Lessons Learned Research Digest

Issue 2 - June 2020

Welcome to the second edition of the Darlington Safeguarding Partnership Research Digest bulletin. The bulletin has been produced to share messages from recently published Child Safeguarding Practice Reviews/Safeguarding Adults Reviews /Lessons Learned Reviews and any local lessons learned. The cases identify lessons to be learned to improve learning and develop practice across multi-agencies to safeguard children and young people and adults with needs for care and support.

This bulletin focuses on reviews published in 2019 and 2020.

Cases highlighted in *italics* indicate those cases where learning may be relevant to reviews undertaken in Darlington;

learning.nspcc.org.uk/case-reviews/recently-published-case-reviews

In addition, the NSPCC provides a thematic briefing highlighting the learning from SCR's which focuses on the different topics;

www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/

Local Learning

CASE	LEARNING
June 2019 - Child F ***Darlington Safeguarding Partnership*** Suffered life threatening illness following the ingestion of prescription medication.	https://www.darlington-safeguarding-partnership.co.uk/media/1824/child-f-scr-report-final-for-publication.pdf

Regional Learning

CASE	REPORT
May 2020 – Adult C **Teeswide Safeguarding Adults Board** 30-year-old lady who died following cardiac arrest after diagnosis and treatment for pneumonia.	Read Learning Lessons Review

Reviews undertaken by the National Panel

THEME	LEARNING
March 2020 - Adolescent deaths or serious harm where Criminal Exploitation was a factor	First National Review undertaken by the National Panel Local and National Learning identified which can be viewed in the link below: Safeguarding_children_at_risk_from_criminal_exploitation_review.

National Learning

PHYSICAL AND EMOTIONAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 – Anonymous Authority – Child 1 Life threatening injuries to a child attributed to physical abuse.	Child 1's sibling was referred for paediatric assessment, which also identified abuse. Mother and partner were arrested and prosecuted. Child 1's sibling was referred for paediatric assessment, which also identified abuse. Child 1 and sibling lived with mother and her partner. Partner controlled mother, prohibited her from having contact with children's father, subjected her to domestic violence and abuse, and abused the children when they began cohabiting. He isolated mother from her family; and was issued a harassment warning by police following threats to relative. Mother sought support for low mood and self-harm from GP. Child 1 had been observed with bruising and other injuries at nursery, but this was not evaluated as a potential safeguarding concern. Child of partner's previous partner (Partner 2) disclosed to teacher that partner was abusive and violent towards their mother, leading to charges for domestic violence and abuse. Police and Crown Prosecution Service applied for him to be remanded into custody and informed that partner was living with two young children with serious child protection concerns; application rejected by magistrates. Read overview report	**Learning:** • risk and harm from control and coercion represents a different threat to other forms of domestic violence and abuse; • intimidated adults and children are unlikely to disclose information; • prior history of domestic violence and abuse is a significant indicator of higher risk in subsequent relationships. **Recommendations:** • issues for national policy considerations include: - guidance on coercion and control as a safeguarding issue and the implications for practice; • guidance and arrangements for training for magistrates in regard to domestic violence and abuse.

2019 – Leeds – Billy Physical abuse of a boy aged under 1-year-old in 2016.	Billy was born prematurely and placed in foster care subject to an interim care order at 2-weeks-old. Pre-birth assessment had concluded that it was not safe for him to be cared for by his birth mother, who had had previous children removed from her care. Moved into the care of his father and partner, and her child in September 2016. Father had history of substance misuse, domestic abuse, having a child removed from his care; partner had history of a child being removed from her care because of poor parenting capacity. Concerns raised about couple's capacity to parent Billy, who had complex needs due to detoxification from mother's substance misuse during pregnancy. Following a home visit where it was reported that Billy had a swollen leg, medical assessment and x-rays revealed fractures and bruises sustained whilst placed with his father and partner. Ethnicity or nationality not stated. Read overview report	**Learning:** • evidence of good practice with professionals working well together to do the best for Billy; • some opportunities missed for professionals from different agencies and disciplines to formulate effective plans together; • purposeful professional meetings may have promoted better clarity and more effective ways to have informed decision making. Uses the Welsh model methodology. **Challenges:** • consider how all involved agencies can contribute effectively to the formulation of a child's plan; • ensure the inclusion of hypothetical risks that may be predicted along with risks identified in a comprehensive assessment to better safeguard children.
2019 – Lewisham and Harrow – Child LH Physical abuse of a 4-year-3-month-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	**Learning:** • 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:**

	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. Read overview report	• 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.
2019 – Medway – incidents at Medway Secure Training Centre. Institutional abuse of children at Medway Secure Training Centre (STC) in 2015.	Abuse was identified by an undercover reporter who filmed his experiences. Subsequent BBC Panorama programme showed apparent excessive use of force in restraints by staff, bullying and aggressive behaviour. Consequently Kent Police launched Operation Woodley, which resulted in the prosecution of nine people for misconduct in public office and common assault. There were no convictions. Independent Reviewer contacted sixty-five Local Authorities responsible for 330 children placed at Medway STC during this time frame; 25 consented to speak with him. SCR Panel Chair and the Independent Reviewer visited Medway STC in April 2018 and talked with seven children from a cohort of 38 residents. Ethnicity of children not stated. Read overview report	**Learning:** • create safe working cultures within organisations, including safe recruitment, policies, training and supervision of staff; • ensure statutory agencies' arrangements for responding to allegations about adults who are in positions of trust are effective in protecting children from abuse; • ensure appropriate, child focussed commissioning practice by national organisations responsible for contracts for service provision within the secure estate; • consideration needs to be given to ensure the advocacy service is fully accessible and there are no barriers to children raising their concerns. **Recommendations:** • re-launch awareness programme and training on safer recruitment processes and audit to ensure these messages are embedded; • consider STC staff undertaking training in Adverse Childhood Experiences (ACEs) to better understand children's needs and behaviours;

		• consider the implementation of regular formal supervision processes for staff.
2020 – Tameside – Child V Significant non-accidental head injuries to a 7-week-old infant in 2018, attributed to shaking.	Father charged with an offence relating to the injury and received prison sentence. Child V lived with Mother and Father; Father had two other children living elsewhere. No Children's Social Care involvement during pregnancy; parents attended routine health appointments. When Child V was 2-weeks-old Police interviewed Father regarding an incident of non-recent sexual abuse; information about the allegation not shared by Police service with any external agency. During last visit by Health Visitor, parents explained that Mother needed to return to work and that Father was caring for Child V. Later the same day Father called ambulance reporting that Child V was unwell; at hospital investigations revealed significant brain trauma. Unconnected allegation of non-recent sexual abuse made against Father in 2016. Ethnicity or nationality not stated. Read overview report	**Learning focuses on the following themes:** • preventing abusive head trauma; • opportunities to consider safeguarding in health appointments pre- and post-birth; • information sharing to enable wider safeguarding. Identifies good practice: health visitor was professionally curious whilst conducting thorough observations of Child V and the family, supported by detailed recording. Uses the Welsh Child Practice Review process. **Recommendations:** • programme of awareness and prevention relating to abusive head trauma is developed, agreed and implemented across the partnership area with all parents and carers; • explore opportunities locally for professionals to be more aware of the significance of adverse childhood experiences and the importance of proactive professional enquiry regarding family histories.

NEGLECT		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 – Anonymous – Child H Attack by a dog staying within the household of a severely disabled 10-year-old girl in January 2018.	Child H has been disabled since birth, unable to walk, talk or feed herself and needs constant care. She was attacked in the early hours of the morning following a move to a new home. Child H and her siblings had been subject to a Child Protection plan for two years due to long running concerns about poor parenting, poor home conditions and neglect. In October 2017 Children and Family Services recommended changing this to a Child in Need plan. Ethnicity of Child H is not stated. Read overview report	**Learning:** • as part of a standard risk assessment, a dog should be considered in the same way as any other safeguarding hazard within a household; • although the Child Protection Conference system is managed by Children's Social Care, it is the multi-agency group who are the decision makers; • when an abused or neglected child is made subject of a Section 47 Enquiry, the strategy meeting should always consider the need to safeguard any siblings. • Methodology: use a bespoke 'systems review' **Recommendations:** • to consider how the lived experiences of children with severe disabilities and/or limited communication abilities can be represented and heard particularly when significant decisions are made about them; • promote good practice whereby practitioners ask parents whether there are pets in the households they visit; • review training around assessing parenting capacity to change and working with behaviours of feigned compliance, resistance and deceit.

2019 – Portsmouth – Child G Neglect of an adolescent boy over several years by his mother.	Child G was diagnosed with a degenerative and limiting illness which required full-time care. Was regularly assessed by professionals as malnourished and under-weight. Mother continually failed to take Child G to health appointments and did not engage with many of the 24 agencies and numerous professionals involved with Child G, including Children's Services. Home environment was deemed to be cold, smelly and untidy. Child G was subject of a Child Protection Plan (CPP) under neglect in June 2015 and was subsequently made subject of a Child in Need Plan in March 2016 after the CPP had limited success. Uses a model of learning based on a Soft Systems Methodology. Ethnicity and nationality of family not stated. Read overview report	**Learning:** • when assessing risk of harm to children with disabilities, it is important that the care of the disability does not distract, or mask, • any actual or potential harm being caused; • children with multiple and complex needs should always be offered an advocate when there is an expectation that they express their views and contribute to their own care arrangements. **Recommendations:** • promote greater understanding across the safeguarding partnership about mental capacity, decision making and implications for safeguarding of children aged 16-18 years old; • seek clarification about the role of the MASH for when professionals from all agencies refer concerns about a child's welfare or safety, and it is an open case to Children's Services.
2019 – Reading – Child I Serious incident involving a 4-year-old child.	Child I was admitted to hospital in June 2016 after ingesting a potentially lethal dose of a sibling's epilepsy medication. Child I taken to hospital by ambulance having been found unresponsive by Father. Blood tests showed high levels of epilepsy medication. Incident treated as non-accidental. Police unable to prosecute due to insufficient evidence. A strategy meeting was held, and Child I's siblings were placed in foster care. Family were well known to services. Mother and Father had presented as homeless prior to becoming	**Learning:** • thorough risk assessments should be undertaken when a partner has left a domestically abusive relationship, but children are with the perpetrator; • it is important to be aware of the pressures and difficulties faced by young parents; • all professionals who can offer insights into a family should be invited to meetings examining levels of need and risk for children and families. Uses the SILP methodology. **Recommendations:** • promote awareness of the Escalation Policy;

	parents. There had been multiple reports of domestic abuse and possible physical abuse of Child I's siblings. This led to Section 47 enquiries, but concerns were not substantiated. Ethnicity and nationality unknown. Read overview report	• GPs should consider social issues in a child's life that may affect the ability of the parent/carer to maintain a medication regime when prescribing children medication; • the LSCB to seek assurance from Children's Social Care that issues highlighted are being addresses in a timely manner, particularly the application of Child in Need procedures.
2020 – Anonymous – Children W Severe neglect and abuse of a large group of siblings by their mother and father over many years.	Care proceedings concluded in 2017 and the children are no longer under parents' care. Six of the siblings are now adults. Evidence of the children suffering significant neglect and abuse by their parents between 2007-2017. Home environment was overcrowded, chaotic, dirty and unsafe. Evidence of physical abuse, domination and coercion, and failure to prevent physical and sexual abuse between siblings. Failure to ensure that the children received medical care or attended school regularly. Parents were uncooperative; aggressive to professionals with some disguised compliance and manipulative behaviour. Several of the children made subject to child protection plans for neglect in 2007-2009; in July 2016 police protection was taken on all the children under 18 living with the parents and interim care orders were granted. Ethnicity and nationality not stated. Read overview report	**Learning:** • overwhelming nature of the complexity and scale of the problems and of the oppositional, hostile behaviour of the parents; • responses from all agencies to concerns and interventions were generally short-lived and episodic; • children's lived experience was not fully appreciated. **Recommendations:** • develop a model for interagency practitioner supervision for complex cases where working together closely and consistently is of paramount importance; • ensure that the use of the Public Law Outline is being used effectively to give local authority and social workers sufficient leverage with families which are deliberately obstructive by clarifying their concerns in a 'Letter before Proceedings' or further action.
2020 – Anonymous – Bilal	Bilal (known as Billy) had not been seen by any professional since the age of 14-months and had	**Learning:**

Serious neglect and physical and emotional abuse of a 9-year-old boy and his siblings by their parents.	not received education, health or social care services to meet his diagnosis of autism. Children were removed from state education and faith schools to be electively home educated. Parents believed spirit possession had caused Billy's autism and sought faith-based treatment overseas. Older sibling emailed Childline after concerns about Billy's declining health and possibility that parents would take family to Africa. Police attended and took children into police protection. Parents arrested and serving custodial sentences for child cruelty. Billy is Black British of African heritage. Read overview report	• the role of neighbours and local communities in recognising and responding to concerns about children and young people; • areas that usefully inform practitioner learning and improvements in practice include taking a child-focused approach, cultural sensitivity and professional curiosity; • contact with the family at transition from health visiting to school nursing services can help determine 'school readiness' of a child and to identify unmet needs. **Recommendations:** • identify how to report and share information about children who have not been seen for a significant amount of time and triangulate whether there are further concerns across agencies; • ensure that children and young people who are home educated can access help and support to meet their needs via the current children and young people section of the LA schools and learning webpage.

SUDDEN UNEXPECTED DEATHS IN INFANTS AND CHILDREN		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 – Anonymous – Child A19 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	**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

	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. Read overview report	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 are better informed if there is no intention to speak to the alleged perpetrator.
2019 – Anonymous – Child F 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. Read overview report	**Learning:** • Child F's voice was heard but was not understood and acted on; • evidence of poor inter-agency 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. **Recommendations:** • 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.
2019 – Croydon – Child Q Death of a 16-year-old boy following a road accident in 2017.	Child Q was one of the 60 vulnerable children included in the Vulnerable Adolescents Thematic Review *outlined in our 1st Edition DSP Research Digest;* an analysis of multi-agency involvement by Croydon SCB. He had unaddressed behavioural and emotional challenges; he was a looked after child with Croydon Children's Services; he was believed to be a gang member and was known to Youth Offending Services. He had frequent moves to various locations within a short space of time often for short periods. The family are Black British Caribbean. Read overview report	**Learning:** • support to parents as early as possible in a child's life paying particular attention to attachment in early years and experiences of separation and loss; • equip children's workforce to provide a trauma informed response to adults and children; • Child Q's behaviours were not adequately addressed in school, which led to exclusion; • ensure that transfer or transition arrangements are as robust as possible; • Child Q required intervention and treatment for various emotional and mental health issues, but treatment was unacceptably delayed. **Recommendations:** • the need to strengthen working protocols between Adult Mental Health and Children's Services to facilitate development of integrated whole family health care pathway; • to influence the Department for Education to review alternative education and agree a consistent methodology of working with high-risk pupils in a multi-agency context; • join up multi-agency risk and safety planning forums to improve services for children at

		high risk in the community, such as gangs, serious youth violence, missing and all forms of exploitation.
2019 – East Sussex – Child T 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. Ethnicity or nationality of Child T is not stated. Read overview report	**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 ongoing 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.

2019 – Lewisham – Child X Death of an 11-year-old boy in May 2017.	Parents called an ambulance because Child X was suffering with a chest infection. Paramedics attempted to take him to the nearest hospital, but parents refused and he was taken to a hospital further away. Child X suffered cardiac arrest en-route and died. Child X had complex health needs since birth, including cerebral palsy and epilepsy. His parents cared for him full time. He was admitted to hospital twice in May 2015 and Father questioned treatment. A Section 17 assessment was triggered in July 2015. Section 47 enquiries were initiated in January 2016 which led to Child X being made subject of a Child Protection Plan for neglect, later stepped down to a Child in Need plan. Several professionals reported aggressive behaviour by Father and parents were difficult to contact and displayed challenging behaviour. Family are Black/African Caribbean and Jehovah's Witnesses. Read overview report	**Learning:** • the threshold for intervention due to neglect was too high; • emergency contingency planning should be given more attention when working with families with children with life limiting conditions; • professionals would have benefited from a unified approach to working with a family they found hard to engage. **Recommendations:** • there should be clear guidance for staff where parents are reluctant to engage; • ensure a system for identifying a Lead Professional for all children with complex needs is in place; • ambulance service should review guidance on how police assistance can be used to ensure the welfare of patients.
2019 – Lewisham – Child Y Death of a premature 9-week-old baby girl in June 2017 from unascertained causes.	Mother had fallen asleep with Child Y and when she was awoken by her 7-year-old daughter, Child Y was not breathing. Mother had history of mental health difficulties and reported being sexually abused as a child in the West Indies and learning difficulties due to a childhood accident. Mother and Child Y's four siblings were known to Children's Social Care Services and Police; NSPCC referral in 2016. History of violence within relationships with Fathers 1 and 2, and private law dispute about	**Learning:** • the need for raised and constant professional curiosity; • learning about invisible men; • a greater willingness to escalate issues if agency responses appear insufficient; • effective record keeping. **Recommendations:** • policies and guidance should be amended to require midwives and health visitors to enquire about, observe and record, where and in what a baby is/is to be sleeping.

	residence arrangements with Father 1. A Family Assistance Order was made in 2015. Allegations of physical abuse and online sexual exploitation involving Siblings 1 and 2 and Father 1 lead to a Children's Social Care assessment. Social workers concerned about Mother's parenting; risks of co-sleeping with Child Y were discussed on several occasions. Five children (including Child Y) and Mother were living in the two-bedroom flat, which health visitors noted were poorly decorated and sparsely furnished. Police observations at the time of Child Y's death showed that the home environment was dirty and smelly, with no suitable sleeping place for Child Y. Child Y was of African-Caribbean ethnicity. Read overview report	
2019 – Nottingham – Child KN15 Death of a 13-year-old girl of unconfirmed causes in June 2015.	KN15 was found by the police two days after she had been reported missing from home following a family argument. She died of unconfirmed causes. KN15 had witnessed domestic abuse between her mother and father during her early childhood. Her parents separated in 2011, and at the time of her death KN15 was living with her mother, her mother's partner (who had self-reported mental health problems), and two siblings. The family was known to social services and frequently moved between Nottinghamshire and Derbyshire local authority areas involving multiple changes of schools and GPs. The police had investigated potential emotional abuse within the household. KN15 went missing from	**Findings:** • the importance of using assessments to support early intervention; • the needs of children who live with adults who have reported mental health problems should be systematically assessed by all partner agencies to ensure that children and families receive the support they require; • assessments should explore the wishes and feelings of the child to understand the cause of a child's behaviour and underlying distress. Uses the Significant Incident Learning Process methodology, a learning model which engages frontline staff and their managers in reviewing cases. **Recommendations:**

	home on several occasions and she presented with challenging behaviour at school. KN15 and family are White British. Read overview report	• LSCBs should review policy and information sharing processes when a child moves school within and between local authorities; • ensure that practice is consistent, and child centred when potential safeguarding concerns are to be discussed with parents/carers.
2019 – Swindon – Child U Death of a 1-year-old boy in November 2017 from unascertained causes.	Neglect concerns had been shared by those involved at the time. A criminal investigation was undertaken with a decision of no further action in respect of Child U as the cause of death was Sudden Unexplained Death in Childhood. Intensive and targeted support was provided to the family by the Family Nurse Partnership, the Family Service, supported temporary housing provision and Children's Social Care. Father had a difficult childhood with concerns around neglect, sexual and emotional abuse. Mother had anxiety issues and slight learning difficulties. Child U and Sibling were the subject of both Child in Need and Early Help plans. Family are White British. Read overview report	**Learning:** • the child's experience must run through all work undertaken with families and thresholds should be focused on the impact of parenting on the child; • professionals need to use the neglect framework and practice guidance to help them identify neglect; • if a parent voices concern about being a parent due to their childhood experiences of sexual abuse, specialist support should be made available; • when assessing if an injury is consistent with the story provided by the parent, consideration should be given to the child's developmental stage. **Recommendations:** • to question how professionals in partner agencies make referrals that provide the evidence and information required when they have safeguarding concerns; • to request assurance from partner agencies that professionals understand the risks of interfamilial sex abuse and a parent's adverse childhood experiences (ACEs).

2020 – Hounslow – Sasha Death of a 17-year-old girl by suicide in August 2017.	Sasha was the third of three children in her family. Her mother had poor health and was unable to care for her. As a young child she had been made subject of a child protection plan, and she was in foster care between 2006 and 2007. Sasha received services from many agencies, including Children's Social Care, Child and Adolescent Mental Health Services (CAMHS), Police, Youth Offending Services, and services in relation to possible child sexual exploitation between late 2015 to August 2017. In the period January 2016 to March 2017, there were three Child and Family Assessments; decision made to accommodate Sasha in care in March 2017. Ethnicity or nationality not stated. Read overview report	**Learning:** • assessing competence, resilience and emotional attachment disorder in adolescents and considering the impact of adverse childhood experiences (ACEs) and impact of cannabis use; • using an holistic family approach to assessing children and young people where their parents have difficulties; • recognising when young people are carers; the importance of reflective supervision. **Recommendations:** • to work with the Safeguarding Adults Board to develop a "Think Family Approach"; • review how practitioners are supported and trained in assessing adolescents who have complex and unresolved emotional issues, possibly coupled with drug use and impulsivity; • promote awareness of and response to Contextual Safeguarding
2020 – Salford – Baby MD Death of a 5-week-old infant in August 2018.	Baby MD had been placed by mother in the parental bed to sleep during the night and was found lifeless the following morning. Parents had consumed a significant amount of alcohol and there had been a domestic abuse incident. Baby MD, together with siblings, was subject to a Child Protection Plan under the category of neglect. Mother had history of alcohol misuse and mental health difficulties; had experienced Adverse Childhood Experiences (ACEs). Mother had four children prior to relationship with father; all children were in the	**Learning:** • trauma-informed practice can support service users in forming effective working relationships with practitioners; • case transfers should ensure all relevant information including significant historical risk factors and parental ACEs is shared; • there is a need to explore more effective safe sleep interventions for vulnerable families. Identifies eight instances of good practice. **Recommendations:**

	care of grandmother or birth father. Baby MD's father had alcohol misuse issues and convictions for violent offences. History of domestic abuse. Mother moved across local authority boundaries twice; historical risk factors not fully shared in the first children's social care transfer. Father was a 'hidden male' after the second move. Ethnicity or nationality not stated. Read overview report	• consider escalating the trauma-informed practice learning to the Greater Manchester Standards Board; • Safeguarding Children Partnership to be assured its multi-agency partners have considered the relevant learning points and developed implementation plans in order to support safeguarding practice when working with complex families with multiple risk factors.

SEXUAL ABUSE and CSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 – Anonymous 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 deregistration 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. Read overview report	**Learning:** • 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; • 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:** • 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.

2020 – Anonymous – Child Z Sexual assault and sexual exploitation of an adolescent girl between the ages 14-18-years-old.	Child Z lived with mother and older half-brother in Local Authority 1 (LA1). Received services for anorexia. Assaulted by older boy she was in relationship with, resulting in social care assessment, which identified risks of suicidal ideation and sexual exploitation. Case closed; referral to other services. Increasing concerns about her relationships with a number of males; diagnosed with emotional dysregulation. Pregnant at nearly 16-years-old; homelessness resulted in referral to Local Authority 2 (LA2). Detained in psychiatric unit; son made subject of care proceedings. Case transferred back to LA1 on her discharge. Mental health deteriorated; further incidents of sexual assault and exploitation. Placed in mental health supported accommodation at age 18-years-old. Uses a hybrid model based on the Welsh Model. Ethnicity or nationality not stated. Read overview report	**Findings:** • resource pressures were such that they were manifest in high thresholds; • medical focus was necessary, but an early consideration of home situation would have been appropriate; • local authority transfer requests were not founded on the best interest of the child; • lack of understanding of the lived experience of Child Z. **Recommendations to LA1 Local Safeguarding Children Board:** • children who themselves have children should have their own social worker and their own separate plan for the avoidance of conflicts of interest; • where the child of a child is made the subject of child protection plan, there should always be formal consideration as to whether or not the child-parent should also be the subject of their own child protection plan.
2020 – Anonymous – Family D Sexual abuse and neglect of three siblings by their father over many years.	Father was convicted of sexual offences and received a substantial term of imprisonment. Mother was a repeat victim of domestic abuse by Father. Anonymous report made to Children's Social Care in 1998 that Ash, one of the siblings, had been sexually abused by Father. In 2007, Ash disclosed to police, but later retracted, that they had been raped by Father. Father was arrested, but no further action taken due to insufficient evidence. In 2016, local authority received information that Casey, Ash's	**Learning:** • professionals need to act with caution when a victim makes a 'retraction' statement; • sexual abuse is a possible cause of vaginal discharge; • professionals need to recognise when they come into possession of information concerning historical sexual abuse which should be shared with other agencies; • providing the victims of domestic abuse with access to an Independent Domestic Abuse Advisor (IDVA) will help professionals

	sibling, had been sexually abused by Father; abuse disclosed to Mother in 2015. Uses the Appreciative Inquiry (AI) methodology. Ethnicity or nationality of family not stated. Read overview report	recognise and respond to the impact of coercive and controlling behaviour. **Recommendations:** • partner agencies should ensure their records capture the detail and rationale for actions and decisions and have processes.

BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Solihull – Unborn Baby A Death of unborn baby due to suicide of mother, who was 37 weeks pregnant, in April 2019.	Mother found hanged and taken to hospital; following emergency caesarean the baby was stillborn. Mother known to substance misuse services, police, community housing, and wider family was known to education services. Midwife placed mother on pathway for substance misusing mothers; social work assessment pending at time of death. Maternal history of attempted overdose, drug abuse, previous partner violence and missed appointments. Ethnicity or nationality is not stated. Read overview report	Does not specify any learning but finds significant evidence of strong practice, particularly in relation to prompt follow up when the mother did not attend or could not be contacted, by the midwife, social worker and housing officer. **Recommendations:** • substance misuse midwifery team should consider informing women on the substance misuse pathway that a positive toxicology result will lead to a referral to social care at the point of testing; conduct a review analysing current referral processes and pathways.
2020 – Anonymous – Georgia Life-threatening self-harm of a 15-year-old girl in May 2019	Georgia was admitted to hospital following a serious and life-threatening overdose. Georgia was subject to child protection plan in both parents' care, and later her mother's care. Taken into care in 2018; no contact with father for 10 years but court ordered assessment regarding Georgia's wish to have contact. Episodes of going missing, using cannabis, and alcohol misuse. Concerns about risk of	**Learning:** • foster carers require training that is trauma informed; • when a child in care moves area it is important for all professionals to share information and for key professionals to speak to their equivalents in the new area; • Independent Reviewing Officers (IROs) must focus on a child, regardless of the pressures

	exploitation. Georgia was in foster care at the time of the incident but was staying with her father and his partner as planned contact. Georgia refused to return to her placement; made allegations about a visitor to the foster home. Delays in Georgia being formally interviewed about allegation, with her ultimately refusing. Three incidents at father's home: overdose and attempt to self-harm; allegation of physical assault by father; serious and life-threatening overdose. Ethnicity and nationality not stated. Read overview report	that professionals working with the child are experiencing **Recommendations:** • undertake a multi-agency audit to consider practice and processes when a child in care is placed outside of area; • seek assurance that professionals in partner agencies are using appropriate formal processes to challenge other professionals if they are concerned about the plan for a child, or do not receive information that is required.
2020 – Anonymous – Harry Attempted suicide of a boy aged under 16-years-old in 2019.	Harry had experienced significant neglect, trauma, emotional and mental health difficulties whilst living with his mother, stepfather and siblings in Scotland; subject to child protection plan in 2016. In 2017, Harry moved to live with his father in England. Incidents of self-harm; suicide attempts on five separate occasions prior to the incident in 2019. Harry's recollection of the incident, resulting in him being admitted to Child and Adolescent Mental Health Services (CAMHS) is that someone tried to kill him, however there is no evidence to confirm this. Ethnicity or nationality of Harry is not stated. Read overview report	**Learning:** • a greater appreciation of the impact of early childhood adversity and trauma and the importance of using this information to inform decision making and safety planning; importance of information sharing across borders and agency boundaries; • the need for prompt action to secure the appropriate type of support and intervention when young people experience an acute and serious mental health episode. Identifies areas of good practice. Uses the SILP (Significant Incident Learning Process) methodology. **Recommendations;** • to inform the Child Safeguarding Practice Review Panel about the apparent lack of explicit guidance about the transfer of school records across borders in Scotland and England;

		• to review and amend guidance and procedures on the management and information sharing practices between local community-based child mental health services, acute health settings and community health services for situations where children re-present to an acute setting.

HOMICIDE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 – Anonymous – Child K 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. Ethnicity or nationality of Child K is not stated. Read overview report	**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.
2019 – Bolton – Baby C Death of a baby within a week of birth.	Both parents concealed the birth, death and burial of Baby C. No agencies were involved until after Baby C's death when mother disclosed to her mother (maternal grandmother), prompting a police investigation. Older sibling had been removed from parents care and adopted. Father was violent and controlling of mother in their relationship. Mother claimed that Baby C had been born with a deformity and would not take breast milk. Mother and father were charged with murder, but the judge ruled that a murder conviction would not be safe, as cause of death was unascertained. Parents pleaded guilty to concealment of birth and were sentenced. Baby C was White British. Read overview report	**Learning:** As the deliberate concealment from all agencies of the pregnancy and subsequent death of Baby C could neither have been predicted nor prevented, this review only looks at potential interventions which could support practice and lessen the likelihood of similar events happening in the future. **Recommendations:** • consider developing a system of notification letters to the GPs of parents who have experienced the traumatic loss of a child through adoption; • explore the possibility of whether, under the General Data Protection Regulation (GDPR), notification outlining the information the GPs will need to know could be legitimately sent, in the interests of the parents, when consent cannot be obtained; • seek reassurance that suitable provision is available to support women who want to break the cycle of repeat pregnancy and care proceedings.
2019 – Croydon – Child Y 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	**Learning:** • early help and prevention is critical; schools should be at the heart of multi-agency intervention; disproportionality, linked to

	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. Read overview report	ethnicity, gender and deprivation, requires attention and action; • an integrated, whole systems approach is needed across agencies, communities and families. **Recommendations:** • 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.
2019 – Greenwich – Child U 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. Read overview report	**Findings:** • 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:** • 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.
2019 – Kent – Child H 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. Read overview report	**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 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.
2019 – Lambeth and Bromley – Child K Death of a 5 ½ year-old boy.	In November 2016 following injuries sustained during an assault by his mother's boyfriend. He was convicted of Child K's murder and sentenced to life imprisonment. Child K's mother separated from his father in August 2014 following allegations of domestic violence. Mother had no recourse to public funds. Child K was identified as a child in need in 2015 by Lambeth children's social care; known to housing services before moving to Bromley in 2016. Child K had contact with his father until the summer of 2016. Mother started a new relationship in March 2016; boyfriend had been in prison and had a history of violent behaviour including domestic abuse assaults. Child K's mother was unaware of his past. Child K was a mixed-race child; mother's nationality is Ukrainian. Read overview report	**Learning:** • full assessments must be made of accommodation arrangements of offenders when they are known to have been domestically violent to adults and or children; • awareness of the vulnerability of victims of domestic abuse whose immigration status is not secure. Uses the Welsh Child Practice Review methodology. **Recommendations:** • ensure that staff involved in cases involving domestic abuse are aware of arrangements for sharing information about offenders; • that the risks to children, including emotional abuse are assessed when assessing incidents of alleged domestic abuse; • reviewing how families experiencing domestic abuse with no recourse to public funding are supported.
2019 – Oxfordshire – Child M Death of a 5-year-old boy in March 2017.	Child M died of stab wounds while in the family home with his mother. Child M's mother had suffered from mental illness and been a patient of mental health services or treated by her GP for at least five years. In 2015, Child M had been placed in foster care by another	**Findings:** • those working with Child M and his mother had a limited understanding of possible risks to Child M; • after the family moved to Oxfordshire no professional had a comprehensive knowledge of the mother's mental health history as case

	local authority at the request of his mother, telling professionals she had thoughts about harming him which were understood to be part of her psychotic thinking. In the weeks before the death, Child M's mother showed no signs of serious mental illness. Ethnicity or nationality of Child M is not stated. Read overview report	transfer and closure summaries did not contain full details; • there was no coordinated transfer with agreed objectives and plan. **Recommendations:** • consider whether the LSCB's current threshold of need document places sufficient emphasis on the need to consider previous and historical concerns; • that mental health service providers and GPs have adequate arrangements in place to identify and assess the needs of children of patients being treated for psychiatric illnesses; • to ensure staff have clear expectations for obtaining and reading case histories; • to seek reassurance that implementation of GDPR has not led to inappropriate limitations on information sharing.
2019 – Walsall – Charlie Death of an infant in November 2017 from injuries linked to being shaken three months earlier.	Father was convicted of murder. Charlie was the youngest of three children and lived with mother and father. Father had history of significant domestic abuse in a previous relationship and violence towards his sister and partner. GP records showed that he sought support for anger issues in 2004. Father suffered a significant brain injury from a fall at work in December 2015; he was supported by various services; Mother became his primary carer. In June 2017 Sibling 1 made disclosures at school about Father being angry and rough play indicative of risk to injury. Call made to Multi Agency Safeguarding Hub; children's social care	**Learning:** • professional curiosity may lead to a fuller understanding of the lived experiences of children; • accurate recording of assessments is vital for understanding risk; • when children talk about their lived experience there should be adequate credence given; • information held by agencies that indicate risk to children should be shared regardless of how or why that information is known. **Recommendations:**

	stated that threshold was not met for a Family and Child Assessment. Mother declined Early Help support. On the day of the incident Charlie was left in the care of Father along with Sibling 2; he suffered significant injuries linked to being shaken. Read overview report	• specific programmes of activities to improve and embed a culture where Think Family and authoritative practice and supervision become the norm in practice considerations.
2019 – Wiltshire – Child K Death of a 1-year-old boy, Child K, in June 2018.	A post mortem revealed injuries including bruises, scratches and a fractured skull. Child K was born 10 weeks prematurely in June 2017; an older sibling was born in October 2016. The family were known to multiple agencies. In December 2017 Care Proceeding were initiated after a paediatric review found Child K had bruising and a suspected broken femur. He was made subject to an interim care order and placed with foster carers. He returned home in February 2018 after the application to court was withdrawn based on contradictory medical evidence. Following Care Proceedings Child K's mother did not co-operate with children's social care or attend hospital appointments for Child K. Family members expressed concern about mother's parenting including allegations she left him home alone. Evidence of domestic abuse and mother reported to have low mood, financial problems and relationship difficulties. Read overview report	**Learning:** • the importance of focusing on the child's experience; • remembering that a number of minor injuries, including bruising on a baby, may be an indication that the child is at risk of harm; • ensuring family history, background and contextual information is taken into account during the referral process. Sets out findings using the Partnership Learning Review model. **Recommendations:** • embedding the Early Help assessment process across the local authority; • ensuring that staff are regularly reminded about the significance of bruising in non-mobile babies; • all agencies should be confident to question medical opinion provided as part of Care Proceedings.
2020 – Anonymous – Tracy Death of a 3-month-old girl in March 2019. Tracy was found deceased at home.	Criminal investigation commenced by police and care proceedings instigated for siblings. Tracy was the youngest of three siblings; all had recently been made subject to a Child Protection Plan for neglect.	**Learning:** • responsibility to initiate an Early Help Assessment (EHAT) is that of any professional who is working with a child and/or family;

	In 2018, an anonymous referral regarding malnourishment resulted in sibling made subject to Child in Need. Family history of domestic abuse; father arrested on several occasions and had restraining order not to contact mother. Concerns about parenting capacity and neglect. Maternal history of depression, alcohol and cannabis use. Several agencies tried to engage with mother and offered to provide services within the Early Help Assessment Tool (EHAT); all offers of supports were refused. Read overview report	• lack of support and alternative options available to professionals when responding to a persistent refusal of services; • anonymous reports of safeguarding concerns can create a challenge for professionals in identifying the facts and responding to safeguarding concerns in a timely and evidence-based approach. **Recommendations:** • produce a pathway for professionals which details what support, processes and resources are available for engaging resistant families; • agency access to policies which detail how they should respond to refusals to engage, share information and escalate concerns into statutory intervention; • ensure that information is available to the public on the timeliness of reporting concerns and outcomes available to agencies in response to those concerns.
2020 – Redbridge – Baby T Death of an 11-month-old girl in October 2017.	Female C was babysitting Baby T when she became unwell. Ambulance services were called, and Baby T was taken to hospital; was found to have sustained a head injury. Later transferred to Great Ormond Street Hospital, where she died. Female C convicted of manslaughter and sentenced to six years imprisonment. Mother was an asylum seeker and reported imprisonment, religious persecution, physical abuse and rape. Had two other children by a different father in Vietnam and had suffered post-natal depression. Mother had no English language skills and relied	**Learning:** • decisions made by Home Office about Mother's claim for asylum and asylum support; • effectiveness of Home Office asylum seeker support services and 'mainstream' health and social care services; • impact of frequent moves of Mother and Baby T; • use of interpreting services in supporting Mother and Baby T; • 'lived' experience of Baby T;

	on interpreters when meeting professionals. Mother and Baby T were moved accommodation by Home Office several times. Mother began working illegally and paid Female C to babysit Baby T. Mother and Female C were Vietnamese. Read overview report	• indications of trafficking or exploitation concerns and agency responses; • 'hidden males'. **Recommendations:** • remind practitioners about policy and practice in respect of modern slavery; • ensure that advice to parents on caring for crying and sleepless babies is accessible in all community languages; • Home Office to ensure pregnant asylum seekers and asylum seekers with young children are referred to local primary care service at the point of first contact.
2020 – Sheffield – Archie Death of a 15-year old boy in May 2018.	Archie was fatally stabbed by another young person. Archie arrived in the UK in 2014 with his mother and lived with his adult sister and three older siblings until mother's return in 2015. Enrolled in a different school to siblings' due to lack of places. Death of adult sister in a house fire had a traumatic impact on Archie. His behaviour in school began to deteriorate and moves to new schools were unsuccessful, resulting in periods where Archie was home educated. Detained for shop lifting; other offending quickly escalated. Frequent episodes of missing from home; involved in gang culture, controlled and exploited by older associates; known to the criminal justice system and youth justice; subject to a Child Protection Plan. Archie was of African Caribbean heritage. Read overview report	**Learning is embedded in the recommendations but also includes:** • impact of bereavement must not be underestimated. **Recommendations:** • when a parent elects to home educate their child, the local authority should seek reassurances that the child is receiving a balanced education, including a home visit for an assessment by a trained professional; • local authority must develop and communicate a clear escalation process for children not on school roll; • ensure there are structures in place to assess, refer and intervene with vulnerable people who may be exploited by gangs and organised crime groups; • clear referral route for vulnerable young offenders;

		• implement Child Protection conferences that assess risk and develop plans in line with increased understanding of contextual safeguarding.
2020 – Swindon – Child G Death of a 10-week-old baby boy in March 2017.	Child G was a twin, born prematurely and spent the first six weeks of his life in hospital. When discharged the twins lived with their mother and father, and older half sibling (Child I) and Mr B, Child I's father who pleaded guilty to the manslaughter of Child G. Mother had a child who was removed from her care by a neighbouring local authority and placed for adoption. Child I was on a supervision order to this authority, but this was not transferred to other council. Child G's mother shared this information and her history of depression and self-harming with a community midwife; no further action was taken. There was no information of concern held by any agency regarding Mr B; he was considerably older than mother and was seen as a protective factor. Evidence that the adults in this case convincingly lied to professionals about who the father of the children was. Ethnicity or nationality not stated. Read overview report	**Learning:** • evidence that there was a potential systemic weakness in the way that information about unborn babies is sought and shared; • professionals should always be alert to the possibility that family members may not always tell the truth. Uses the Welsh Model methodology. **Recommendations:** • ensuring that staff use the correct unambiguous terminology; • professionals should consider consulting with the GP's of parents as this will avoid missing information on parental mental health and parenting capacity; • professionals should document and share any history of risk/vulnerability when making referrals and providing or seeking information.
2020 – West Sussex – Baby T Death of a 10-week old boy in 2017 as the result of non-accidental head injuries.	Forensic post-mortem found two injuries: one several days prior to death and another closer to time of death. Father convicted of manslaughter and grievous bodily harm; custodial sentence. Family known to	**Learning:** • preparation for parenthood needs to involve both parents learning practical and emotional aspects of caring for a new born baby; • managing crying; • access to advice and support when needed;

	universal services only; no vulnerabilities in family background. Ethnicity or nationality not stated. Read overview report	• when a baby is taken to hospital with symptoms indicating potential harm, consider the possibility of non-accidental injury. **Recommendations:** • Safeguarding Partnership should continue to use ICON: Babies Cry, You Can Cope! and DadPad (prevention of abusive head trauma tools) and evaluate these programmes; • medical professionals should provide documented analysis of any symptoms of non-accidental head injury.

ADULT - NEGLECT		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 – South Gloucestershire – Family Z; Earnest, Agatha and David. The Z Family experienced increasing care and support as they grew older.	SAR was commissioned when Earnest Z died in 2017. David looked after Earnest and Agatha in their own home, although his ability to do this well was not assessed, as he had his own care and support needs. After Earnest died, Agatha's needs were largely unmet and she was neglected; often hungry, cold, frightened and in pain. Many professionals worked with his family, but their response was not always coordinated, timely or effective. **Working with Control**; One family member exercised complete control over the others daily lives, including what they ate and drank, what	**Learning:** • There was too much reliance on historic information about what the Z family had wanted in the past and this became more important than focus on the current needs. • The provisions of the Mental Capacity Act were not used effectively, formal capacity assessments did not lead to best interest decision making, a necessary approach to the Court of Protection was not undertaken for several months. • Risk assessments were not reviewed and updated in the light of new information, the impact of challenge on risk levels was not monitored.

	they wore, how comfortable they were and what medication they could take. As two of the family members became frailer, this need for control to try to prevent their loss of health became acute, with serious consequences for wellbeing and human rights. Whilst not meeting the definition of 'coercive control', this type of total control, that of a carer for those dependent upon them, can have serious and even fatal consequences. Read Learning Brief	• The impact of the control exerted by one family member was not properly understood or analysed in terms of family dynamics and accumulated risk. • The nature of the control exerted by one family member was allowed to impede the engagement and assessment of other increasingly vulnerable family members over a period of years. • The principles of Making Safeguarding Personal were not followed, and the input of advocates not fully utilised in decision making. • A Carers Assessment was undertaken but not utilised to address the perspectives of the controlling family member. • One hospital Trust did not use the provisions of the Mental Capacity Act. • Local authority recording systems impacted on joined up working. • Multi agency planning meetings were not used effectively and were not responsive or timely. • Agencies did not use escalation processes to challenge the decisions made by the local authority. **Recommendations:** • To seek assurance that South Gloucestershire Adult Social Care has been able to implement all recommendations to improve the quality of Adult Safeguarding processes. Whilst the local authority has made a significant start in improvement action changes in practice must be regularly audited and reports made to the

		SAB on progress against agreed demonstrable outcomes. • To seek assurance from North Bristol NHS Trust that it is now compliant with the provisions of the Mental Capacity Act 2005 in all activities and that provisions have been implemented to support people unable to access clinical services. • To review the South Gloucestershire Domestic Abuse practice guidance. • South Gloucestershire Adult Social Care are recommended to review and update their adult safeguarding procedures and systems in the light of the learning. The learning will need to be embedded into MSP practice, risk assessments, recording practices and multi-agency meetings in particular. • Adult Social Care is also recommended to review how advocates are enabled to fulfil their role as representatives of the adult, and to promote the engagement of advocates with adults who have substantial difficulty in being involved in the safeguarding process. This duty is relevant to all adults at risk, but particularly so when there are issues of control by a third party. • Whilst Adult Social Care senior practitioners are now 'checking' the use of the MCA in adult safeguarding processes there must also be activities to increase practitioner's confidence and skill in using the provisions of the Act. • Domestic Abuse training and reflective supervision must address staff awareness and

		confidence when working in situations where adults are being controlled; and situations where people have mental health issues which are impacting on the safety of others or leading to harm. • South Gloucestershire Adult Social Care and Avon and Wiltshire Mental Health Trust are recommended to discuss how the awareness and confidence of practitioners can be promoted in working with people who have mental health issues and to devise opportunities for this to be promoted. • North Bristol NHS Trust is recommended to regularly audit and quality assure the use of the provisions of the Mental Capacity Act 2005 throughout all Trust activities. • In addition, the Trust is recommended to develop policy and procedures to ensure that people who do not have the mental capacity to decide whether and how to access out-patient clinics are identified and able to access the secondary care they need.

ADULT - SELF NEGLECT AND HOARDING		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 – Rochdale Borough Council – Adult 2 She tragically died in a house fire, which is thought to have been caused by smoking in bed.	Family, neighbours and agencies had been concerned about the welfare of Adult 2 for some time, due to her excess use of alcohol and her self-neglect and hoarding behaviours. Although concern for Adult 2's well-being was evident over many years, attempts to intervene to positively improve her situation were not	**Learning:** • Staff in all agencies need to be confident about issues of mental capacity and in complex cases • need to be able to call on support in making an • assessment. Assessment of mental capacity should be recorded as a matter of routine.

	successful. The only support she actively sought was that of her GP in respect of physical health issues, many of which resulted from her alcohol abuse. In this she was inconsistent and would seek help, but then not keep appointments. Read Learning Lessons Review	• Staff in all agencies need to have an understanding of those things that might lead to a refusal of service. In this case Adult 2 herself • said she was embarrassed and ashamed about the state of the house. • Staff need to be confident in providing reassurance and encouraging trust in order to initiate preventative support. • Staff in all agencies need to be sighted on the risks associated with self-neglect and hoarding, • and be confident in assessing associated risks. • Staff in all agencies need to be sighted on risk and prevention of harm, even where the individual themselves rejects the offer of support.

ADULT – PHYSICAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2019 – Reading, West Berkshire & Wokingham Council – Paul Paul was discovered on the floor in his home by a visitor. He had been there for more than 24 hours.	Paul lived with his cousin Bruce, prior to his death Paul's Uncle/Bruce's father lived with them also. Paul and Bruce had a volatile relationship but were close. When they were required to move from their family home after the death of Paul's Uncle/Bruce's father, their volatile relationship became more problematic.	**Learning:** • Paul and Bruce's needs were assessed by Adult Social Care individually but without consideration of them holistically. • Paul did not engage with services, but this was exacerbated by the staff turnover in adult social care which was not conducive to building a relationship with him.

	Both Paul and Bruce were known to Adult Social Care and both had complex needs. Paul did not engage with services, but Bruce did. Paul's son was concerned that his father was self-neglecting. There were numerous allegations made by Bruce that Paul had hit him, however the response from the local authority in regard to these allegations was not compliant with Section 42 of the Care Act and did not follow best practice in regards to Domestic Abuse. Paul was discovered on the floor in his home by a visitor. He had been there for more than 24 hours, Bruce did not/could not raise the alarm. Paul passed away in hospital. There was an initial concern that Bruce had caused harm to Paul, but a police investigation concluded there was no evidence of this. After his death Bruce struggled to cope and was eventually detained under the Mental Health Act. Read full report	• Commissioning of support could have been improved to provide feedback on the home life situation of Paul and Bruce. • Pauls' refusal of services was accepted by Adult Social Care without consideration of the risks to Paul and Bruce, or the concerns raised by Paul's family about possible self-neglect. • Section 42 processes were not followed, and the risks to Paul and Bruce were not effectively addressed. • Paul and Bruce were spoken to together regarding the concerns regarding Domestic Abuse, best practice is that perpetrator and victim should never be interviewed together as this can result in greater risk to the person. • Paul's case was closed by Adult Social Care even though there were ongoing safeguarding concerns. • Use of advocacy was identified for Bruce but not for Paul. • Paul and Bruce were not identified as each other's carers. Paul was sometimes identified as Bruce's carer, but not the other way around. Neither Paul nor Bruce were offered carers assessments. • When a strategy meeting was held people who needed to be involved in the case were not at the meeting, meaning that not all the risks were identified or addressed. • Support given to Bruce after Paul's death was lacking, there was a poor partnership response to Bruce.

		• Making Safeguarding Personal principles were not applied. • Learning from previous SARs, commissioned by the Board, has not been embedded into practice. • The Board requires assurance regarding the quality of supervision across the partnership.

ADULT - BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Hampshire Safeguarding Adults Board/ Lewisham Council – Tyrone Goodyear Tyrone was a 24-year-old man who committed suicide in February 2019.	Mr Goodyear had been in irregular contact with mental health services since he was 15 years old and had been assessed to have Autism Spectrum Disorder (ASD), learning difficulties and Obsessive-Compulsive Disorder (OCD). Mr Goodyear was known to have tried to kill himself once before. Mr Goodyear lived with his mother and five of his siblings in four-bedroom temporary accommodation. This was causing friction between the family members. Mr Goodyear's mother wanted the family to be rehoused. When Mr Goodyear overheard that this would not happen his behaviour changed and in December 2018, he left the family home to stay in hotels around London. Mr Goodyear left home and his mother reported him missing, but he was soon found by police, who were not concerned about him. He then stayed in hotels in different parts of London but maintained contact with his mother. They approached the Council for housing for Mr	**Learning:** • People with Autism Spectrum Condition are more likely to commit suicide than the general population, and the factors that predict this can also be different from the general population. • People with Autism Spectrum Conditions may "camouflage" their needs in order to fit in. They may not be accessing any services, but this does not mean that they do not have unmet needs. **Recommendations:** • Make sure that people understand the information you provide. Do not assume adults have the mental capacity to do this. • If you are concerned about how someone is coping, then consider making a referral to Adult Social Care. • Consider raising a Safeguarding Concern (preferably with consent) in relation to the adult, even if you think the person and the situation does not meet the legal duty under

	Goodyear and were told that it might be available in four to six weeks' time. Mr Goodyear and his mother were also in contact with mental health services and with Mr Goodyear's General Practitioner (GP). There were concerns that Mr Goodyear might harm other people. A mental health assessment conducted on 18th January 2019 concluded that Mr Goodyear was not at risk of harm to himself and/or others. Mr Goodyear was offered further mental health support but since he was moving between hotels in different parts of London this support was not provided. Mr Goodyear was found dead in a hotel room in Enfield on 21st February 2019. He had taken his own life via an overdose. Housing, mental health services and the GP had tried to work together but this was not coordinated and there was a lack of knowledge about how each agency operated. Read full report	safeguarding. Non-statutory enquiries can still be conducted. • Work with the adult at risk's family and remember to offer a carer's assessment if this is applicable. • Don't believe that the most obvious problem that someone brings to you is the only one. • Be persistent and flexible when working with people who you are concerned about, or who are harder to reach (seldom heard).
2019 – Lancashire County Council – Adult J Adult J was found deceased at home in 2018 and is believed to have taken his own life, the cause of death was found to be "Asphyxia by Ligature".	Adult J had involvement with Mental Health Services for a number of years with a diagnosis of 'acute and transient psychosis' and had been discharged to the care of his GP where he continued to be prescribed anti-psychotic medication. Adult J had in place a care plan which acknowledged a history of non-compliance with medication, presenting a high risk of relapse if medication was not taken for a period of	**Learning:** • **Flagging of non-compliance with anti-psychotic medication** – the review found that GP systems in relation to non-compliance with medication were not appropriate for Adult J's needs. The practice had in place a standard procedure for following up on non-compliance with medication when prescriptions were not collected after a period of 3 months. In the case of Adult J, a relapse would occur if

	approximately 3 weeks. The care plan also set out Adult J's wishes that his ex-partner and mother were involved at the point of relapse. A total of 16 contacts were made to services in the nine days leading to Adult J's death, raising concerns for his welfare, suspicions of relapse, and reports that he was acting 'bizarrely and odd'. These calls were made by Adult J's ex-partner; mother; and sister. Read Learning Brief	medication had not been taken for approximately 3 weeks. This relapse signature was available on case records and should have been flagged on the system to identify a timelier follow up. • **Barriers to referrals** – despite a number of contacts from concerned family members, a referral was not opened due to the belief that Adult J had not given consent and was not willing to engage. This judgement had been made without any direct contact with the service user. In addition, consideration was not given to the ability to override consent where there is concern for the wellbeing of the individual. In the case of Adult J, the relapse signature and non-compliance with medication should have highlighted the need for a referral. • **Engagement with family members** – Adult J's family members were provided with inconsistent advice and redirected to other services to gain advice and support regarding a mental health assessment. Staff within these services should have taken the responsibility of contacting partner agencies themselves, rather than placing this back on the family member. • **Mental Health Act assessments** – due to the concerns raised by family members in relation to Adult J's behaviour and non-compliance with medication, staff should have considered a home visit to check the welfare of the individual before the decision was taken to undertake a Mental Health Act

		assessment, however this was not the case and the decision was made without any direct contact with the service user. In the event of safety concerns for the staff member, a joint visit with another agency should have been considered. • **Multi-agency working** – No direct contact was had between professionals and Adult J in the lead up to his death. A professional was responsive to a concerned call from Adult J's ex-partner and agreed to undertake a home visit, however working in isolation meant capacity to do so was limited. Contact and joint working with other professionals may have assisted in this visit occurring sooner, by the most appropriate professional and at the right time. • **Use of case records** – reviews often present problems where agencies do not have shared access to electronic records. Positively, this review highlighted that this is now possible amongst some agencies, however on this particular occasion, there was an overreliance on written records within the system which could have been overcome if professionals had direct conversation. In addition, two case notes had been made to record that Adult J's phone was broken and he was therefore uncontactable via this method, however practitioners did not view this information on recent records and proceeded to attempt contact via telephone. • **Professional challenge and escalation** – the review highlighted a lack of professional

		challenge where requests for intervention had been inappropriately passed from one service to another; and where an agency has not responded to an appropriate request for intervention. All professionals should be familiar with their own agency's escalation policy, and in the case of multi-agency challenge, the Lancashire Safeguarding Adult Board procedure for Resolving Professional Disagreements.