South Gloucestershire Safeguarding Children Board News and Research

Quarter Two

Domestic Abuse

Serious Case Reviews:

Serious case review: Child B *Author: Keith Ibbetson LSCB: Camden Safeguarding Children Board (2016)*

Serious injury of a nine-week-old girl resulting in permanent disability in November 2014. The 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 were in their early twenties and had been known to a number of services in Camden, including mental health services and a young parents' support service following a domestic abuse incident. Child B's mother had briefly been looked after by a London local authority as a child. Findings include: 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 include: 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 violence; LSCBs and training providers should take account of the 'halo effect' of seemingly cooperative parents; the LSCB should work with commissioners to ensure perinatal services are consistent and accept post-natal as well as antenatal referrals; the LSCB should consider what steps can be taken to improve effectiveness of risk assessments for children affected by domestic violence. Full Report Here

Serious case review: Child K *Author: James Blewett LSCB: Rochdale Borough Safeguarding Children Board (Jan 2017)*

Death of a baby girl who drowned in a bath in the presence of her older brother and sister. The three young children had been left alone in the bath whilst in the care of their mother. Child K's family had professional involvement from specialist services and there was a history of domestic violence. One sibling had been subject to a child protection plan. Following a move to Rochdale the family lived in separate households with Child K's sister living with her mother and her brother living with her father. There was extensive contact and shared care. Child K was born in Rochdale. Child K's mother reported to her GP that she was feeling depressed following the birth but an offer of family support services were declined as Child K's mother was suspicious of social workers. Issues identified include: poor decision-making by the police reflecting poor communication between the police and children's services and poor judgement on the part of the officers involved; the need to find ways of engaging with families who do not reach the threshold for extra help or reject it. Sets out findings using the RBSCB Systems Model which is not a full scale systems review and is used for reviews which are less complex and/or where there has been limited professional involvement. Recommendations include: 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. Full report here

Linked Research & Resources:

Children living with domestic abuse. Ofsted has published a report looking at the extent to which children's social care, health professionals, the police and probation officers are effective in safeguarding children who live with domestic abuse. Findings from joint targeted area inspections (JTAIs) Find the report here

Domestic Abuse Recovering Together (DART) Evaluates the DART intervention, a group work programme for mothers and children who have experienced domestic abuse. Find the report here

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

Adolescence

Serious Case Reviews:

Serious case review: Martin *Author: Jane Wonnacott*
Published by NSPCC on behalf of an unnamed London local safeguarding children board (Spring 2017)

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; the mother moved to London from a rural location to live with a new partner and two teenage daughters who had experienced a troubled childhood. Martin received special education provision, first from a home tutor and then in a special school outside the borough. Although there were worrying concerns about his emotional wellbeing at home and school in December 2015, a referral to children's social care was not made. Issues identified include: the challenge for professionals working with families where members have a range of complex needs; lack of 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 include: to strengthen the sharing of information to ensure a whole family approach when working with children in complex, blended families; to re-launch the CAMHS pathways within the borough; to review the effectiveness in which Education Health and Care plans are shared with health professionals and partner agencies should be asked that contracts with service providers include an expectation that they should fully participate in any serious case review process. Full report here

Serious case review: Harry *Author: Fergus Smith LSCB: Thurrock Local Safeguarding Children Board (June 2017)*

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. Harry's parents separated when he was aged 5 after which he lived with his father and step-mother. A formal diagnosis of epilepsy was made at age 7. Neither primary nor secondary school records recorded this diagnosis 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 two separate assaults of railway ticket inspectors led to his detention in the YOI. Identifies findings: possible side effects of medication (aggression, impulsivity, violence) may not have been explored; no annual reviews by the GP practice of medication in 2009, 2010, 2012 or 2014 in accordance with practice policy; delay on the day of death by YOI staff to provide an immediate response including failure to use a 'pouch key' and to call emergency services; weaknesses in internal information sharing within the YOI. Makes recommendations to the YOI to strengthen its procedures around medical risk factors of under-18-year-olds; the health service 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. Full report here

Linked Research & Resources:

Adolescent service change and the edge of care. Presents an overview of nine projects funded through the Children's Social Care Innovation Programme, looking at adolescents at the edge of care. Find report here

Family and Adolescent Support Service (FASH) Evaluates the Family and Adolescent Support Service (FASH), a service designed to introduce a radical change in the way support for children, adolescents and their families is organised in the Borough of Enfield. The model aimed to provide a full range of support services for children and young people over the age of 11 and their families. Find the report here

Child Sexual Exploitation

Serious Case Reviews:

Serious case review: Jack *Author: Stephen Ashley LSCB: Bradford Safeguarding Children Board (June 2017)*

A teenage boy, Jack, was sexually abused over several years from the age of 13, by multiple adult males. He had come out as gay to friends at school. The school had responded appropriately and his parents had sought help from the

family GP. 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. Key learning: a 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. Review was conducted using a Partnership Learning Review model. Recommendations include: 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. Full Report Here

Serious case review: Jeanette *Author: Barry Raynes* *LSCB: Calderdale Safeguarding Children Board (2016)*

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 had to care for her mother 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 cigarettes, alcohol and drugs. Following disclosure to the police, 54 suspects were arrested, and 25 were charged. Issues identified include: failure to allocate a consistent children's social care worker; lack of suitable forums to discuss children at risk; lack of action to 'disrupt' the activities of men who abuse children; a lack of systems, practices and procedures in services to children in need and children at risk of sexual exploitation. Recommendations include: that police and the LSCB ensure that regional statistics relating to perpetrators of child sexual abuse are accurate; that 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 and 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. Full report here

Serious case review: Child Sexual Exploitation 1998 - 2016 *Author: Eleanor Stobart*
LSCB: Buckinghamshire Safeguarding Children Board(2017)

Discusses all the cases of child sexual exploitation (CSE) in Buckinghamshire from 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 one young person (J), but the impact of CSE on the other young people has not been reviewed. Looks at the chronology of events starting in 1998 and the operations and reviews since then that have shed light on the experiences of young people and how professionals responded to them. Outlines reviews carried out by Thames Valley Police, Children's Social 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 survivors and victims and two parents. Points out that some had rebuilt their lives and moved on, while others lives had been irrevocably changed and appeared damaged, lost and alone. Identifies what needs to change in order to improve agencies' response to children, young people and adults facing CSE. Discusses evidence of improvement in tackling CSE, including the strategy and action plan developed by Buckinghamshire Safeguarding Children Board as well as Barnardo's RUSafe service, and the Swan Unit a multi-agency team working on CSE. The review 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; the development of a strategy to engage with all communities within Buckinghamshire on CSE; the government should consider introducing a national central database of all licensed taxi drivers. Full report here

Linked Research & Resources:

About A Boy The BBC has published a short film telling the story of “Ben” who was groomed and sexually abused from the age of 13, by 30 or 40 adult men. The abuse began shortly after he came out as gay on social media. Listen Here

Supporting Parents of Sexually Exploited Young People. The Centre of expertise on child sexual abuse has published findings from an evidence review looking at what helps parents to maintain or rebuild positive, supportive relationships when their child has been sexually exploited. Find report here and a helpful infographic here

Talking About Social Media Use in Schools. The UK Safer Internet Centre's blog advises teachers on supporting pupils to use social media in a healthy way. Find the article here

Child Sexual Exploitation and Mental Health. Presents an overview of eight projects in the Children's Social Care Innovation Programme that focused on young people who were experiencing or at risk of experiencing child sexual exploitation (CSE) or mental health issues. Find the report here

Criminal exploitation of children and vulnerable adults: county lines guidance. Guidance aimed at frontline staff who work with children, young people and potentially vulnerable adults. County lines is the police term for urban gangs supplying drugs to suburban areas and market and coastal towns using dedicated mobile phone lines. Find the report here

Barnardos and University of Bedfordshire. Barnardo's in partnership with the University of Bedfordshire have published a number of rapid evidence assessments that will support service development for those working directly with victims or those at risk: Outreach work CSE Direct Work with Sexually Exploited or at Risk Children CSE Prevention

Children with Additional Needs/Substance Abuse

Serious Case Reviews:

Serious case review: Child A *Authors: Jane Wiffin and Dave Peplow*
LSCB: Hertfordshire Safeguarding Children Board (Nov 2016)

Discovery of multiple injuries resulting from the severe physical abuse of Child A, aged eight, in March 2013. Mother and stepfather were arrested and bailed. A member of the extended family was convicted of offences arising from Child A's physical abuse in 2016. 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. Stepfather had a history of domestic abuse, drug and alcohol problems and criminality; mother had physical health problems and was arrested for assault. The police, stepfather's probation officer and his drug and alcohol service made referrals to children's social care. Following child protection enquiries, concerns were substantiated but Child A and his siblings were not judged to be at continued risk. Findings include: there is multi-agency confusion about the child in need processes for disabled children leaving them without effective outcome-focussed plans and multiagency reviews; there's an unwillingness to label the early signs of poor quality care provided to disabled children as neglect leaving those children's needs unaddressed. Uses the Social Care Institute for Excellence (SCIE) learning together systems model and poses questions for the local safeguarding children board (LSCB) based on the findings. Recommendations include: the LSCB should explore how embedded the "think family" agenda is and take remedial action as appropriate. Full report here

Serious case review into services provided to Child S and Family *Author: Alan Bedford*
LSCB: Waltham Forest Safeguarding Children Board (May 2017)

Death of 3-year-old Child S, cause unknown, in summer 2014, six months after moving to a London Borough. Child S had lived for most of his/her life in another Local Authority. Child S's mother had a history of long term substance misuse. Child S, a sibling Child Y, and the mother were known to Children's Social Care (CSC), universal and specialist health and disability services, pre-school support services and drug support services in both local authorities. Child S had been the subject of a Child Protection Plan in 2013 but removed from the plan in the same year. Child S had serious health concerns from birth, eventually identified as cerebral palsy. Contact with all agencies was sporadic and featured many missed appointments. When the family moved to the London Borough there were concerns about the lack of support for Child S's health in the transition. Learning points focus on: coordination and leadership; escalation of concerns; core and follow up assessments; continuity in social work practice; healthy scepticism about long term drug use; reporting and sharing information in drug services; experience of the child; transferring information between areas;

hidden men; safeguarding children with disabilities; police sharing information. Recommendations for the two LSCBs include: pre-birth planning and assessment appropriate with drug using parents; Children in Need meetings properly recorded and CSC assessments up to date; compliance with 2009 guidance on safeguarding children with disabilities; review compliance on transferring cases; embedding healthy scepticism about long term drug using parents. Full report here

Linked Research & Resources:
Innovation in social care assessments for disabled children research report. Find the report here

Safe Sleeping/Substance Abuse

Serious Case Reviews:

Serious case review: Child D *Author: Helen Davies* *LSCB: Swindon Local Safeguarding Children Board (2016)*

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. Child D was born prematurely and had been at home for four 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 a 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 D's 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. Key issues include: communication between agencies; professional standards; mother's impact on staff; safe sleeping; the impact of parental ill health; and hospitalisation. Methodology used is in keeping with the underlying principles of the Statutory Guidance set out in Working Together 2015. Recommendations include: training for staff about working with men; use of chronologies; identifying sexual exploitation; and assessing parental capacity to change. Full Report Here

Serious case review: Child B *Author: Mick Muir* *LSCB: Staffordshire Safeguarding Children Board (Jan 2017)*

Death of a 14-month old girl in July 2014. Cause of death was not ascertained but there were concerns that Child B 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 due to concerns about their mother's alcohol misuse. Mother was involved with a number of agencies, and practitioners described her as being pleasant, intelligent, and having insight into her difficulties. In total there were five critical incidents related to the children's mother's alcohol misuse. Key findings include: there was evidence of poor practice and a number of missed opportunities to safeguard Child B and her siblings; there was a tendency to parent-centred practice; Child B's mother was involved with a number of agencies yet was not challenged or confronted about her behaviour; there were no records of any inter-agency communication before the initial child protection conference; professionals did not listen to Child B's siblings who said they were left to care for Child B and did not want to live with their mother; there was failure to involve birth fathers in assessment and planning. Uses the Social Care Institute for Excellence (SCIE) Learning Together systems methodology. Makes recommendations around involving fathers and other significant men connected to a child in child protection cases; listening to the voice of the child; and interagency communication. Full report here

Linked Research & Resources:
How Parental Substance Misuse Affects Children. Community Care has published key points from a review looking at the research into the impact of parental substance misuse on children, as well as examples of effective interventions. Read the article here
Safe Sleeping Guidance from The Lullaby Trust and NHS Choices

Sexual Abuse

Serious Case Reviews:

Serious case review: Child P *LSCB: Norfolk Safeguarding Children Board (2016)*

Sexual abuse of a 15-year-old girl by her step-father. Child P disclosed two incidents of sexual abuse in 2014. Step-father received custodial sentence and mother imprisoned for her knowledge of and failure to prevent the offences.

Step-father was a known sex offender and was involved with the family for 10 years. Convicted of indecent assault on his 14-year-old sister in 2001 and placed on the sex offenders' register. In 2006 he was arrested on suspicion of indecent assault on the 14-year-old half-sister of Child P's mother. History of domestic abuse. 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. Children's Social Care drew up four written agreements with Child P's mother in the period 2006-2014 where she promised not to allow her partner unsupervised contact with Child P. Child P was known to children's services and had frequent visits to A&E and GP during her childhood with conditions including ear infection, stomach upset; accidental scalding, a low weight was consistently recorded. Low mood reported and referral made to CAMHS. History of poor attendance at school and evidence she was being bullied. Evidence of physical abuse by mother. Key findings include: insufficient knowledge on the part of children's social care about how sex offenders operate; and fragmentation of available intelligence within / across agencies. Recommendations include: 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; and GP safeguarding policies should include processes for responding to safeguarding enquiries. Full Report Here

Linked Research & Resources:

What Children are Telling ChildLine about Sexual Abuse. Find the report here

Lucy Faithfull Foundation research about Child Sexual Abuse. Find their research here

Risk Assessment; Parents in the Criminal Justice System

Serious Case Reviews:

Serious case review: Child R *Author: Moira Murray* *LSCB: Haringey Safeguarding Children Board (2016)*

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 by ambulance following cardiac arrest at home whilst in the care of the father. Bruises and injuries were seen to be consistent with physical abuse and traumatic brain injury. Child R died on 26 January. Child R was living with his parents, who were both East European, and older sibling. In 2002, the mother was convicted of murder in her country of origin, and after a serving 9 years in prison she broke her parole in 2012 to come to England. In January 2014 whilst pregnant with Child R she was served with a European Arrest Warrant and bailed whilst awaiting extradition. Father had a history of drugs, shoplifting, and alcohol-related aggressive behaviour. The family had had limited contact with agencies. Key issues identified: agencies failed to undertake a risk assessment once the criminal background of the mother was known. Identifies learning for the police, the courts and the 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 include: when police are 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. Full report here

Serious case review: Philip, (and his siblings, John and Darren) *Author: Jane Wiffin*
LSCB: Gloucestershire Local Safeguarding Children Board (2016)

Serious, non-accidental injuries to "Philip", aged three. Mother's partner pleaded guilty to grievous bodily harm and was sentenced to three years imprisonment. Mother pleaded guilty and received a sentence of 12 months, suspended for 12 months. Philip and his brothers, aged 10 and five, were placed with a relative. In nine months, the police, GP and nursery staff made six referrals about the family to children's social care. Concerns included: poor home environment, mother's parenting difficulties and extensive bruising on Philip's body. After the fifth referral, Child in Need (CIN) processes were initiated. Family received support from the children's centre, health visitor, community nursery nurse and family support worker. Family history included: mother and father's substance misuse; father's threatening behaviour; mother and her new partner's offending behaviour. Findings include: the importance of formal early help in keeping children safe; the need for more child-focussed practice, less reliance on parental self-report and greater recognition of the role of fathers / father figures; the importance of effective decision-making and assessment in the management of physical abuse. Recommendations include: Gloucestershire Safeguarding Children Board should review the guidance for all professionals on the assessment of potential non-accidental injury and ensure it is compliant with NICE Guidelines, including information provided to paediatricians prior to child protection medical. Full report here

Linked Research & Resources:

Barnardos iHop The **Practitioner's Guide to supporting children and families affected by parental offending** is a fantastic free resource packed with practice tips and tools. The i-HOP **Quality Statements and Toolkit** enables services to self-assess and develop an action plan for work with this potentially vulnerable group.

Parental Learning Disability

Serious Case Reviews:

Serious case review: Bethany *Author: Amy Weir* *LSCB: Central Bedfordshire Safeguarding Children Board (2016)*

Death of a girl, Bethany, aged 19 months on 11 April 2015. Cause of death was inconclusive after an open verdict at the inquest. Both parents had learning 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. The parents received Early Support in parenting Bethany, and later a Care Order was put in place for Bethany to remain in her mother's care with the support of professionals and extended family when the father moved out. After key family members withdrew their support, the Care plan was in breach and the process to take Bethany into care was started. Bethany died before steps towards removal could be completed. Findings include: the assessment of parental capacity is essential; vulnerability of the parents should not override the needs of the child; over-reliance on extended family support in planning; there were issues of professional bias. Recommendations include: 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. Full report here

Linked Research & Resources:

BILD Resources about Parenting can be found here

Parents with Learning Disabilities by Ailsa Stewart and Gillian MacIntyre. Article from April 2017 here

Looked After Children

Serious Case Reviews:

Serious case review: Child T *Author: Naomi Bentley-Lawson*
LSCB: Warwickshire Safeguarding Children Board (March 2017)

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. The foster mother pleaded guilty to manslaughter and was sentenced to a term of imprisonment. Key learning include: the role of fostering social workers includes considering the needs and wellbeing of the children in foster care from a safeguarding perspective; regular and consistent supervision of foster placements is crucial for safeguarding children; unrealistic expectations and views of foster carers due to lack of knowledge of child development must be challenged and addressed through training; information sharing between teams within a local authority is important. Recommendations include: ensure that partner agencies give sufficient scrutiny and importance to the safeguarding of looked after children; 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; the role of the Family Nurse Practitioner needs to be clarified where children are in foster care. Full report here

Linked Research & Resources:

NSPCC Information about Safeguarding Children in Care. Find the page here

Radicalisation

Serious Case Reviews:

Serious case review: Siblings W and X *Authors: Edi Carmi and Anna Gianfrancesco*
LSCB: Brighton and Hove Local Safeguarding Children Board (July 2017)

Reported deaths of two 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. 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 one family member was killed for his political beliefs. The family left the UK for several years, and were victims of racism when they returned. The children disclosed physical and domestic abuse 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. Professionals believed the boys were in the parents' country of origin. Uses the SCIE (Social Care Institute for Excellence) Learning Together methodology to identify findings, including: 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 include: 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. Full report here

Linked Research & Resources:

Safeguarding and Radicalisation (DfE) Findings from research conducted with 10 local authorities in March and April 2016 include: staff were most confident responding to radicalisation in local authorities where safeguarding and child protection teams had arrived at a clear conclusion about who should take ownership of these cases, and developed guidance around assessment and handling of radicalisation cases. Full document here

What the Prevent Duty Means for Schools Find the report here

NEW Prevent Resources: Reclaim Radical (Leicester Prevent) Leicester's Young Advisors have launched an excellent new toolkit which includes a series of films spelling out the difference between 'radical' and 'radicalised'. The films have been developed with the help of the city council's youth service, the Prevent programme and local film company Badshoes Film. Toolkit available here Films available here

Neglect

Serious Case Reviews:

Serious case review: Child M *Author: Howard Jones LSCB: Waltham Forest Safeguarding Children Board (June 2017)*

6-year-old child, "M", who witnessed the murder of her mother, "B", in September 2014. M had been looked after and subject to a child protection plan. This was stepped down to a Child in Need plan before the case closed. During the period under review, there were concerns M was experiencing neglect. The police made five reports to children's social care. M's school made a referral to the education welfare service and a multi-agency referral to children's social care. A decision that the case did not meet the threshold for a child protection investigation was challenged. A planned social worker visit did not take place because B and M moved to another authority. A referral was made to the new authority but B and M had no further contact with agencies prior to B's death. B had been looked after as a child and experienced physical and sexual abuse, she had substance misuse problems and experienced domestic abuse. Findings include: inconsistent information sharing processes resulted in no one agency having an overview of the child's history and needs; universal services were not consistently applying assessment frameworks to help aggregate repeat low-level presentations of neglect; families with known child protection concerns were not being "tracked" across local authority boundaries. Recommends the LSCB consider questions including: how confident they are that agreed thresholds in use across all services are embedded in practice, being applied consistently, and are sufficiently sensitive to identify indicators of cumulative neglect. Full report here

Serious case review: Child J *Author: Jane Wiffin LSCB: Nottingham City Safeguarding Children Board (2017)*

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 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 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. Uses a hybrid systems methodology to identify findings including: 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 include: professionals should not accept the term self-harm in children under 10 without a consideration of potential wellbeing or safeguarding concerns. Full Report Here

Linked Research & Resources:

How Safe Are our Children. Child Neglect 19,448 reports of child neglect in 2016-17, compared with 12,110 in 2011-12, a 61% increase over the five year period. Full Report here