to Children's Social Care from 2006-2013 related to parental drug misuse and family violence. Catherine taken to A&E for bumps and bruises believed to be related to poor parental supervision. Concerns about mother's heroin use whilst pregnant with Andrew. Twins born prematurely and diagnosed with Neo Natal Abstinence Syndrome. All siblings subject of child protection plans, stepped down to Children in Need in June 2016. Learning includes: when professionals do not have an understanding of the family history, relationships and functioning it is difficult to have a clear picture about what daily life is like for the children; significant decisions should be informed through key assessments being completed, including pre-birth parenting assessment and risk assessments. Recommendations include: seek assurance that the model used in assessing risk within conferences is being used effectively; seek assurance in the practice of Independent Child Protection Chairs and their management of conferences; consider establishing a practice by which CP plans should not be removed at the first review unless there are evidenced circumstances; seek assurance that the professional resolution and escalation procedure is understood and effectively applied in all partner organisations.

Full Overview Report available here

Serious case review: Rosie *Author: Catherine Powell* *LSCB: Bedford Borough SCB (Oct 2018)*

Life threatening and life changing neglect of a 3-year-6-month-old girl in September 2017. Rosie suffered neglect within her home environment by both biological parents and required emergency admission to a hospital children's ward with on-going specialist care. Rosie was found to be malnourished, unkempt, in poor physical health, socially isolated and developmentally delayed. Family was known to universal health services and receiving care from GP, health visiting and maternity services. Father was known to police relating to domestic abuse against a previous partner and substance misuse services. Evidence to suggest that both parents have learning difficulties. Rosie is White British. Learning includes: children who are suffering from neglect (and other forms of child maltreatment) may be 'hidden in plain sight'; pre-birth planning and assessments offer early help and support to vulnerable parents and ensure the future safety and well-being of the unborn child; more needs to be done to promote collegiate working,

respect and mutual understanding of others' roles and responsibilities, including the limitations in practice; all those delivering care to children, young people and their families must have the relevant competencies to do so. Recommendations include: seek assurances that practitioners are asking parents/carers why young children are not accessing early years' provision; ensure that practitioners delivering care to children, young people and their families have achieved, as a minimum, the competencies set out in the relevant professional guidance, including oversight from an appropriately qualified professional.

Full Overview Report available here

Serious Case Review: Madison *Author: Peter Maddocks LSCB: Nottinghamshire SCB (Feb 2018)*

Disclosure of abuse and asking to be taken into care by 16-year-old female child, who had been living with her mother, step-father and half siblings in March 2016. Extensive contact with various services during much of Madison's childhood for slow physical growth and speech development; records describe hair pulling, faltering growth and frequent absences from school and minor or unexplained injuries, looking underweight and frequently hungry. Her birth father died of a heart attack when Madison was an infant. Mother disclosed to GP that she did not love Madison. Children's social care were involved over a period of years identifying Madison as a child in need; section 47 enquiries were undertaken. In February 2016, the school nurse received a chronology of extensive child protection concerns from March 2003 to February 2016. Madison was taken into foster care in March 2016. Learning includes: the need to distinguish between behaviour that might indicate cruel rather than neglectful care; children more readily disclose information to adults such as teachers or health practitioners with whom they can trust; professionals must be aware and sceptical about how parents may seek to influence how information is processed; recognition and response to self-harm. Recommendations to the LSCB: to ensure the voice of the child is sought by professionals to appropriately inform judgements and decision making during enquiries and assessments; to ensure that chronologies are appropriately collated and analysed to inform judgements and decision making when concerns are raised in regard to child abuse.

Full Overview Report available here

Serious case review: Child FD17 *Authors: Glenys Johnston LSCB: Derby City SCB (2018)*

Serious injury of a 9-year-old child in October 2016 from burns caused by a scalding hot bath. Both parents were charged with neglect and were given suspended sentences. Family, which consisted of mother, father and 6 siblings, was of Roma heritage and moved from Slovakia to the UK in 2015. Family was known to health visitors, police, schools, fire service, children's services, housing services and doctors. Parents intermittently engaged with professionals but on occasions children were not taken to health appointments. Younger children were often left home alone with older siblings. Children were often absent from school and showed challenging behaviour. Following this incident concerns were also raised about the care of the youngest sibling who showed signs of significant neglect and all the children were placed in foster care. The children have since returned to Slovakia to live with their grandparents. Learning includes: the importance of obtaining a family history when a family moves to a new country and concerns are raised; importance of being able to communicate with families without sufficient interpreting services. Recommendations include: all agencies should ensure that their staff understand the impact of culture, race, and heritage when identifying neglect and they should not condone practices and beliefs that are not in accordance with practice in England.

Full Overview Report available here

Serious case review: Child N1 *Authors: Valerie Charles LSCB: Manchester SCB (Nov 2018)*

Death of a 3-year-old child in March 2017. Child N1 was found unresponsive in the bath; cause of death unascertained. Mother was convicted of two counts of neglect. Child N1 was an only child. Mother had a history of mental health problems and there were incidents of domestic abuse. Family frequently moved between different areas. Mother's cultural and ethnic heritage is Pakistani English, father is Pakistani, and both are of Muslim faith. Mother left the father a number of times and stayed with her family, but felt pressured to return to father by her family. Learning includes: importance of ensuring that communication has been received and is being acted on and timely transfer of records, particularly in cases where families are moving between areas; ensure the perspective and the daily lived experience of the children is the primary focus of professional intervention; importance of gaining the involvement and perspective of fathers to inform assessment and intervention; importance of routinely recording that there has been consideration of the need to make a safeguarding referral; importance of communication and information sharing between agencies and across areas when working with mobile families. Recommendations: to ensure that where enquiries are being made under section 47 of the Children Act 1989, all relevant agencies are involved in strategy meetings or discussions to share and evaluate information, and plan the work.

Full Overview Report available here

Linked Research & Resources:

Joint targeted area inspections to focus on children living with neglect: Overview of findings available here

South Gloucestershire Neglect Toolkit: Available here

Neglect Mapping Resource. Research in Practice has produced a Mapping Resource bringing together a selection of Research in Practice resources to help the sector build evidence-informed learning and development pathways in relation to child neglect. View the Mapping Resource

Sexual Abuse

Serious Case Reviews:

Serious case review Family A *Author: Mark Dalton* *LSCB: Somerset SCB (2018)*

Significant neglect and sexual abuse of three children over a 15-year-period, resulting in care proceedings for the youngest and middle child in 2017. Referrals were first made to children's social care in 2003 regarding neglect; formal investigations of sexual abuse began with a disclosure by the oldest child in 2017. Parents had been offered help from multiple agencies over a number of years which they declined. History of poor school attendance and missed health appointments. The youngest child has a diagnosed learning need and behaved in ways that were indicative of sexual abuse; this was not fully investigated as the mother did not to give consent for the child to be interviewed. The older two children also made allegations of sexual abuse that were not investigated fully. Key issues and learning focus on: the long-term impact of chronic neglect; vulnerabilities of children with additional needs; safeguarding practice in the schools; school attendance; engagement of parents presenting as hostile; and professional differences. Recommendations include: frontline practitioners working with children and families from all agencies should be trained to work with families who display aggressive and evasive behaviour; child protection supervision for all cases where children are the subjects of Child Protection Plans or Child in Need plans must be a priority for all agencies; family support advisors should keep professional records of their involvement with families.

Full Overview Report available here

Linked Research & Resources:

Training in South Gloucestershire: Details here

Sexually Harmful Behaviour

Serious Case Reviews:

Serious Case Review: Peter 17 years: John 15 years: Tom 11 years: Christopher 9 years

Author: Mark Dalton LSCB: Dudley SCB (2018)

Concerns sexually harmful behaviour between three adolescent males aged 17, 15 and 11-years and the sexual abuse of a 9-year-old boy placed together in local authority foster care. The four young people shared some characteristics in terms of exposure to inappropriate sexual behaviour, neglectful parenting and, with one exception, several changes of placement. The foster home was approved for two children, or three if siblings, and males only. Success with John had led to overconfidence by social workers in the ability of the foster carers to prevent abusive behaviour occurring within the home. Approvals for the placement were obtained retrospectively, with little or no evidence of management oversight or challenge. Learning: none of the children, apart from Tom , received the necessary therapeutic support to enable them to adjust to foster care; there was a need to address their psychological and emotional problems not just physical needs; there was drift and delay in enacting decisions taken at Looked After Child reviews; the local authority did not have sufficient carers to provide suitable placements; the impact on the foster carers discovering sexual abuse should not be underestimated; important to understand barriers to using formal procedures for escalating concerns; social workers were under extreme pressure with an unstable workforce with high caseloads. Recommendations to the LSCB include: Children's Services must ensure that the procedure on variations and exemptions to usual fostering limits is adhered to; ensure compliance with placement procedures with placement planning meetings taking place prior to placement; to review the current provision for young people who display sexually harmful behaviour

Full Overview Report available here

Linked Research & Resources:

South Gloucestershire Guidance: find a copy here

Exploitation/Gang Affiliation/Trafficking

Serious Case Reviews:

Serious case review: Chris *Author: Nicky Hill* *LSCB: Newham SCB (Aug 2018)*

Death of a 14-year-old boy in September 2017 as the result of a bullet wound to his head. Chris was shot at close range from a stolen vehicle whilst in a group of four young people. Ongoing murder enquiry with no arrests made in relation to Chris's death. Chris lived with his mother and sister and later his maternal grandfather; parents' relationship had broken down due to domestic abuse. Chris diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder which caused behavioural problems at home and school. Family was known to several agencies, including police, prior to Chris's death. Chris moved school and was groomed by a gang to sell drugs; disclosed to his mother who subsequently disposed of a quantity of Class A drugs in Chris's possession that belonged to drug dealers. Chris told Children's Social Care that he feared for his life. Chris identified as being of Caribbean heritage. Learning includes: lack of analysis and professional curiosity in assessment can negatively affect understanding of a child's development and vulnerabilities; not sharing information between agencies can leave practitioners with an incomplete oversight of the presenting issues. Recommendations include: increase cross-agency awareness of the role social media plays in gang tensions and violence; review processes for the relocation of young people and families out of Newham; where multiple risk indicators exist, consider additional transitional support between primary and secondary education with a focus on child criminal exploitation and gang affiliation.

Full Overview Report available here

Serious case review: Peter *Author: Malcolm Ross* *LSCB: Nottinghamshire SCB (Oct 2018)*

Death of a 16-year-old boy by suicide in June 2017. Peter was known to multiple agencies including children's social care (CSC) and child and adolescent mental health services (CAMHS) in relation to self-harm, obsessive compulsive disorder, body image, eating disorder, his sexuality and possible child sexual exploitation (CSE). Peter struggled with his own identity. Attempts at agency intervention declined by Peter and mother. Peers suggested that Peter was meeting men for money in exchange for sex arranged over social media. Peter's father was concerned that Peter had a lot of unaccounted for money. Learning includes: professionals should make notes of disclosures made by children as soon as possible after the conversation, which must not include leading questions; notes must be suitable for disclosure to any future enquiry or investigation. Recommendations include: ensure that staff understand, in line with the school's updated policy, that it is not the role of staff to investigate disclosures by interviewing the child or others involved, unless asked to do so by police, CSC or NSPCC; review the interagency CSE procedures to ensure that when there are sufficient concerns to support a section 47 enquiry that the appropriate multi-agency response is triggered; undertake an audit of CSE meetings; promote the increased use of the Early Help Assessment Framework by agencies and explore the barriers which prevent professionals from completing them.

Full Overview Report available here

Serious case review: Child C *Author: Geoff Corre* *LSCB: Shropshire SCB (Nov 2018)*

Death of 17-year-old male child from Vietnam in December 2016 by drug misuse. Child C presented to services as an unaccompanied asylum-seeking child in April 2016 after being discovered in a lorry in Shropshire. Child C was suspected to have been trafficked into the UK. During the review process it was established that Child C was in fact an adult being 21 years of age. Child C went missing from his foster care placement within days of being placed. He remained as a missing person, until he was found deceased in Derbyshire. Child C was known to police, social services and health services. Learning includes: a number of issues concerning agencies' awareness of the indicators of trafficking and associated risks, their assessment of young people who present as unaccompanied asylum seekers, the management of risk in cases where children remain missing for a long time and the impact of a child's status on how they are managed and reviewed. Recommendations include: interagency guidance on children who present as unaccompanied asylum seekers and trafficked children should have a dedicated referral pathway that outlines the role of each agency; national guidance should be issued to clarify how Police and Local Authorities work together and agree on who takes primacy in the identification and confirmation of age of a person who presents as an unaccompanied asylum-seeking child.

Full Overview Report available here

Linked Research & Resources:

South Gloucestershire Exploitation Information: available here and training available here

Care of Unaccompanied Migrant Children and Victims of Modern Slavery: Statutory Guidance here

Criminal Exploitation Toolkit: available here