Learning from local / national **Serious Case Reviews**

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Gloucestershire Safeguarding Children Board

Presentation plan

- National Context
- Local Context
- Summary of learning from local SCR's
  - Abigail (August 2014)
  - Lucy (July 2016)
  - Ben (June 2016)
- Key Messages

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Policy

Serious Case Review's are undertaken when abuse or neglect is known or suspected and a child has died or where serious harm has occurred and there are concerns about inter-agency working

The **purpose** is to understand what happened in each case, learn about what happened, to promote good practice and reduce risk of such tragedies happening again

Wood Report into role and function of the LSCB's is recognising the current issues with SCR (toxic brand) and asking for centralised SCR's overseen by a child safeguarding practice review panel to review cases of national importance and good quality, rapid local reviews

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National Picture (Brandon 2016)

Between 2011-2014 there was

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

Where children are in the child protection system they are faring well – on the whole

- 12% of SCR for children on CP plans (bearing in mind number are rising – most children are being protected)
- 55% of SCR's relate to children **NOT** known to Social Care at the time (2011-2014)

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

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Is anyone working with the children?

(Brandon 2016)

- Two thirds of children/families in SCRs were known to Children's Services in the past (at least to level of 'child in need')
- Most SCRs reveal previous known vulnerability but many families are out of contact with services
- Some cases are closed because children/families are not 'cooperating' not because of improvement
- Implications for careful, planned, flexible 'stepping up' and 'down' services from social workers to and from early help/universal services.
- Need for long term planning and helping, as well as early intervention

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Early help tensions (Brandon 2016)

- Are ‘stepped down’ cases really early help?
- Early help is the best way to reduce child death (Munro, 2011, Laming, 2003;2009) but where/how do the ‘previously known’ families fit?
- ‘Step up‘ - tensions when universal services/early help refer in child protection concerns
- Tension between the voluntary nature of early help approaches (eg Troubled Families, Common Assessment Framework etc) which might not be robust or tenacious enough to manage referral for child protection (‘step up’)

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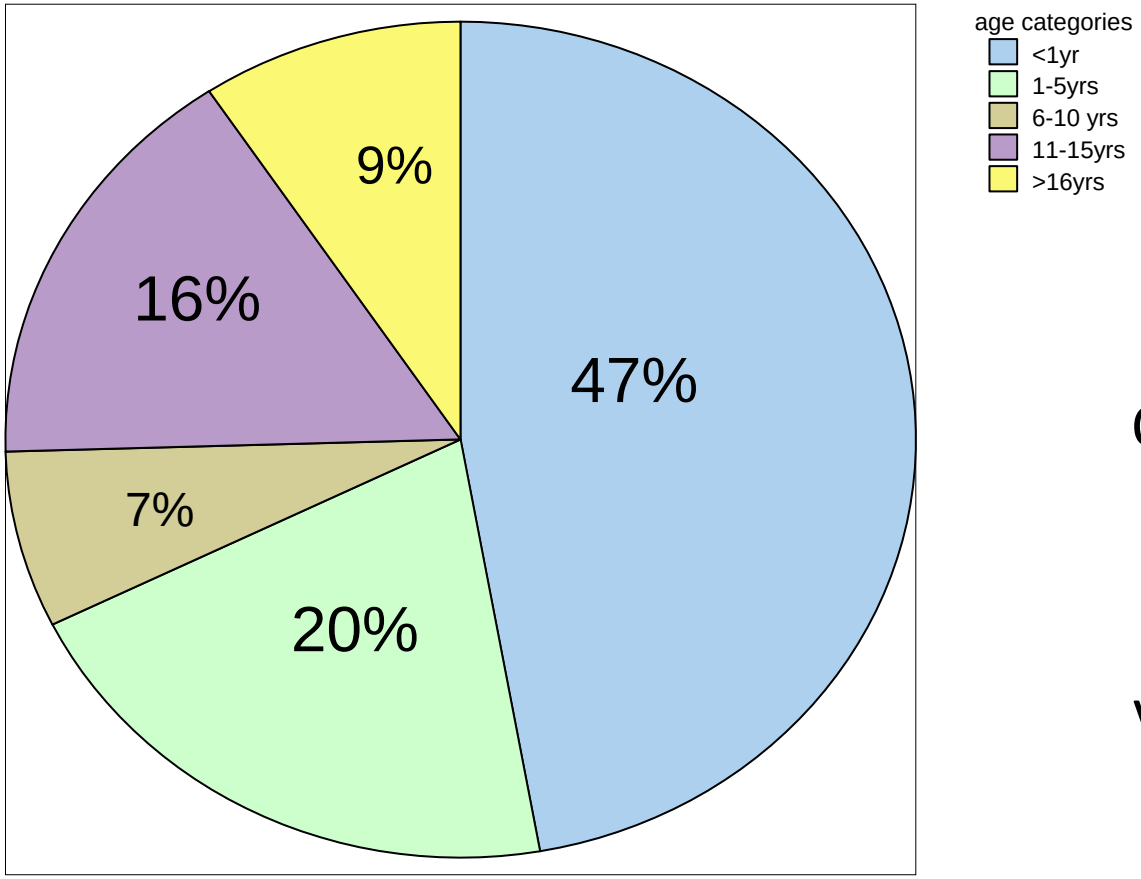
Patterns for the child



Older Child 'hard to help' or missing from view

Very young babies – innately vulnerable

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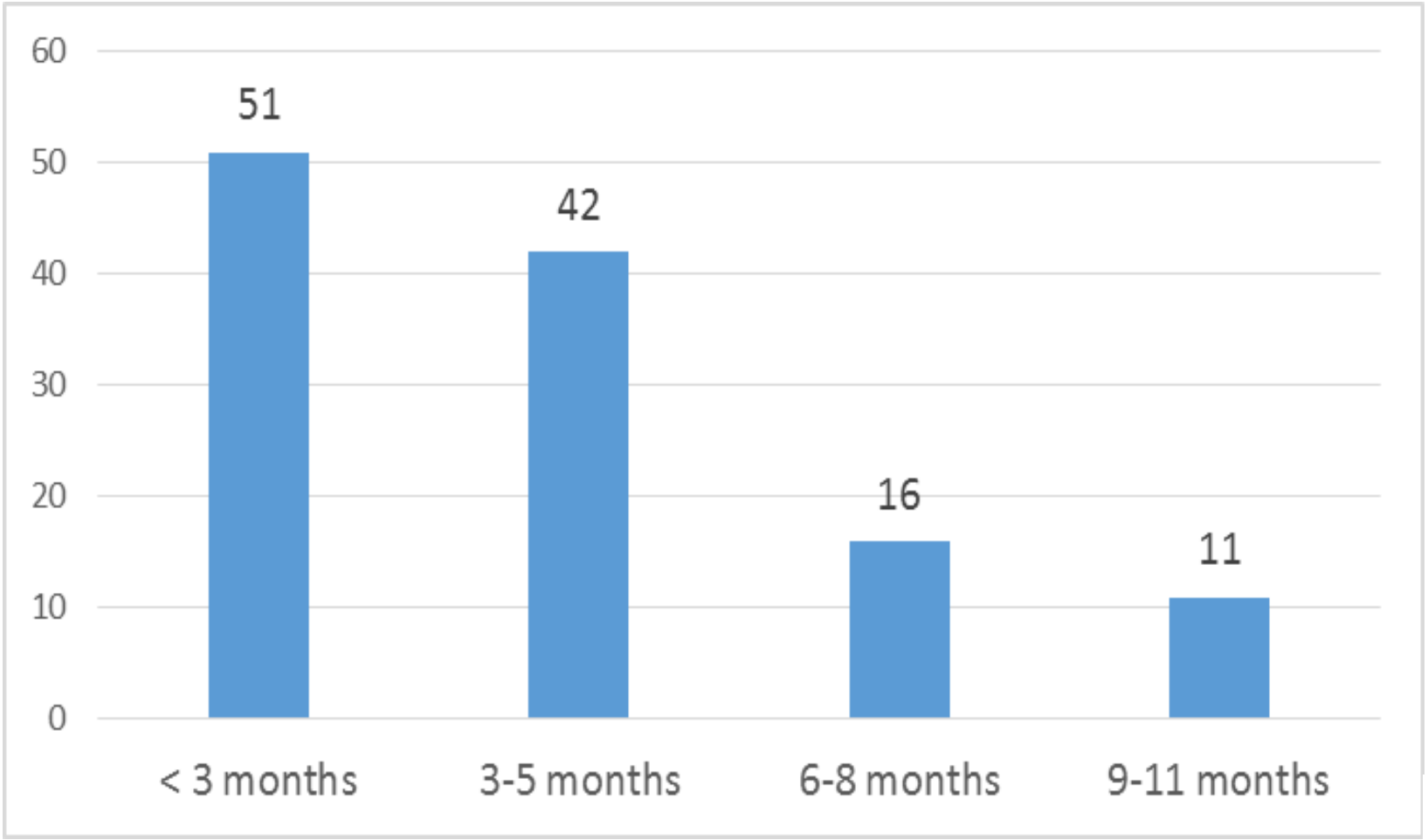
The youngest babies



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- New research being published in early July 2016 collating patterns
  - Child
  - Parents
  - Workers
- It will provide breakdown of learning / patterns for different agencies
- Identifies what happens systemically when families and professionals are overwhelmed
- Promotes a positive practice cycle

Watch out for the GSCB alert!

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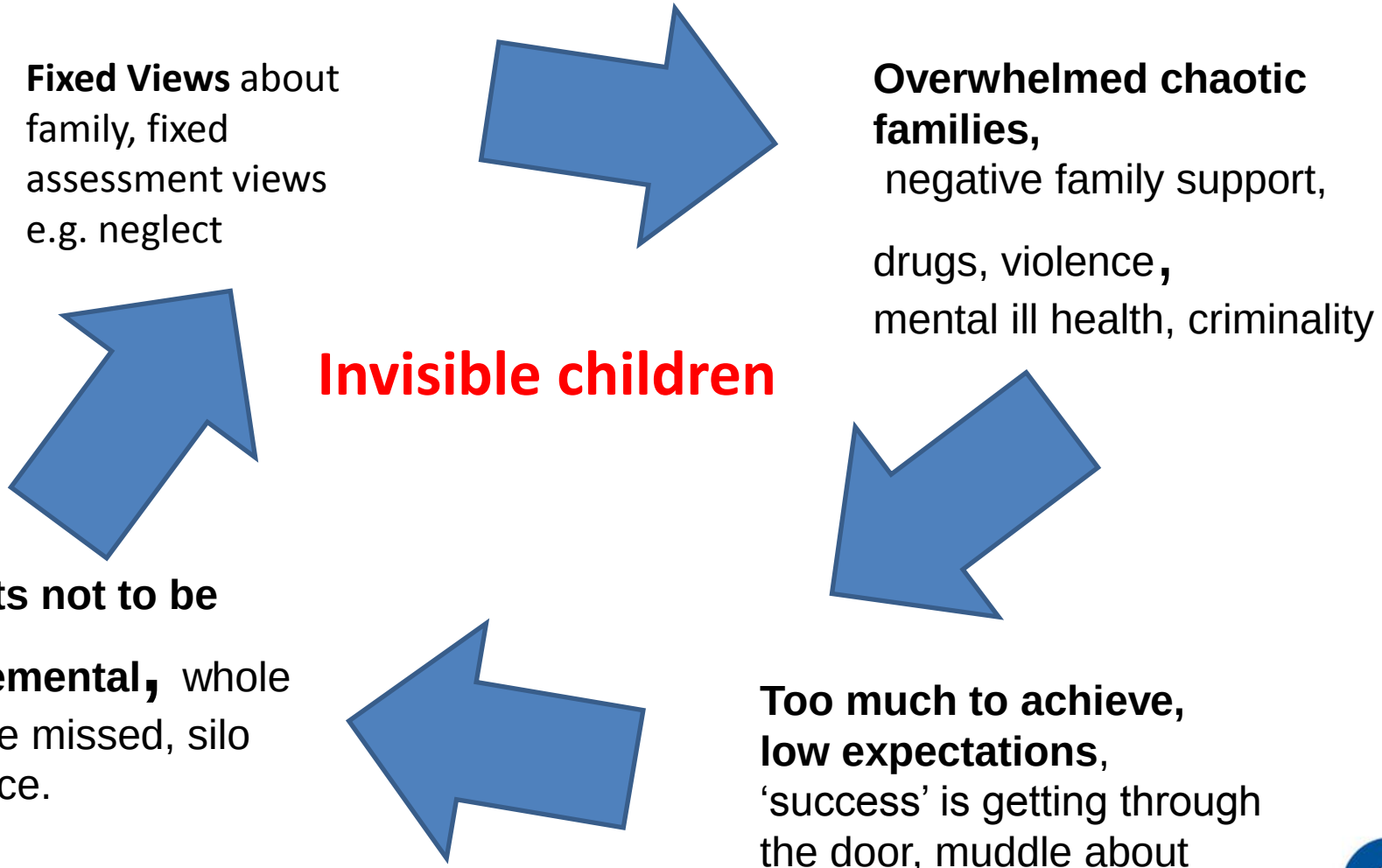
Negative Practice Cycle…



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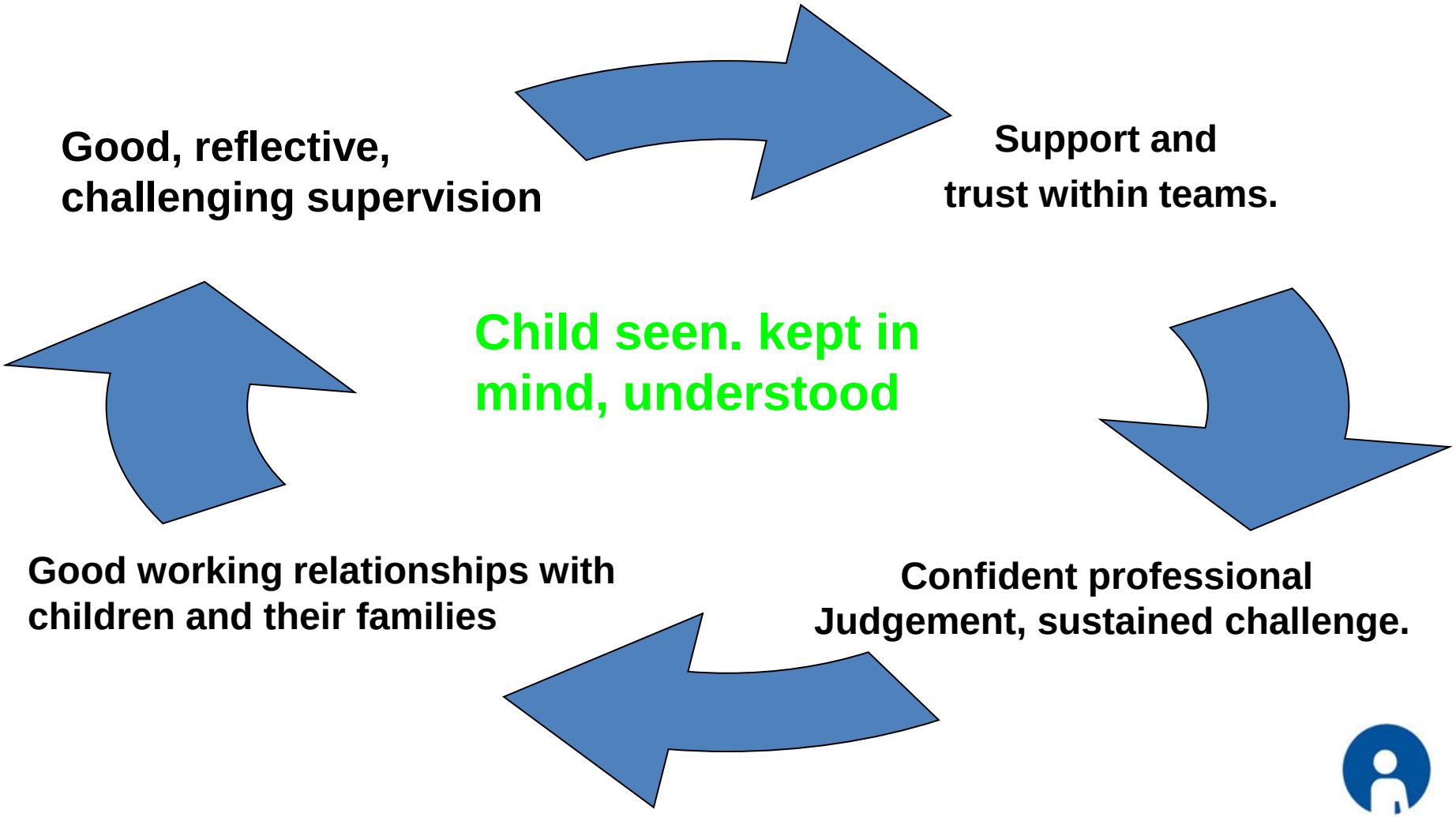
Positive Practice Cycle



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Current Local Context

- Gloucestershire Safeguarding Childrens Board (GSCB) provides the governance to SCR's in the county. The SCR sub group considers new cases where a SCR needs to be considered and makes recommendations to the Chair of the GSCB. The sub group provides oversight of SCR's being undertaken and tracks action plans.
- Currently there are 4 SCR's being completed all of which are at different stages. 3 to be discussed today (pre publication)
- The last SCR in Gloucestershire was published in August 2014

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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 worked well?

- Joint working – engaging with parents, assistance through CAF process, joint visits between professional groups, good multi-agency attendance at meetings, communication between schools and HV / GP's
- Professional persistence – gaining access to the house and children, challenge and escalation amongst professionals, police persistence
- Child focused remedial action – legal action was taken and Abigail and her older siblings are now placed with permanent long term carers and are receiving care and support which is making positive improvements to their live

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What did we learn?

Neglect

- Recognising and responding to long term neglect as a **whole** rather than seeing events as 'isolated incidents', the need to establish a **cumulative picture** linking tooth decay, head lice, poor growth and weight gain, poor hygiene, severe nappy rash, non compliance, missed appointments…
- The need to draw together **multi-agency information** and pull together the evidence CHRONOLOGIES….
- Understand the **physical and emotional impact of neglect** – infected nappy rash is serious and extremely painful for a child causing physical harm.
- **Delayed responses** is a form of professional neglect – waiting to hold meetings, taking time to undertake assessments and then make decisions to change direction, people not attending, meetings only considering one aspect or one child means delay in identifying whole picture

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What did we learn continued..

Peaks and Troughs

- The challenge for professionals when progress is made for a period of time but then not sustained
- The impact of parents complying or saying that they will comply but then progress not sustained.

Disguised compliance – the appearance of complying

- Parents avoided professionals, aligned themselves with particular professionals and alienated others, small steps to fulfil expectations were made but nothing sustained
- This brings significant challenges to professionals as it is hard to grasp the reality and assess the full impact on a child/ren

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What did we learn continued..

Focusing on the child

- Parents views / needs were demanding and prevented professionals being able to focus on or see the child
- Parents behaviour physically stopped professionals seeing the child e.g. putting child in cot upstairs and saying she was asleep when HV came to the house
- Practice needs to focus on the child and that includes direct work and engagement, talk to siblings, see child in different settings

Sharing information

- Is consent given by parents to share information across agencies? If not or if this is withdrawn, does this have a safeguarding impact on the child? Professional decisions needs to made and recorded

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What did we learn continued..

Start again syndrome

- Responses were incident led and case history not considered
- An assessment of parental capacity to change, including their motivation to change needed to be undertaken to really understand the likelihood of change and impact of risk

Systemic paralysis

- When is 'enough is enough'?
- Did professionals unconsciously collude with the parents denial of the situation?
- Some professionals had worked with the family for many years and felt overwhelmed and at times confused by the complexity of the needs of the parents and the children
- The impact of this is to become desensitised to the family's way of living, focus on keeping the family on side was a practical way of handling the situation.

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What did we learn continued..

Professional Splitting

- Powerful behaviour by the mother resulted in professionals having different views and at times this 'split the professionals'
- Complaints made to one professional about another, aligning themselves with one professional and not another caused some professionals to see concerns as child protection and others not. This created professional differences which took the focus off Abigail and her needs.

Resolving professional differences

- Professionals need to speak up, be heard in order to be listened to. If not then take action….

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What difference did this make to practice?

- **Childrens 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, reviewed timely, 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. **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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Lucy's SCR

(due to be published June 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

- Lucy lived between the houses of her grandparents, her father, her boyfriend and her mother. Social Care were involved in trying to find her accommodation / Lucy refused the offer of a foster placement. School, CYPS and Adult mental health were supporting Lucy and her family.
- She had been **reported missing** on a couple of occasions by her parents.
- The SCR found that different agencies and professionals had been aware of assaults on Lucy by her boyfriend Daniel over their 9 mth relationship.
- Before her pregnancy had been confirmed a member of the public found Lucy distressed in the street and phoned the Police. Lucy initially reported being assaulted by Daniel being 'knocked to the ground and kicked in the stomach' when he found out she was pregnant.
- The Police spoke to Lucy again the next day and she agreed to make a formal statement but then retracted her statement. Daniel was subsequently arrested but was released without charge.

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- Lucy was referred to CYPS for support due to self harming behaviour and anxiety. Social Care agreed to complete an initial assessment.
- During this period of time
  - another member of the public reported an on going domestic abuse incident that was happening at the local park. Police and ambulance arrived but Lucy denied that domestic abuse had occurred (Social Care not informed)
  - Lucy attended Emergency Department saying she had been *'hit to the ground, punched in the face by an un-named male and had a bleeding nose'*
  - Lucy's attendance at school dropped and she missed appointments with sexual health clinic although saw her midwife
  - A Multi Agency meeting was held – Lucy was reported to have been self harming
  - Lucy was reported missing to the Police
  - Lucy was seen on two separate occasions by professionals with a bruised eye and reports made by her mother that her boyfriend had smashed her mobile phone

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- Lucy became homeless as she turned 16yrs old. Lucy declined the offer of a foster placement and went to live with her boyfriend and his parents against the advice of the social worker.
- An initial child protection case conference was held in relation to Sarah, the unborn baby. Lucy was closed to social care as it was felt that her needs could be met through the unborn baby's care plan.
- Lucy separated from her boyfriend as per the discussions held at the CP conference

22 weeks following the referral to social care and 3 weeks after the initial Child Protection conference Lucy was the victim of a serious physical assault by her boyfriend which resulted in her death a couple of days later. The unborn baby also lost her life.

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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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Reflection time....

Think about your practice - talk to your neighbour

- How do you really understand a child / young persons experience?

- Where can you get your information from to help you understand?

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Ben SCR

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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Contextual summary continued..

- Antonia sought antenatal care immediately and reported to professionals she was happy with the pregnancy and wanted to make a fresh start
- Little was understood by professionals about Jack and his family.
- Ben was born prematurely and was initially very unwell. He subsequently made good developmental progress. Ben was referred to social care at this point due to concerns about Antonia's 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 children centre and health visitor and regular visits completed up until the time of the critical incident

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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 into 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 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.
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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Key Messages

- Child's experience
- Engage and Listen
- Look at the past to understand the future
- Impact
- Be curious
- Assess, plan and review
- Reflection
- Look after yourselves…..

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Reflection time..

- Reflect with your neighbour (or 2!) about the learning relating to
  - Abigail
  - Lucy
  - Ben
- Identify three changes you will make to your practice

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