Learning from Local and National Serious Case Reviews

GSCB Roadshows 2016

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Children's Safeguarding and Care

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Presentation plan

- National picture
- Local picture
  - Lucy
  - Ben
  - Philip
  - Megan
- Developments since Abigail
- Summary of key messages

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National Picture

Marion Brandon's (2016) thematic review looked at SCRs between 2011-2014 and found there was

- **197 SCRs where children had died (24% fatal physical abuse, 3% severe neglect, 18% suicide)**
- **96 SCRs where children had suffered serious harm (52% non-fatal physical abuse, 15% neglect, 14% sexual abuse, 5% CSE)**

- **12% of all SCR for children on CP plans (bearing in mind number are rising – most children are being protected)**
- **55% of SCRs relate to children not known to Social Care at the time**

Implication for universal services staff to recognise and respond to abuse and neglect

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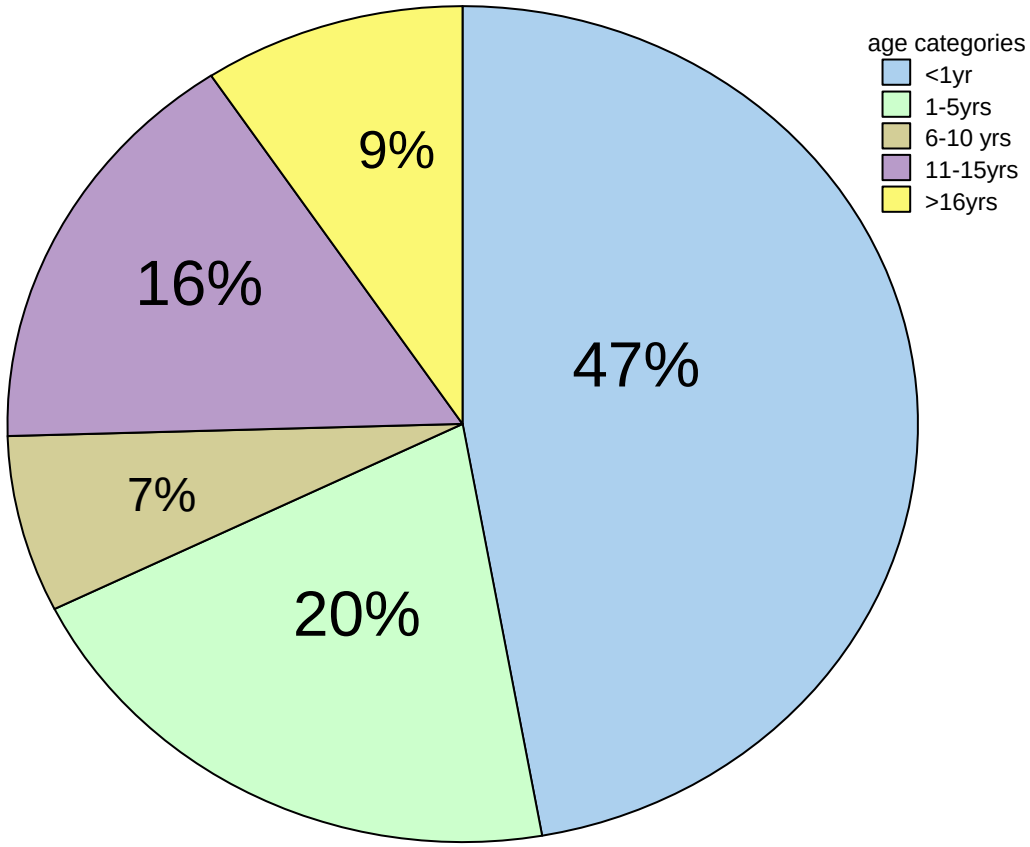
Patterns for the child



- Older Child 'hard to help' or missing from view.
- Very young babies – innately vulnerable (120 under 1yrs)
- 67% pre-school age

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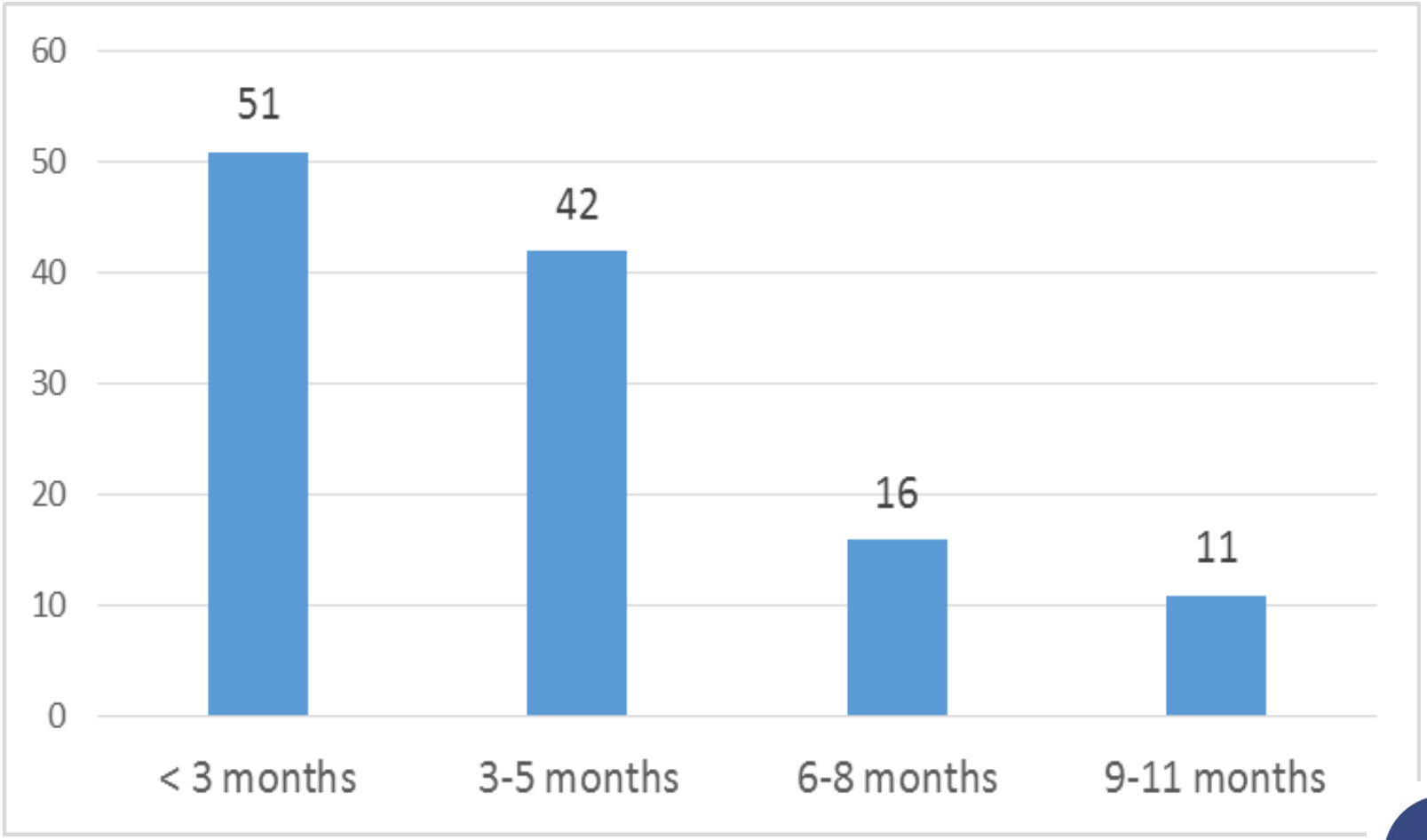
The Youngest Babies



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Key Findings (Brandon 2016)

- **No change** in the number of deaths linked to maltreatment, if anything there has been a reduction in fatality rates for all but the older adolescent age group
- **'Stepping up' and 'Stepping down'** are vulnerable times – highlights the need for long term planning and support where children have known risks of vulnerabilities
- Children 'stepped down' linked with non co-operation rather than progress being made
- There is **good awareness of risk factors** across all staff groups – universal, Early Help and Specialist services
- However, staff and **not always rigorous in assessing** and following through on identified risks
- Where threshold for social care is not met there is **little analysis or risks of harm.** Support plans are unclear and drift.

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The Study identified factors that impacted on the pathways to harm or pathways to protection in summary these included

- Hearing the voices of the child or young person
- Communication and information sharing
- Assessment and thresholds
- Reluctance to take responsibility

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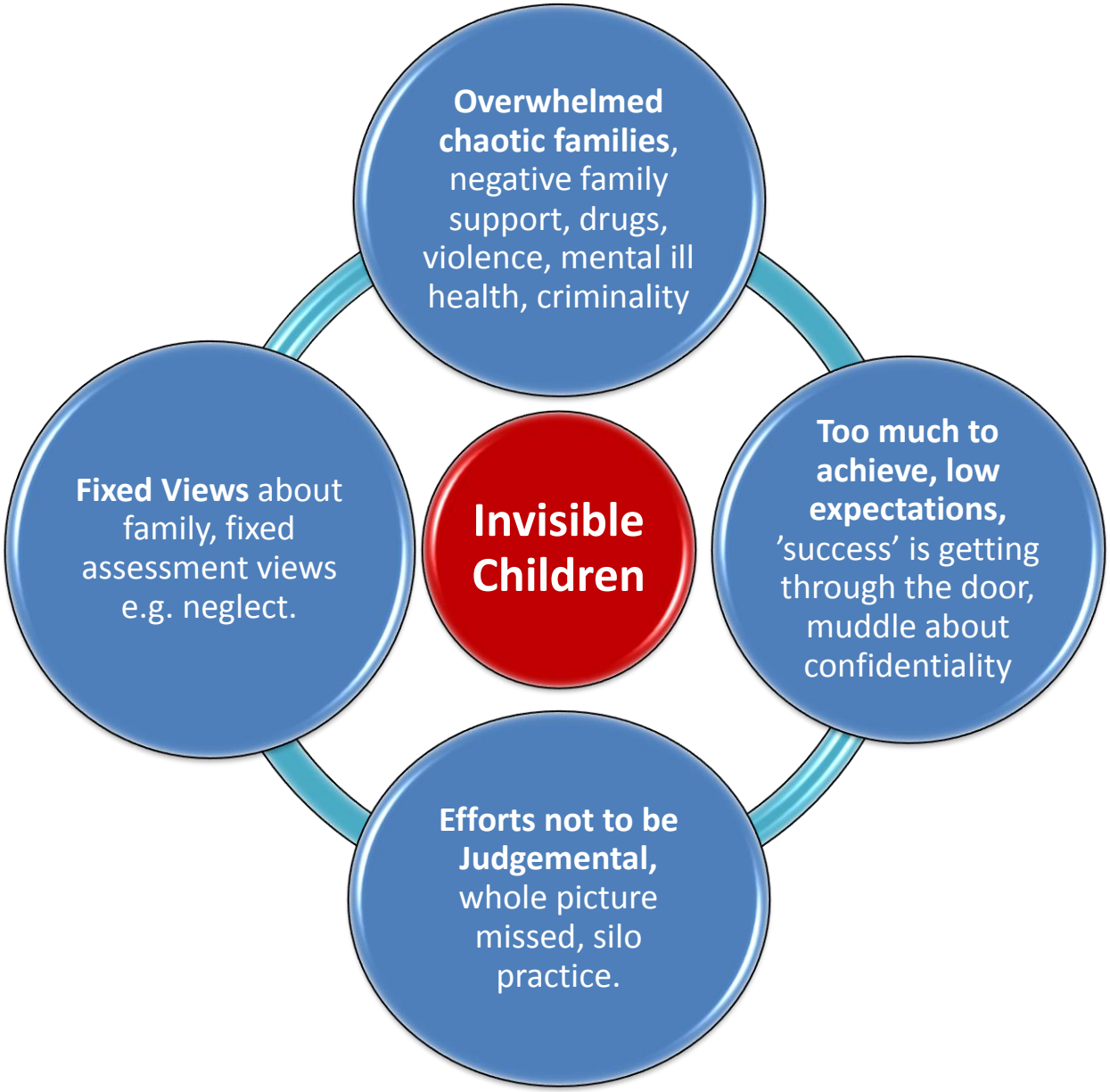
Pathways to harm …



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Pathways to Protection

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Current Local Context

- The SCR relating to **Abigail** was published in August 2014
- Gloucestershire have published two SCRs this year, **Ben** (June 2016) and **Lucy** (July 2016)
- Two others are being completed, **Philip** and **Megan** and are yet to be published.
- A further SCR has recently been commissioned and will be commencing shortly

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Lucy's SCR (published July 2016)

- Lucy was 16yrs old when she was killed by her 18yr old boyfriend.
- Lucy was pregnant at the time of her death.
- A CP conference had been held in relation to the unborn baby and social care had been working with Lucy just before she died

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Contextual summary for Lucy

- Unsettled accommodation arrangements.
- Reported missing.
- Different professionals knew different information about previous assaults by her boyfriend.
- Concerns reported by members of the public.
- Retracted statements.

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Key Learning points - Lucy

1. The **needs of pregnant young mothers** need to be equally assessed and considered alongside the needs of the unborn baby (if necessary allocated to a second worker)
2. **Domestic abuse within teenage relationships** needs to be understood and risks identified.
3. The response to **risk in older young people** and subsequent decision making and actions taken need to be clear and considered. Especially where the young person is using their autonomy and perhaps doesn't believe they are at risk.
4. **All professionals** working with the young person and extended family **hold relevant information** which needs to be 'heard' and reflected upon. Assessments need to include all these views and ensure opportunities for regular communication is facilitated
5. The needs of **perpetrators of domestic abuse** need to be identified and addressed

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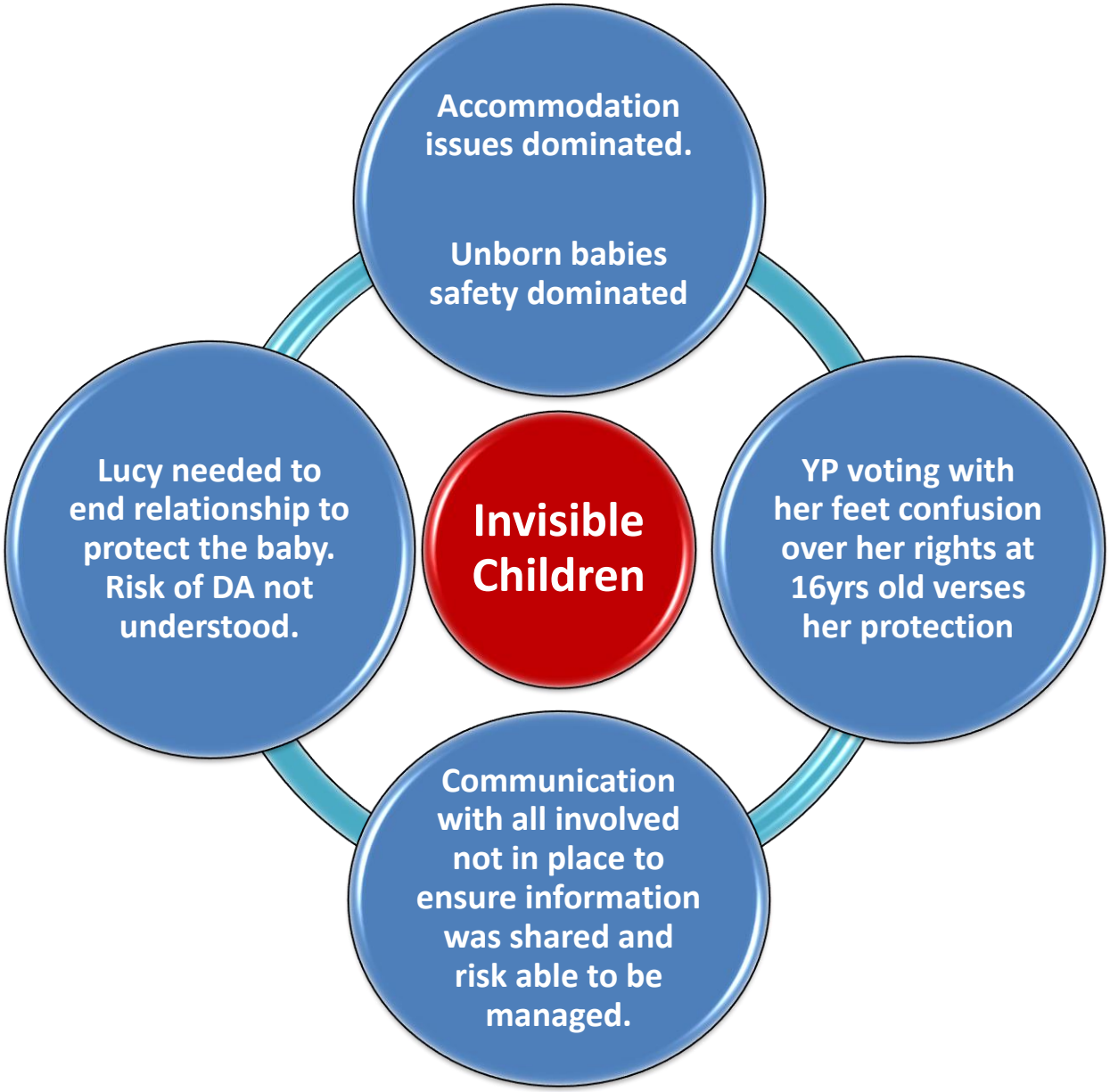
Pathways to harm … Lucy



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Ben SCR (June 2016)

- Ben was a 9 month old baby who suffered a significant head injury from his father. Ben died as a result of his injuries.
- Prior to his death Ben lived with his mother (Antonia) and father (Jack). His mother was 21yrs old and had had a difficult childhood which resulted in her having a problem with alcohol in her early teens, she left home and became pregnant with her first daughter, Daisy, at the age of 16yrs.
- Swindon LA were concerned about the neglect of Daisy at an early age which led to her moving permanently to the care of her maternal great grandmother.
- Antonia met Jack when she was 19yrs old and homeless. She became pregnant with Ben a month later.

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Key Learning Points - Ben

1. **Premature babies** have specific needs which need to be understood and considered during social work assessment processes
2. The risk factors related to **shaken baby** are evidenced and need to be taken in to account when working with parents of unborn babies or young parents
3. **Historical information** relating to coping mechanisms of parents and past behaviour must be taken in to account when assessing the needs and risks of children. Practitioners need to be inquisitive and curious about what has or has not effected change.
4. **Pre birth or 'at birth' risk assessments** need to be evidenced based and thorough
5. Where it is believed a child is better supported within the early help arena **social care must assist with sharing their assessment** of need and help bring clarity to the follow on plan of support.
6. A **lead professional** needs to be identified in the community and 'hold the baton'
7. **Fathers need to be equally involved and assessed**. Their past history, views, feelings and wishes need to be taken into account with equal consideration as to that of the mothers.

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Philip SCR

- This SCR relates to Philip, a 3yr old boy who had been taken to hospital by his mother following 4 days of abdominal pain and vomiting. At the hospital Philip was found to be seriously unwell, with multiple and serious bruising, several fractured ribs and a perforated intestine. These injuries were life threatening and considered to be non accidental. (Fortunately Philip did not die from these injuries and is making good progress).

- Philip's mother and her boyfriend have been charged with GBH and neglect (knowing or should have known) .

- Philip was subject to a Child in Need plan at the time and there had been 5 previous referrals to Children's Social Care. These had resulted in 3 Initial Assessments being completed.

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Key Learning Points - Philip

1. **All professionals** involved in the care of a child or young person **must be considered** when assessing potential need and risk.
2. The **response to unexplained injuries** needs to be robust. Explanations for injuries need to be considered and recorded. (chronology)
3. **Reports from children** to professionals need to be recorded and seen in the context of which they were made. (Older sibling to the Police)
4. Initial views and **hypothesis need to be re-evaluated** in light of new information (reflection)
5. The practice for **children in need** needs to be strengthened to ensure the plan meets the needs and risk of a child

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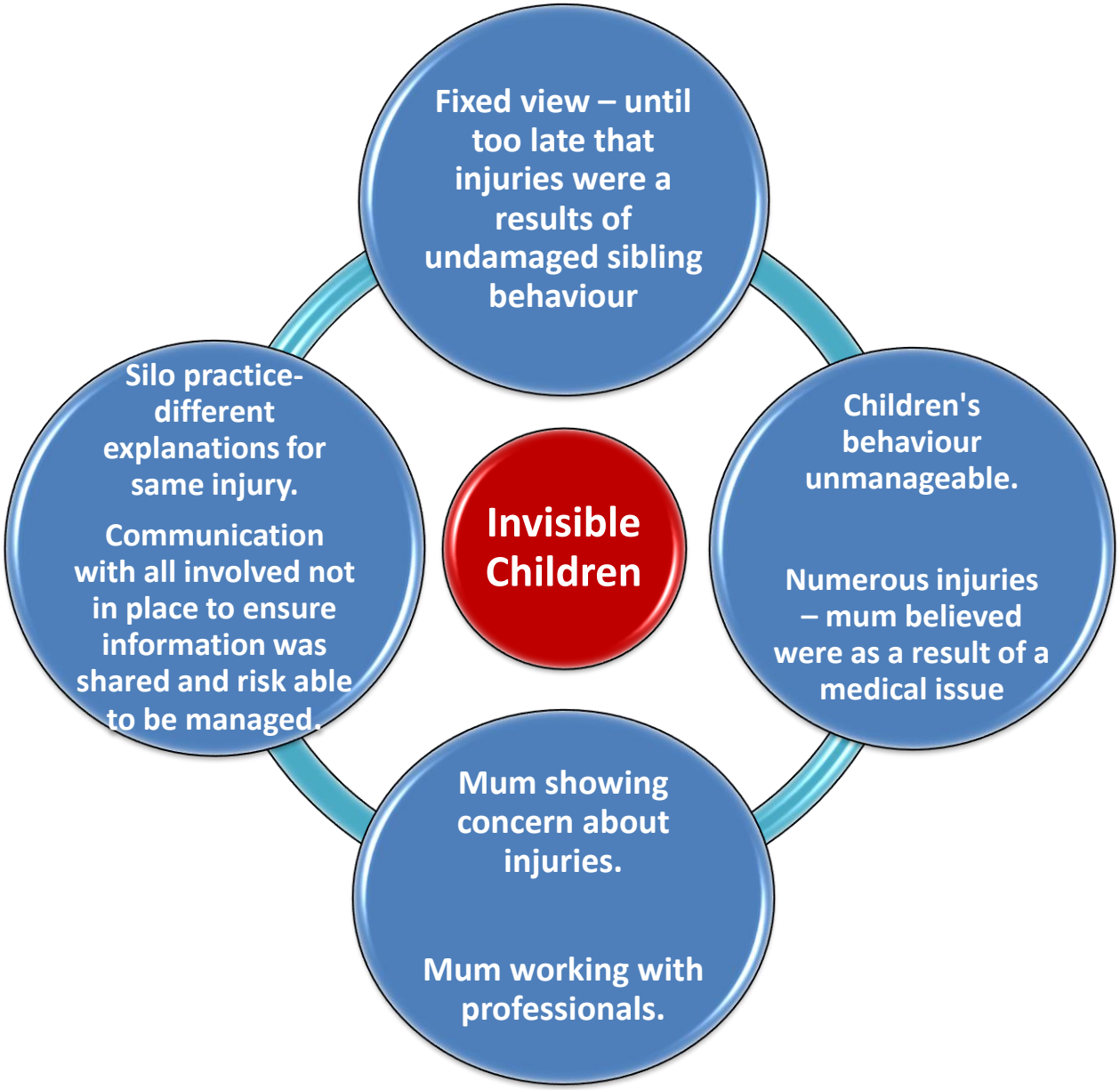
Pathways to harm … Philip



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Megan SCR

- This SCR relates to Megan, a 5yr old girl who was admitted to hospital having fits and with over 90 bruises to her body. These bruises were felt to be non-accidental in nature. At the time of hospital admission, Megan was receiving support from universal services only.

- Megan lived with her paternal grandma, Pauline on a Special Guardianship Order (SGO). This was because her mother was unable to look after her. Pauline was not identified as being a relative until very late in the care proceedings and Megan was placed with her shortly afterwards. Megan was 2 years old when she went to live with Pauline.

- Pauline did not always engage with services. Megan's nursery and later her school had concerns about her wellbeing but these were not shared with any other agency and Pauline's explanations were accepted.

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Key Learning Points - Megan

1. **Special Guardianship Orders (SGO) Assessments** should always be as robust as other assessments and there should not be an assumption that the SGO will be granted in every case.
2. Professionals are not always clear about the **legal status** of a child who has a Special Guardianship Order. Some professionals were reassured as they thought this meant that Megan had a Social Worker.
3. Professionals should always demonstrate **professional curiosity** and find out about family make-up and relationships.
4. Not all professionals have a good understanding of the **signs and indicators** of a child who might be living in a neglectful environment.

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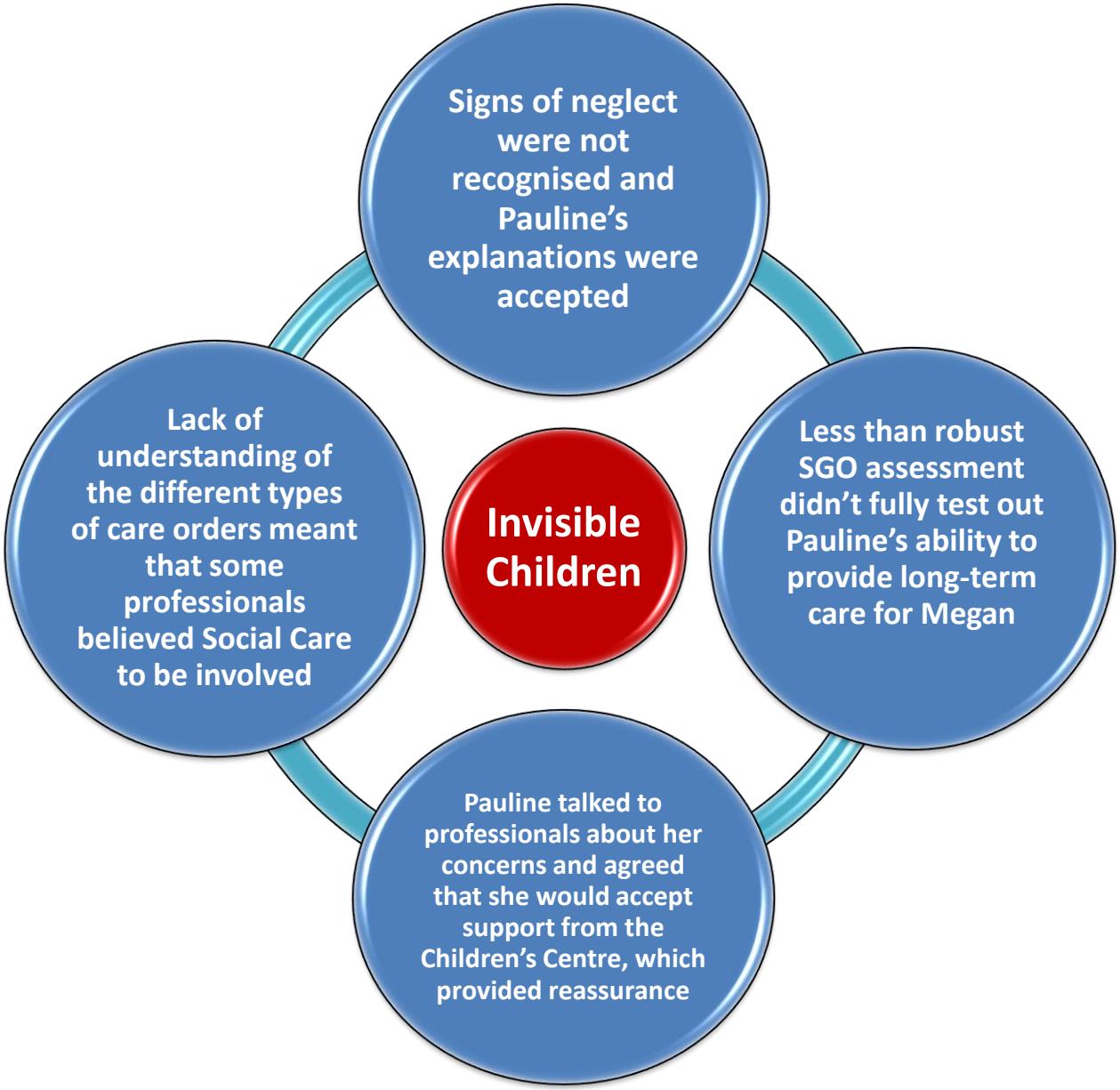
Pathways to harm … Megan



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Abigail (August 2014)

- Abigail was a 3yr girl at the time the review was undertaken. She was from a large group of siblings.

- Abigail was significantly neglected by her parents. Her older siblings had also been significantly neglected over a number of years.

- The SCR was completed because partner agencies wanted to understand how our current and local safeguarding system *allowed* a child to experience such significant neglect over a prolonged period without effective intervention.

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What difference did this make to Practice?

- **Children's needs are paramount**, supervision must assist practitioners to focus on the child and not allow the parental needs / behaviour to dominate and impact on decisions made **Safeguarding Practice Reflection Standards**

- Practitioners need to **listen to children's views and wishes** and these must be central to the work with children (assessments, interventions and plans) – **seeing children alone and listening to what they are saying**

- Strategy discussions are needed and **sharing information is required when a concern** or lack of progress is evident. **Reflective professional meetings** useful

- **Plans** need to be robust, timely review, focused on outcomes required, timescales and a **contingency plan**

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What difference did this make to practice?

- **Historical information** needs to be understood – **chronologies**

- Build confidence to **challenge or question decisions** made by other professionals / agencies. Professional disagreement is a positive sign of a healthy safeguarding system. **Shadowing opportunities / Joint training / Escalation Policy – GSCB**

- **Neglect strategy (GSCB)** provides a shared understanding of neglect. Need to use evidence based tools to measure neglect and monitor progress / distance travelled.

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Pathways to Protection

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Summary of Key Messages

- Child's experience
- Engage and Listen – *to child and each other*
- Look at the past to understand the future
- Impact – *what does X mean to the child*
- Be curious
- Assess, plan and review
- Reflection
- Look after yourselves…..

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