South Gloucestershire Safeguarding Children Board News and Research

Quarter Four

## Domestic Abuse

**Serious Case Reviews:**

*Serious Case Review: Case R* *Author: Briony Ladbury LSCB: Norfolk Safeguarding Children Board (January 2017)*

Two young parents: born 1993. Were together for four years up until the incident leading to this SCR. Mother had history of a domestic abuse incident with previous boyfriend in 2010, aged 17. Not referred as a safeguarding issue, although she was under 18. Father suffered from anxiety, unknown to mother, which was exacerbated by drugs and alcohol, leading to occasional violent outbursts. Baby R born summer 2014. Health Visiting Service offered targeted support via a Universal Plus Pathway, due to mother's young age. Baby R aged 10 weeks: police called to an incident involving mother, father, baby and a neighbour. Father drunk and abusive, Mother pulled to the ground with baby in arms, resulting in baby alone on the pavement beside the altercation. Father carries baby indoors and lays down on broken glass. Baby R was uninjured. Ambulance called to take mother and baby to hospital. Father arrested. Parents reunite after period apart. May 2015: Baby R sustained life threatening injuries. Father arrested at hospital. Later sentenced to three years for Grievous Bodily Harm. Mother and father have not seen each other since. Baby makes full recovery and is doing well back in the care of his mother. Recommendations include use of risk assessment tools to improve the overall response to babies, children and young people experiencing domestic abuse in the county including within multi-agency forums and MARAC. Review of out of hours responses to child protection. Child centred risk assessment within Domestic Abuse cases.

*Serious Case Review: Child BB.* *Author: Arthur Wing LSCB: Surrey Safeguarding Children Board (March 2017)*

Death of a 23-month old child in May 2014 due to non-accidental injuries. 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. Child BB and the mother were only known to universal services and none of the agencies were aware of any concerns about the child's wellbeing, nor were they aware that the mother was in a recent relationship with a man whom she met through an online dating site, with a history of domestic violence and allegations of ill-treatment of children in another local authority area. Key findings: concerns regarding inter-agency communications between police, probation services and children's services about incidents and call-outs in relation to domestic violence in the other local authority area; 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.

**Linked Research & Resources:**

*Domestic Violence and Abuse Training in South Gloucestershire:* There is a new training pathway for inter-agency Domestic Violence and Abuse training in South Gloucestershire. You can build up your knowledge and skills from an introductory e-learning module through to the level of training that you need to fit your job role. There are lots of course dates available in 2017-18 **Further Information**: http://learning.southglos.gov.uk

*Responding to domestic abuse: a resource for health professionals*. Authors: Department of Health: Aims to support continuing improvement in the health service response to domestic abuse. Includes actions to take to support adult victims and young people over 16 who are in abusive partner relationships; includes actions to protect dependent children from neglect and harm that may result from parental experiences of domestic abuse. Designed to inform health and social care professional planning as well as local commissioning and operational planning. Go to publication

*Young children exposed to intimate partner violence describe their abused parent: a qualitative study.* Authors: Karin Pernebo, Kjerstin Almqvist. Summary: Explores how children who have witnessed intimate partner violence describe their abused parent, and their relationship. A thematic analysis of interviews with 17 children aged 4 to 12 years who had witnessed intimate partner violence identified a number of themes: coherent accounts of the parent; deficient accounts of the parent; and the parent as a trigger of trauma. Findings showed that children are able to talk about their abused parent and reflect on their relationship with that parent, and highlight the benefit of including children in research. Journal of family violence (Vol.32, No.2), February 2017, pp 169-178 Go to publication

*Posttraumatic stress disorder in children exposed to intimate partner violence: the clinical picture of physiological arousal symptoms.* Authors: Sarah R. Horn, Laura E. Miller-Graff, Maria M. Galano, Sandra A. Graham-Bermann. Summary: Explores post-traumatic stress disorder in young children who have experienced domestic violence. Uses data from therapists' qualitative reports of 56 children aged 6 years and below exposed to intimate partner violence. Findings revealed that children were most likely to show emotion dysregulation, behavioural outbursts, mood swings and temper tantrums. Discusses implications for clinical practice.Journal: Child care in practice (Vol.23, No.1), January 2017, pp 90-103 Go to publication

*Domestic abuse and safeguarding children: critical issues for multiagency work.* Authors: Sue Peckover, Berenice Golding. Summary: Reports on the learning from a development project aiming to improve multiagency work in domestic abuse and safeguarding children. The project ran from 2011-13 and was led by WomenCentre and was undertaken in nine local authorities in the north of England. Recommendations for improvements to multiagency work to achieve better outcomes for women and children are discussed. Journal: Child abuse review (Vol.26, No.1), 2017, pp 40-50. Go to publication

## Mental Health

**Serious Case Reviews:**

*Serious case review: Child B* *Author: Malcolm Ward LSCB: Merton Safeguarding Children Board (January 2017)*

Serious physical assault in September 2015 of a 16-year-old girl, Child B, 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. B became a looked after child. 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. Lessons learned include: 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. Uses the Multi-Agency Child Practice Review methodology and recommendations include: 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.

**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 S* *Author: Sian Griffiths LSCB: Norfolk Safeguarding Children Board (January 2017)*

In July 2015 Child S, who was 3 years old, was taken by ambulance to the family's local Hospital Accident and Emergency Department with a serious head injury and other bruising on her body. Her mother's partner, who had been caring for Child S at the time was charged with Section 201 Grievous Bodily Harm and was subsequently sentenced to 32 months in prison. There were serious concerns initially about the possibility that Child S might have sustained permanent physical impairment as a result of the head injury. However, Child S made a good recovery with no evidence of permanent injury. Following

her admission to hospital both Child S and her younger sibling were placed on Interim Care Orders by the Family Court and were subsequently made subject to Special Guardianship Orders within their extended family. Recommendations included that a review is undertaken to consider the effectiveness of professional consultations provided by Children's Services in which the child concerned is not named. Also that the Board to seek assurance that proper mechanisms and support systems are in place in order to ensure that Early Years practitioners are aware of the Board's safeguarding priorities; understand the way in which multi-agency systems for protecting children work in Norfolk and know how to seek professional support when concerned about safeguarding children.

**Linked Research & Resources:**

*NSPCC Physical Abuse Research and Resources* Resources

## Neglect

**Serious Case Reviews:**

*Serious case review report in respect of: Child E* *Author: Kevin Ball LSCB: Luton Local Safeguarding Children Board*

Death of a 7-month old child of British and Pakistani background in January 2014. A post mortem indicated failure to thrive, dehydration and malnutrition as contributory factors. The mother and maternal grandmother were later found guilty of child cruelty. Child E was born prematurely and lived with the mother and two older siblings in the maternal grandmother's home. The father did not live with the family. There was contact with midwives, health visitors, the GP and hospital services including Accident and Emergency dating from before Child E's birth until the death. Hospital and GP appointments were missed and a number of home visits denied. Concerns were expressed by health visitors about cigarette smoke, a cluttered and dirty home environment and bed sharing. Findings include: failure to recognise a young mother struggling to cope with parenting; assessment tools were not implemented; lack of coordination in transferring cases between health visitors; the mother's failure to engage with services was not noticed; an intervention would have either helped Child E get better care or highlighted the true level of risk. Recommendations were made for Cambridgeshire County Services (CCS) and Luton and Dunstable University Hospital (LDUH), Luton Children and Learning Department and Luton LSCB. These include being aware of the importance of weight gain over time in premature babies and recording this; professionals working in Luton should be able to implement a multi-agency strategy for the assessment of neglect which sets practice standards for the use of assessment frameworks and tools.

*Serious case review: Child BW* *Author: Amanda Clarke and Kathy Webster LSCB: Blackpool SCB (Feb 2017)*

Death of 3-month old child in 2015 due to medical causes. A child protection plan had been in place one year before the death for child BW and siblings, who lived with their mother, due to concerns of neglect. In 2013 there had been concerns about neglect when family lived in a different area, which resulted in a common assessment framework process being started to support the family. A 'Getting it Right Assessment' was completed in 2014 due to increasing concerns about the family. Issues identified include: views on a good enough home environment can be subjective and is complicated by working in a deprived area; safe sleep advice had been provided but was not followed; mother's disguised compliance may have added to the optimistic view of her intentions and capacity to change. Good practice identified: robust information sharing processes and good local professional relationships. Recommendations include: wider promotion and clarification for staff of the Graded Care Profile 2, and any other agreed neglect assessment tool for the multi-agency partnership; audit on how expected outcomes are recorded on Children's Services' documentation particularly Child Protection Plans, to clearly highlight what difference is expected to be made, and the consequences should positive change not occur; audit of pre-birth child protection 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 the Multi-Agency Pre-birth protocol; review of position of progress of the recommendation regarding safe sleep assessment from an earlier serious case review ; develop training on non- engagement and disguised compliance.

*Serious Case Review: LN15* *Author: Hayley Frame LSCB: Nottinghamshire Safeguarding Children Board*

Death of an 8-year-old boy in October 2014 as a result of a normally treatable kidney infection. LN15 was known to paediatric services from the age of 14 months for developmental delay, chronic constipation and floppiness. Attendance at physiotherapy, neurology and occupational therapy appointments was sporadic and he was not registered with a GP for two years before his death. In September 2014 his school attendance decreased due to ill health. Issues identified include: correspondence not received due to frequent house moves; not seen by paediatric services for three and a half years prior to his death; safeguarding issues when a child is not registered with a doctor especially those with long term conditions; evidence of the mother making decisions about treatment and medication; the child's needs and global development not recorded by staff caring for him. Lessons learned

include: changes to practices at the Trust including an end to the partial booking system for children and provision of a key worker to link between services; the need to record address, telephone number and GP details at every appointment; updating interagency cross authority procedures to provide more detail of medical neglect. Makes recommendations to strengthen cooperation between hospital-based services and general practitioners; to have policies in place to change Did Not Attend records to Was Not Brought to emphasise the child's vulnerability; for NHS England to review Royal College of Paediatrics and Child Care standards for the care of children with long term health conditions.

*Serious case review: Young Person* *Authors: Fran Pearson and Jan Horwath LSCB: Halton SCB (March 2017)*

A 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 the young person was taken into care due to concerns about his health and the cumulative effects of neglect. The 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. Issues include: from early age, professionals held information about the 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. Uses the Social Care Institute for Excellence (SCIE) Learning Together model to identify 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

*Serious case review: Child Q* *Authors: Sally Trench and Anne Morgan LSCB: Oxfordshire SCB (2017)*

Child Q, 14 months old, died from an apparent drowning in the bathtub at her family home. At the time, Q and her 5-year old half-sister were both subjects of Child Protection (CP) Plans, under the category of Neglect. This review has used the SCIE Learning Together model – a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Findings include: CP Plans for Neglect do not consistently spell out the specific risks to children and the consequences if the desired outcomes for their improved safety are not achieved. As a result, the professionals involved are less clear and confident about when to take protective action. Being proactive about incidents regarding children already subject to a CP plan. Risk of 'start again' when cases are transferred. Lack of engagement with fathers. Timely distribution of plans and minute of CP conferences vital for effective implementation.

*Serious Case Review: Child R* *Author: Nicki Walker-Hall LSCB: Salford Safeguarding Children Board (March 2017)*

Serious harm caused by the medical and nutritional neglect of Child R, aged 3 years and 9 months. His parents were arrested for neglect in October 2015 but released without charges. His siblings, Child A and Child B, were taken into care. Child R had short gut syndrome following complications of a premature birth and bowel surgery. He received nutritional support administered by his mother at home. The family received support from a large number of health practitioners. Child A was subject to a child protection plan under the category of neglect for 3 months. Following a referral from medical staff and an initial assessment, a Team around the Child process was recommended but the family declined a Common Assessment Framework (CAF) process and services from tenancy and family support workers. Concerns included: homelessness, a limited support network, substance misuse and strained relationships with professionals. Both parents were looked after and had a number of different placements. Findings include: not recognising R as a child with a disability resulted in a missed opportunity to assess his needs and provide early help services; practitioners had insufficient understanding of the parents' backgrounds and experiences and how these affected their attitudes towards disability, health and social services; the lack of a multi-agency approach with an allocated lead professional led to poor co-ordination of services and impeded information sharing. Recommendations include: Section 85 notifications of prolonged admissions to hospital of a child with a disability or complex chronic health condition should lead to an assessment of need by the local authority; health partners should arrange multi-agency participation at discharge planning meetings for children with complex health needs or a disability and a lead professional should be allocated to the family as soon as possible.

**Linked Research & Resources:**

*Joint targeted area inspections to focus on children living with neglect* Ofsted, the Care Quality Commission, HM Inspectorate of Constabulary, and HM Inspectorate of Probation have announced a series of six joint targeted area inspections (JTAI) to examine how local partner agencies, including local authorities, health and probation services and the police, are working together to protect children living with, or at risk of, neglect in England. The inspections, starting in May 2017, will focus on the experiences of children aged between 7 and 15 years old, who may be at higher risk of going missing or being exploited, or who exhibit challenging behaviours in adolescence. Guidance for inspectors has been published. **Source:** Ofsted, Care Quality

Commission, HM Inspectorate of Constabulary, and HM Inspectorate of Probation **Date:** 18 April 2017 **Further information:** Guidance joint inspections of the response to children experiencing neglect: May to December 2017 (PDF)

*The impacts of abuse and neglect on children; and comparison of different placement options: evidence review.* Authors: Department for Education (DfE), Research in Practice, Julie Wilkinson, Susannah Bowyer. Summary: Summary of key research findings on the impacts of abuse and neglect on children, and the strengths and weaknesses of different types of long-term placements in relation to their impact on children. Focuses on key UK research from 2000 to 2016, making reference to relevant international evidence. Key messages include: abuse and neglect have adverse impacts for most children; decision makers should assess different permanence options to determine which placement will best meet children's needs through the whole of their childhood and beyond; children and young people may need therapeutic support to help them recover from maltreatment. Publication details: London: Department for Education (DfE), 2017 Go to publication

*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

*Improving child dental health* Public Health England has published a resource outlining how health professionals can help prevent tooth decay in children under 5. It includes an outline of the impact poor oral health has on children and families and stresses that it may also be indicative of dental neglect as well as wider safeguarding issues. Source: Public Health England Date: 14 June 2017

## Harmful Sexual Behaviour

**Serious Case Reviews:**

*Serious case review into services provided to Child F and Family* *Author: Alan Bedford LSCB: Unnamed*

Harmful sexual behaviour and death of 17-year-old in 2015 as the result of stab wounds. Child F lived with his mother, and experienced uncertainty related to the family not having their residence in the UK regularised, poverty and poor housing which affected his health. Maternal history of abuse, domestic violence and mental health problems. Father deported in 2006 following imprisonment for serious drug offence. Assessed as 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. Learning points identified include: when cases are not pursued in the public interest it is still necessary for the young perpetrator to be given a full understanding of the implications of his actions face to face; lack of support for mental health needs due to referrals to and fro between agencies; good chronologies of key events would help spot risks; impact of long bail periods should be recognised and support should be provided to young person; agencies should take great care when describing sex as consensual when in law it cannot be; young teenagers are often unclear about consent. Recommendations include: review safeguarding approach to child perpetrators of sexual abuse and harmful sexual behaviour; encourage education providers to ensure law around consent is explained clearly; ensure that a young person's stated concern about violent risks to them is taken seriously by agencies.

**Linked Research & Resources:**

*Technology-assisted harmful sexual behaviour* The NSPCC has published a report analysing data from their Turn the Page service, which supports children and young people aged 5-18 who display harmful sexual behaviour (HSB), looking at the characteristics of children and young people who display HSB using online and mobile channels. Findings from analysis of 275 cases and case file data from a random sample of 91 boys and young men include: 46% of all the children and young people who were assessed for Turn the Page displayed some form of Technology-assisted harmful sexual behaviour (TA-HSB), including 7% who only displayed TA-HSB with no offline HSB; within the random sample of boys and young men, the most common form of TA-HSB was the possession, making and/or distribution of indecent images of children; the developmentally inappropriate use of pornography was identified as a trigger for offline HSB in more than half of the cases where boys and young men displayed both offline and TA-HSB. Source: NSPCC Date: 18 May 2017 Further information: Children and young people who engage in technology-assisted harmful sexual behaviour: a study of their behaviours, backgrounds and characteristics (PDF)

## Special Guardianship Orders

**Serious Case Reviews:**

*Serious Case Review: Child A and Child B* *Author: Kevin Harrington LSCB: Oxfordshire SCB (March 2017)*

This Serious Case Review (SCR) concerns two siblings, referred to in this report as Child A and Child B, who were both under 5 years old at the relevant times. There had been concerns for the welfare of the children throughout their lives. They both had special needs, as did their birth parents. They had lived, separately and together, with a number of different carers. There had been extensive involvement with health and social care agencies and the Family Court. That involvement had led to the placement of the children with a couple, Mr K and Ms L, under a Special Guardianship Order (SGO) made by the Family Court. They lived with them for about a year but were removed when evidence emerged suggesting they both had been seriously sexually and physically abused by Mr K. A number of serious criminal charges were brought against him, some of which were found proved. He received a very lengthy custodial sentence as a result. Recommendations included that the Board should use its arrangements for disseminating the learning arising from Serious Case Reviews to highlight the particular vulnerability to abuse of children with disabilities and special needs. The Board should require the local authority to demonstrate that it has used the findings of this review to inform its arrangements for care planning for "looked after" children with particular reference to:

- Working with families where there have been long standing child care concerns
- Responding to new child protection concerns
- The use of Special Guardianship, with particular reference to the involvement of the Permanent Placements Panel
- The use of Family Group Conferences
- The arrangements for assessing whether siblings in care should be placed together or separately

*Serious case review: Shi-Anne Downer (birth name): AKA Keegan Downer: born on 9th March 2014: died on 5th September 2015 aged 18 months*

*Author: Russell Wate* *LSCB: Birmingham Safeguarding Children Board (Feb 2017)*

Death of Shi-Anne Downer, 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 number of months; Shi-Anne's guardian was subsequently convicted of murder. Shi-Anne's mother had a history of drug abuse, mental health issues, reluctance to engage with services and time in prison; her father was in prison at the time of her birth; and her five 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). Her guardian was not related to Shi-Anne but had previously been married to Shi-Anne's father's cousin, and her name was put forward by a family friend. Issues identified include: 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 five years later; the assessments for the 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. Uses a blended methodology to establish lessons that can be learned, including: ensure all relevant checks are carried out and consider the need for a period of monitoring before a SGO is finalised.

**Linked Research & Resources:**

*Special guardianship orders.* An article in Community Care reports on recent serious case reviews where children have died while under the care of a special guardian, and highlights concerns about how Special Guardianship Orders are being used. **Source:** Community Care **Date:** 27 April 2017

*Special guardianship orders.* Authors: Kamena Dorling. Summary: Looks at special guardianship orders and the need for rigorous assessments when placing a child with a special guardian. Findings from the case review of Keegan Downer, an 18-month-old, revealed that flawed assessments and decision-making led to her death after she was placed in the care of a special guardian. Describes statutory guidance from the Department for Education and amendments following concerns over poor-quality assessments, potentially risky placements and inadequate support for special guardians. Journal: Children and young people now, 28 March-10 April 2017, pp 32

*Briefing: safeguarding lessons.* Farrer & Co has published a briefing looking at what can be learned from the death of Shanay Walker, a seven year old girl who died from a brain injury in July 2014 while under a special guardianship order. Lessons for all organisations working with children include: reminding staff that they all have a responsibility to identify children suffering or likely to suffer significant harm and to alert others to their concerns; routinely follow up referrals to children's social care in writing; information which suggests that a child has self-harmed should be taken very seriously, particularly in primary age children where self-harm is rare. Source: Farrer & Co Date: 23 May 2017

*Making noise – short animation* The University of Bedfordshire in partnership with the NSPCC has released a short animation to help practitioners gain insight into the feelings and perspectives of children affected by child sexual abuse in the family. The film puts the focus on children and young people's voices for positive change after sexual abuse, and was produced in partnership with a group of young people who advised on the Making Noise research project and its dissemination. Source: YouTube Date: 20 April 2017