Gloucestershire Safeguarding Children Board

Learning Review Newsletter – Summer/Autumn 2016

Welcome to the first edition of the Gloucestershire Safeguarding Children Board's Learning Review. Serious Case and other reviews are carried out so that agencies and individuals can improve the way in which they work together both individually and collectively to safeguard and promote the welfare of children.

As safeguarding is everyone's responsibility, the purpose of this newsletter is to provide a concise update of important learning points across a range of reviews.

In this edition, you will find out more about the following cases:

- **Abigail, a 3-year old girl from a large sibling group who was significantly neglected by her parents. Her older siblings had also been significantly neglected over a number of years. Abigail had such extreme infected nappy rash at the point that she was admitted to hospital that she couldn't walk.**

- **Ben, a nine-month old baby who suffered a significant non-accidental head injury and died as a result of his injuries. Prior to his death Ben lived with his mother (Antonia) and father (Jack). Ben had been born prematurely and was initially very unwell. He subsequently made good developmental progress and was discharged home with early support being provided by the children centre and health visitor.**

- **Lucy, a 16-year old girl who was killed by her 18-year old boyfriend. Lucy was pregnant at the time of her death**

- **Philip, a 3-year 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.**

"Abigail" Serious Case Review

A Serious Case Review was carried out during 2013/14 because partner agencies wanted to understand how our current and local safeguarding system *allowed* a child to experience such significant neglect and over such a long period of time without effective intervention.
Key learning that emerged from this review included:

- **Always keep a clear focus on the experiences of the child**. We know that this can be difficult when having to negotiate the many demands and difficulties of the parents, especially those who may disguise compliance or be manipulative
- **Communication across and between agencies needs to be open and transparent**. Information sharing between agencies should not be seen as a barrier.
- **The impact of neglect** on a child's safety, wellbeing and development is significant. Professionals need to focus on building a shared understanding of the child's history through a chronology of significant events across all agencies involved.
- **It is the robustness of the plan that will keep the child safe**. Plans must have the child's needs at the heart and include a contingency plan.
- **Reflection on safeguarding practice** is essential for all staff, especially when dealing with complex abuse and neglect cases
- **Healthy challenge** is an important part of working with families and other professionals. Be persistent, have an inquiring mind and keep asking questions

"Ben" Serious Case Review

This Serious Case Review was commissioned in 2014 due to the nature of the child's death. When Ben was 9 months old he was brought to hospital by ambulance having collapsed whilst in the sole care of his father. Ben died two days later of brain damage and the cause was assessed to be a non-accidental head injury. Ben was born prematurely and was initially very unwell. He subsequently made good developmental progress. Ben was referred to social care by the hospital due to concerns about his mother (Antonia's) issues in the past and concerns about visiting patterns. At the point of discharge from hospital a brief social care assessment was completed which identified no ongoing concerns. Early support was provided by the children centre and health visitor; and regular visits completed up until the time of the critical incident.

- **Premature babies** have specific needs which need to be understood and considered during social work assessment processes
- The risk factors related to **shaken baby** are evidenced and need to be taken into account when working with parents of unborn babies or young parents
- **Historical information** relating to coping mechanisms of parents and past behaviour must be taken into account when assessing the needs and risks of children. Practitioners need to be inquisitive and curious about what has or has not effected change.
- **Pre birth or 'at birth' risk assessments** need to be evidenced based and thorough
- 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.
- A **lead professional** needs to be identified in the community and 'hold the baton'

- **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.

Did you know: between 2011 and 2014, 47% of serious case reviews carried out nationally were in relation to children under the age of 1

"Lucy" Serious Case Review

Lucy was 16 years old when she was killed by her 18 year old boyfriend. Lucy was pregnant at the time of her death and her unborn daughter also died as a result of the attack. Lucy had a history of emotional difficulties and had experienced long periods of instability in her family life, having moved between living with her mother, father and grandparents from a young age. Lucy effectively became homeless at the age of 16, despite the offer of a foster placement by social care and efforts to negotiate with individual family members to avoid that happening. There were a range of agencies supporting Lucy and her family including school, CYPS and Adult mental health. There was a known assault by Lucy's boyfriend before her pregnancy was confirmed and a referral was made to Children's Social Care. This was the only assault where Lucy identified her boyfriend as the perpetrator.
Lucy moved in with her boyfriend and his family against the advice of the social worker; and following a strategy meeting, an Initial Child Protection Conference was held in relation to the unborn baby. Lucy's case was closed to social care as it was felt that her needs could be met through the unborn baby's care plan. Lucy moved back in with her mother in an attempt to separate from her partner (Daniel). Just over a week later Lucy was seriously assaulted by Daniel and both Lucy and her unborn baby died a few days later.

- The **needs of pregnant young mothers** needs to be equally assessed and considered alongside the needs of the unborn baby (if necessary allocated to a second worker)
- **Domestic abuse within teenage relationships** needs to be understood and risks identified
- 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
- **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
- The needs of **perpetrators of domestic abuse** need to be identified and addressed

"Philip" Serious Case Review

This SCR relates to a 3yr old boy who was 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. Philip's mother and her boyfriend were arrested at the time on suspicion of GBH section 18. They were subsequently charged and criminal proceedings have now concluded. Fortunately, Philip did not die from these injuries and has made a good recovery. 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, 2 of which were in relation to unexplained injuries/bruising on Philip. The explanation for the bruising was **'rough play'** between siblings, which was witnessed by the Social Worker and also a health condition which caused him to bruise easily. A paediatrician examined Philip and found some injuries were old and some newer. The explanation for the injuries was accepted as a possibility and no medical reason for the injuries was found. Family support was therefore offered to promote parenting skills and a multi agency approach was sought.

- **All professionals** involved in the care of a child or young person **must be considered** when assessing potential need and risk. This includes child minders, nurseries and pre-school establishments. Updated information is required at each point key decisions are made.
- The **response to unexplained injuries** needs to be robust. Injuries must be reported to Social Care. Explanations for injuries need to be considered and recorded. Explanations given to involved professionals must be scrutinised and differences understood. Full picture needs to be brought together in one place
- **Reports from children** to professionals need to be recorded and seen in the context of which they were made. (Older sibling to the Police)
- Initial views and **hypothesis need to be re-evaluated** in light of new information (reflection)
- The practice for **children in need** needs to be strengthened to ensure the plan meets the needs and risk of a child

The full summary of all local Published SCR's can be found at
http://www.gscb.org.uk/seriouscasereviews

The Philip SCR, @ 21st September 2016 is still awaiting publication.