South Gloucestershire Children's Partnership News and Research

Quarter Two 2019

Suicide/Self Harm

Serious Case Reviews:

Child safeguarding Practice Review: Child A19 *Author: Alison Sandiford* *LSCB: Unnamed (2019)*

Death by suicide of a teenage girl in January 2019. A19 started self-harming in 2017 and in September 2018 mother contacted the school with concerns about A19's self-harm and suicidal thoughts. In October 2018, A19 disclosed that she had been sexually assaulted by a distant family member; school reported this to the police; A19 did not wish to support a prosecution. Towards the end of term, A19 disclosed to a teacher urges to self-harm or worse; information shared with mother who agreed to take her to a GP. In the new term, A19 messaged a former teacher disclosing self-harm the previous day and referred to the sexual assault. School was alerted; lessons included the issue of suicide that day. A19 taken to hospital later that day and died six days later. Ethnicity or nationality of A19 not stated. Learning: early help for young people suffering self-harm and/or suicidal tendencies needs development to promote multi-agency working; responses to a young person disclosing sexual abuse may be more effective if they feel included in discussions regarding decisions and potential outcomes; training required to assist social workers exercise their right to disclose information confidentially. Recommendations: to enhance the use of the self-harm referral pathway and refer young people when support is needed; to ensure similar enquiries are managed by the police in a sensitive manner when a young person feels unable to proceed with a prosecution and victims better informed if there is no intention to speak to the alleged perpetrator

Full Overview Report available here

Concise child practice review report: in respect of SEWSCB Author: Linda Brown and Nick Wilkie LSCB: Gwent (2018)

Death of an adolescent girl by suicide in January 2017. The young person had experienced physical, emotional and possible sexual abuse as a child. Parents had separated and the young person moved in with her father from the age of 9 years old. Struggled with school transition and from school year 8-to-9 began self-harming and had suicidal thoughts. Referred to School Inclusion Centre in October 2015. Excluded from school and referred for Home Tuition after an incident with a blade in April 2016. Referred to Child and Adolescent Mental Health Services (CAMHS) in October 2015 and was regularly seen by the service with her father. Between May 2016 and December 2016 four serious attempts at self-harm resulted in hospital admissions. Learning points include: CAMHS to review its use of "texting" contact and develop guidance on use to ensure it meets required governance standards; consider the development of a multi-agency locally agreed policy/protocol for the management of high risk cases of self-harm and potential suicide; signpost and make accessible information and guidance for young people and their families/carers experiencing difficulties in managing social media and the internet; CAMHS service to review how they communicate with families about the outcomes of their psychiatric assessments and ongoing formulation of the young person's mental health; explore opportunities for practitioners to gain broader experience and knowledge to promote and deliver collaborative and multi-agency approaches to the prevention

Full Overview Report available here

Linked Research & Resources:

Training available in South Gloucestershire here

Mental Health/Substance Misuse

Serious Case Reviews:

Serious case review: Child H *Author: Fiona Johnson* *LSCB: Kent (2019)*

Death of a 5-year-old boy in June 2018. Mother killed herself and Child H during planned unsupervised contact outside the family home. Parents had separated following incidents of domestic violence by mother against father and Child H's adult half siblings. Maternal history of sexual abuse by her father and mental health problems from 1998; she was treated for depression with anti-depressants up to 2014. Family known only to universal services until April 2018. The family are white British. Findings: information about the mother's mental health history was not passed on to the health visitor so her initial assessment did not take this into account; most professionals did not immediately consider the issue of the mother's employment when assessing risk following the incident of domestic abuse; the DASH risk assessment tool has insufficient focus on emotional abuse and mental health issues and too much focus on physical harm; male victims of domestic abuse do not see themselves as victims; mother's relationship with Child H could be described as enmeshed which may explain the homicide-suicide incident. Recommendations to the LSCB: to require Kent Police to resolve difficulties causing delays in providing CAFCASS with relevant information when they are undertaking safeguarding checks; to ensure when Police Officers take a person to hospital it is possible to pass on relevant information confidentially to a clinician in a speedy time-frame; to develop an increased understanding of the needs of men as victims of domestic abuse and what this means about the nature of services provided.

Full Overview Report available here

Serious case review: Child K *Author: Unnamed* *LSCB: Unnamed (2019)*

Death of a young boy as a result of injuries sustained as a consequence of his mother's actions. Mother arrested and charged with Child K's murder; she pleaded guilty to manslaughter on the grounds of diminished responsibility. Psychiatrists concluded that she was suffering from an acute mental disorder at the time of the incident. Father was a registered sex offender following conviction at age 16 and was subject to an indefinite Sexual Offences Prevention Order. Child K was subject to a Child Protection Plan when a few months old and his sister from birth due to risk of sexual abuse and neglect. Learning: a more thorough assessment of mother's background would have identified high risk factors including a family history of mental illness and childhood abuse; no-one knew the mother used illegal drugs and parents were not challenged regarding their lack of engagement with the drug project; the risk the father posed to his child was not assessed by the time Child K was born; concerns about the family were not discussed at the multi-disciplinary team meetings held at the GP practice; parents were often not present for planned visits. Recommendations: practitioners must be provided with appropriate knowledge and skills to identify those at risk of developing mental health problems; relevant learning is disseminated to organisations, such as faith establishments, that are likely to encounter people at times of crisis; provide information to be used by GPs when referring women for terminations.

Full Overview Report available here

Serious case review: WB S36 *Author: Andrea Warlow & Amanda Baker* *LSCB: Western Bay (2019)*

Death of an 8-month-old baby boy in the spring of 2017. Mother had been sharing her bed with baby and his older sister. Mother reported she had found him unresponsive. An ambulance was called; no injuries were identified and examining paediatrician stated that he had died prior to arriving at hospital. Concerns raised that Mother continued to bed share with her older child and that she was drinking alcohol. Baby was the youngest of six siblings. Four older siblings had been removed from parent's care; two adopted, two in foster care. Mother was psychologically assessed and found to have impulsive sensation seeking and histrionic personality traits. It was suggested she put her own needs before her children's. Family was in contact with services across two local authorities. Ethnicity and nationality not stated. Learning includes: develop guidance to help Children's Social Care staff work better with colleagues from other Local Authority areas, particularly where members of the same family reside in more than one area; co-sleeping advice should be further reinforced after baby reaches 6 months, particularly with respect to risk factors; practitioners should be clear about family structure and seek information about all adults involved with a child and to consider the type, level and quality of contact and care; all conversations held with Children's Services should be documented in the child's records - even if the outcome of the conversation is no further action. Makes no further recommendations other than those included in learning points.

Concise Learning Review – no overview report

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 U *Author: Fergus Smith* *LSCB: Greenwich SCB (January 2019)*

Death of an 8-week-old boy in September 2016 due to non-accidental injuries. Child U was taken to hospital in respiratory arrest and transferred to intensive care but died three days later. Initial explanation was that father was bathing Child U who slipped and hit his head. Mother was an 'over-stayer' but father had achieved permanent residence status in 2012. Mother indicated during ante-natal care that she would need an interpreter for future health appointments but this was not arranged and father acted as interpreter on occasions. Both parents arrested and father faced trial for murder in 2018 and found not guilty. Parents originated from the Ivory Coast. Finds that there were no significant deficits of policy, procedure or practice, but opportunities for learning across the network include: scope for greater professional curiosity; greater precision in record keeping; more consideration of the significance of birth fathers/relevant men; enhanced recognition of the need for interpreters. Recommendations include: LSCB to identify and support opportunities for 'evidence-based' programmes directed toward reducing the risk of head injuries in very young children; Lewisham & Greenwich NHS Trust (LGT) to: develop an information sharing pathway when a pregnant woman attends their services and is booked at another hospital; remind staff of the need for compliance with Trust guidelines on the use of interpreters; to consider including 'safeguarding concerns' tick box to GP discharge letters.

Full Overview Report available here

Serious case review: Madison *Author: Adrienne Plunkett* *LSCB: Wakefield (2018)*

Death of a 6-day-old baby girl in July 2017. Father was sentenced to life imprisonment for murder. On the third day after birth father contacted emergency services reporting that Baby Madison had breathing difficulties after falling off the sofa. Madison was transported to hospital and was found to have a brain injury considered to be non-accidental, and extensive bruising and injuries. She died in hospital three days later. Family had been known to Children's Social Care since September 2015 due to concerns about poor home conditions and neglect in relation to Madison's sibling. Evidence of domestic abuse but no indicators of either parents presented a risk of harm. Death of maternal grandmother two months before the birth of Madison had a significant impact on the parents. Ethnicity or nationality of family not stated. Learning includes: in cases of concerns about long-term neglect it is important to understand the child's lived experience, and assess the totality of the child's care; importance of reflective and challenging supervision in cases where there are concerns about long- term neglect to guard against the rule of optimism; importance of recognising a lack of engagement/disguised compliance. Good practice identified includes: early recognition of the family's need for enhance support by the health visitor. Uses the Significant Incident Learning Process (SILP) methodology. Recommendations include: use a standardised, objective approach to the assessment of neglect; need for a shared understanding and common language of levels of needs/thresholds, particularly following a referral to Children's Social care.

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 T *Author: Nicki Pettitt* *LSCB: East Sussex (June 2019)*

Death of an 18-year-6-month-old male in May 2017. Child T had been in hospital for three months prior to his sudden and unexpected death. At admission, he was in an extremely poor physical and emotional state; he had type 1 diabetes which he had developed at age 13 and diabetic control was inadequate. Agencies had been involved prior to January 2014 due to concerns that he was morbidly obese at primary school and attendance was low in secondary school. Findings: prior to admission to hospital there was limited consideration of the child's lived experience; trust was placed on what the mother was saying without considering the impact on Child T; mother's avoidant behaviour was not effectively identified or challenged; professionals need to remember a person is a child until they are 18 years old; despite processes being in place to identify neglect when a child is Did Not Attend/Was Not Brought, they were not used in this case and a lack of professional curiosity and ownership of the case led to on-going neglect. Recommendations: to share the learning from this review with both adult and child safeguarding boards; to ensure that any child with a serious health condition has a written down multi-agency plan to coordinate and review the child's health care and support needs; to ensure that education providers take responsibility and the initiative to make available appropriate diabetes education and practical information in schools and colleges.

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 Management review *Author: Lesley Walker* *LSCB: Isle of Man (June 2019)*

Review of the practice and care of several children between 2002 and 2011 in the Isle of Man. Report focuses on learning and does not include details of facts or a chronology of events. Good practice identified includes: eventual conviction of the father/foster carers due to the dedication of the police officers involved; prompt safeguarding action when children first disclosed physical abuse which led to their removal from foster care. Learning includes: need for staff to fully understand the behaviours and presentation that is indicative of sexual abuse; need for staff to understand the factors that have an impact on disclosure; importance of multi-agency engagement in all aspects of the child protection process; need for staff to feel confident in working with challenging families; need for professionals and sectors to enhance their confidence and build opportunities to hear the voice of children and young people; importance of professional curiosity and for professionals to respectfully challenge each other. Recommendations to the Safeguarding Board include: review single agency training on child sexual abuse to ensure sufficient focus on the key indicators and disclosure process; provide clarity on the use of professional meetings as a tool in dealing with difficult and complex cases, highlighting the opportunity they provide for multi-agency reflection

Full Overview Report available here

Linked Research & Resources:

Training in South Gloucestershire: Details here

Looked After Children

Serious Case Reviews:

Serious Case Review: Child LH *Author: Jane Doherty LSCB: Lewisham & Harrow Joint review (July 2019)*

Physical abuse of a 4 year old boy by his maternal aunt in 2017. Child LH was hit in the face and a child protection medical assessment showed 43 injuries, consistent with being non-accidental. Aunt charged with assault and received a suspended 20-month sentence. Child LH's mother diagnosed as having a learning difficulty and siblings subject of Child Protection Plan for neglect since January 2015. Child LH placed with his aunt in June 2016 via Special Guardianship Order (SGO). Aunt had historical contact with police for accusations of grievous bodily harm and racial abuse. In June and July 2017 Child LH was not taken to pre-school for a number of days. Aunt took Child LH to GP in September 2017 after abuse incident. Family is Black African/Caribbean. Learning includes: important to ensure that SGO placements are supported by a robust plan that is tailored to the individual needs of the children (including any children who are existing members of the household) and their potential carers; practitioners should be aware that information from a DBS check may not contain significant pieces of information that should be included in any assessment prior to placing a vulnerable child. Recommendations include: ensure that for prospective SGO assessments, the needs of children already living in the household, and their wishes and feelings are fully considered; oversee a multi-agency review of current arrangements for Children in Need that are also subject to SGOs. This is to ensure that the needs of children in SGO placements are met wherever they are placed

Full Overview Report available here

Serious case review: Child F *Author: Sharon Hawkins* *LSCB: Unnamed (Feb 2019)*

Death of a 14-year-old young person from an aggressive malignant tumour. Child F suffered chronic neglect and abuse before entering foster care at age 7. At age 8, Child F was diagnosed with a Growth Hormone Deficiency and was started on therapy. From age 13 and 9 months, Child F presented at the GP twice and at A&E on five occasions, once for a leg injury and four for

feeling unwell. Foster carers thought the illness was fabricated and a result of previous trauma. At age 14, Child F was moved to a respite foster carer. Attendance at the GP led to transfer to a specialist children's hospital and Child F subsequently received palliative care in a hospice. Child F was White British. Learning: Child F's voice was heard but was not understood and acted on; evidence of poor interagency communication and information sharing; the need to manage conflict and work with challenging carers whilst not losing focus on the child; quality of care issues raised by Child F received an inadequate response by Children's Social Care. Uses a systems approach with the practitioners' event based on the Child Practice Review Model. Recommendations include: children cared for by the Local Authority should be provided with advice either from an independent legal advisor or advocate when they are in disagreement with professionals or carers; raise awareness regarding prevalence and symptoms of brain tumours in children and young adolescents; foster carer recruitment, training and supervision should encompass lessons from this review.

Full Overview Report available here

A serious case review (SCR) commissioned under Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 *Author: Peter Maddocks LSCB Unnamed (May 2019)*

Sexual abuse of three girls by their male foster carer. The victims, Grace, Lisa and Carey provided evidence to convict the perpetrator, who was sentenced to 9 years imprisonment. Perpetrator and his wife were approved foster carers from 1998 until their de-registration in December 2014. They had 38 children placed with them; 28 were placed prior to 2011. Grace made several disclosures from 2011 but no action was taken. She was contacted by police investigating disclosures by Lisa and Carey in 2014. Learning includes: mishandled or ineffective investigation of child sexual abuse is especially damaging for the victims and leaves them in greater jeopardy; presentation of perpetrators as pillars of the community and hiding in plain sight; foster carers who have well-established and long relationships with people such as social workers and teaching staff will undermine a child's confidence in talking with anybody about sexual abuse or other maltreatment by that those foster carers; role of local authority designated officer (LADO) has a significant role in regard to any criminal investigation, enquiries and assessment as to whether a child or children are at risk or in need of services. Recommendations to LSCB include: ensure that an apology and an appropriate account of the lessons learnt is provided to the three 'children'; ensure that all practicable steps have been taken to identify and contact any other children who were placed with the perpetrator. Recommendations relating to national policy include: professional bodies and regulatory authorities have a role in promoting improved awareness of child sexual abuse and exploitation and the responsibilities of professionals in regard to the protection of victims and prevention of crime.

Full Overview Report available here

Exploitation/Gang Affiliation/Trafficking

Serious Case Reviews:

Serious case review: Child Y *Author: Charlie Spencer* *LSCB: Croydon (May 2019)*

Death of an adolescent boy due to a fatal stabbing. Child Y's murder believed to be linked to a feud between local gangs. Emotional and learning needs highlighted when Child Y began secondary school. He was excluded twice and had several managed school moves, including one to a Pupil Referral Unit. Moved in with aunt after physical punishment by father; Children's Services involved, and Interim Supervision Order made. Victim of a stabbing and admitted to hospital. Allocated support worker from Safer London Gang Exit Service (SLGE). Family is Black Caribbean. Learning includes: early help and prevention is critical; schools should be at the heart of multi-agency intervention; disproportionality, linked to ethnicity, gender and deprivation, requires attention and action; an integrated, whole systems approach is needed across agencies, communities and families. Recommendations include: review evidence-based practice to revise and publish Croydon's model of intervention to effectively respond to vulnerable, risky, and gang-linked young people; review service arrangements and introduce support for mental health patients to support a child's relationship with their parent and provide support to the care giving parent; ensure adequate sustainable resources are in place to support the multi-agency response to address gangs and serious youth violence.

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