Lessons Learned Research Digest

Issue 4 – October 2021

Welcome to the fourth edition of the Darlington Safeguarding Partnership Research Digest bulletin. This 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 2021.

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/

CASE	LEARNING
Darlington Safeguarding Partnership	*There have been no Child Safeguarding Practice Reviews published in the past 12 months.*

Regional Learning

CASE	REPORT
March 2021 **Hartlepool & Stockton on Tees Safeguarding Children Partnership** **Child T**	**Practice Review;** This review examined the response of agencies over a four-year period in their attempts to safeguard Child T. The review was commissioned by the Hartlepool and Stockton-on-Tees Safeguarding Children Partnership (HSSCP) following an incident in June 2020 when Child T's mother (referred to as Mother) attempted to murder him by strangulation. Child T survived the incident and is now in foster care with his older sibling while Mother serves a term of imprisonment following conviction. Read full overview (PDF)
March 2021 **Hartlepool & Stockton on Tees Safeguarding Children Partnership** **Emma**	**Practice Review;** Emma was three months old at the time of her death on the 10th May 2020, had been discovered by her mother not to be breathing and was pronounced dead by paramedics. The review is to consider how agencies worked together and with the family leading up to her death. 2. Emma died as a result of (suspected) asphyxiation. It is believed that the asphyxiation was caused by Emma being propped up on a pillow in her pram and her head having fallen forwards, restricting her airways. Read full overview (PDF)

April 2021 **South Tees Safeguarding Children Partnership - Liam**	**Practice Review;** In May 2020 when he was aged two years and 11 months, Liam was taken to the Emergency Department (ED) of South Tees NHS Foundation Trust Hospital (STHFT) by his Paternal Grandmother (PGM). He was floppy and unresponsive. Liam had been in the sole care of his father (Father) prior to PGM bringing him to the ED. Tragically, whilst Liam was still in the ED Father took his own life. Read full overview (PDF)
May 2021 **South Tees Safeguarding Children Partnership – 'Daniel'**	**Practice Review;** Daniel was a child in the care of Redcar and Cleveland Borough Council when, aged 17 years old, he was the victim of a shooting, believed to have been made in retaliation for an assault committed by Daniel a few days earlier. Daniel was taken to hospital where, as a result of his injuries, his left leg was amputated below the knee. Between 2016, when Daniel was accommodated by the local authority and March 2020, when he sustained his life-changing injuries, interventions by key agencies were not able to keep Daniel safe; professionals struggled to engage Daniel and he persistently rejected services aimed at reducing the risks to which he was very clearly exposed. Read full overview (PDF)
May 2021 **South Tees Safeguarding Children Partnership – Fred**	**Practice Review;** Fred, an older teenager, was found unconscious in the street after what is believed to be an accidental overdose. He was admitted to hospital, where tests were positive for a combination of alcohol, and drugs which could have had serious consequences; fortunately, he has made a full recovery. Read full overview (PDF)
May 2021 **South Tees Safeguarding Children Partnership – Kingfisher**	**Practice Review;** This review considered two cases. One where a young baby died, and one where a two-year-old was seriously injured. Both of the families were well known to statutory agencies and on either a child in need or child protection plan at the time of the incidents. • Lucy was two years old when she was injured in an accident that was contributed to by parental neglect. Her mother was receiving support as a care leaver and Lucy was on a child in need (CIN) plan at the time of the incident.

	• Mia was less than a month old when she died. The cause of death is not yet known7 . Mia was on a child protection plan (CPP) due to neglect concerns for her older siblings. Her father misuses drugs and is on a drug treatment programme Read full overview (PDF)
May 2021 **Newcastle Safeguarding Children Partnership - Laura**	**Serious Case Review;** Sexual abuse of a girl aged between 11-19-years-old. Laura disclosed a history of sexual abuse by her mother's partner in 2017 at 19-years-old. Read full overview (PDF)
February 2021 **North Yorkshire Safeguarding Adults Board – 'Anne'**	**Safeguarding Adult Review (SAR):** 'Anne' was a 34 year old mother of 3 who became resident in supported housing accommodation. Anne had a history of mental health problems and disclosed substance misuse issues in relation to alcohol, diazepam and mephedrone. In the days up to her death, Anne was appearing unwell and under the influence of substances and was found dead in her flat in January 2018, cause of death drug toxicity. Anne may have been supplementing her prescribed medication with illicit substances. Anne had a long history of being involved with services and considered to have capacity to understand the risks associated with her medication. Despite Anne's presentation changing possibly due to influence of substances, workers did not consider the need to intervene and no safeguarding concerns raised. Read full overview (PDF)
August 2021 **Sunderland Safeguarding Adults Board – 'Alan'**	**Safeguarding Adult Review (SAR);** 'Alan' was a man in his 50's who died as a result of an accident in a fire caused by a cigarette in February 2020. Alan had a pattern of longstanding and repeated involvement with a range of public services, including health, social care and criminal justice services, throughout his adult life. This was underpinned by his chronic alcohol dependency, with Alan having begun drinking at a young age. Alan also had a long history of drug misuse, physical and mental health concerns. He lived a chaotic lifestyle and at the time of his death Alan was homeless and subject to statutory safeguarding, though sadly he died before any meaningful safeguarding work was undertaken. Read full overview (PDF)

National Reviews (undertaken by the Child Safeguarding Practice Review Panel)

THEME	LEARNING
Safeguarding children under 1 year old from non-accidental injury caused by male carers	National Review in children under 1 year old who have died or suffered serious harm through non-accidental injury. The Panel's third review which focusses on the circumstances of babies under 1 year old who have been harmed or killed by their fathers or other males in a caring role. The review sets out the recommendations and findings for government and local safeguarding partners to improve how the system sees, responds to and intervenes with men who may represent a risk to babies they are caring for. Read full report here

National Learning - Children

PHYSICAL AND EMOTIONAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
Feb 2021 – Hull City Council – Baby B Serious non-accidental head injury and bite marks to Baby B.	A 20-week-old baby who was taken to hospital on 23 December 2016. Baby B's father was found guilty of grievous bodily harm and received a 12-month prison sentence. Baby B was born prematurely at 28 weeks and remained in a neonatal intensive care unit for 14 weeks prior to discharge. Baby B was the first child born to their mother who was 17 years old and the second child of their father who was 20 years old. Baby B was identified as a Child in Need while in hospital. Issues of concern included: the relationship between the parents; their ability to parent safely due to low level maturity; concern about Father's use of cannabis and history of violent and aggressive behaviour. Evidence of domestic violence. Baby B's mother engaged with all ante-natal services and had a high number of medical presentations during her pregnancy but did not disclose domestic abuse. Ethnicity or nationality is not stated. Read full overview (PDF)	**Learning:** • maintaining a focus on fathers of children to establish more clearly the implications of their needs and role in the family; • need to ensure that the Local Safeguarding Children Board escalation policy is disseminated across the whole safeguarding partnership to ensure practitioners and managers challenge when there is a difference of opinion. **Recommendations:** • children's social care to ensure that multi-agency Child in Need plans are in place for children in need; • partner agencies to brief their staff on their responsibility to ensure child in need plans are in place.

Feb 2021 – Sutton Council - Child O Serious harm suffered by a 11-week-old baby boy in October 2016.	Child O was taken to hospital by his parents where he was found to have injuries indicative of abusive head trauma. Child O was seen as vulnerable, but no safeguarding concerns were identified. Sibling S had previously been subject to a Child in Need plan. Following hospital discharge, both Child O and Sibling S were placed in foster care. Maternal history of: mental health problems; severe adverse childhood experiences; persistent non-engagement; teenage pregnancies; subject to Child Protection Plan. Family are White British (former travellers) and known to multiple agencies. Read full overview (PDF)	**Learning focuses on the following themes:** • importance of: timely record keeping and information sharing, including relevant past histories; • engagement with fathers, young people and hard to reach individuals, including at or below the Child in Need threshold; • high quality, reflective, restorative supervision and management oversight; planning to achieve outcomes; • professional scepticism/challenge; • adherence to agency and multi-agency policy, procedures and good practice in a timely way, especially when dealing with new born babies; • consider the impact of adverse childhood experiences; • incorporate family culture and context into assessments; • quality assurance of supervision for health providers. **Recommendations:** • ensure the needs and risks of new born babies are given sufficient attention in their own right; • promote restorative practice; • seek multi-agency involvement before closing a in Child in Need case.
Mar 2021 – Birmingham City Council Serious injury to a 4-month-old baby consistent with shaking and an impact to the head in	Mother was convicted of child cruelty to the baby and their sibling in March 2020. Both baby and older sibling were taken into care and adopted.	**Learning:** • if families do not want or refuse early help it, concerns should be escalated; • intervention pathways need to be clear;

November 2015, resulting in permanent impairment.	Family was known to multiple agencies, including Children's social care. Concerns that neither parent seemed to have bonded with the baby. Parental history of: refusal to accept support or engage with services; social care interventions; teenage pregnancies; adverse childhood experiences; violence and crime (father), mental health issues (mother). Ethnicity or nationality of the baby is not stated. Read full overview (PDF)	• new birth visitors should have all the information before the first visit; • need to remain focused on all family members and their needs; • information should be linked, shared proportionately and well-recorded; • assessments should identify risks and vulnerabilities; • referrals should be seen in context; • engage with fathers. • Blended approach based on Root Cause Analysis. **Recommendations:** • improved provision and organisation of early help services including how new birth visits are carried out; • develop operational guidance to enable triggers where there are multiple referrals/ contacts including using chronologies; • fast decision-making when there is an open case, and another referral is made.
Apr 2021 - City & Hackney London Borough Council - Child A Review relating to Child A, following concerns about suspected fabricated or induced illness including the prescription of opioids for pain management, covering the period from birth to the age of 11-years-old.	Child A was born by emergency caesarean section at 27- weeks-old and was diagnosed with a condition found in premature babies. Child A underwent a wide range of medical and surgical investigations, suffering from an increasing number of conditions leading to more health professional involvement. Evidence of mother declining heath visiting support and cancelling and postponing appointments.	**Findings:** • practitioners did not listen to the voice of child; • acceptance of what mother said, and responding without any objective assessment led to unnecessary and inappropriate medical intervention; • lack of professional challenge and curiosity culminated in the ongoing medicalisation; • an insufficient response in meeting educational needs.

	Child A attended a school for children with physical disabilities and additional sensory needs, before parents opted for home tutoring. Poor health and authorised absences requested by mother impacted on educational progress. Read full overview (PDF)	**Recommendations:** • embedding the voice of the child in procedures and training and ensuring that children are involved at each stage of their care; • review practice guidance on fabricated and induced illness to ensure it takes account of children who are coming to harm through excessive medical intervention; • training should include the potential safeguarding impact on children not being brought for health appointments; • ensure escalation policy incorporates supporting professionals being able to challenge colleagues.
May 2021 – Plymouth City Council – Baby F Life-changing head injury of an 11-week-old boy in September 2016.	Parents were subsequently charged in connection to injuries. Over the first few visits from health visitors after Baby F was born, Mother reported low mood, relationship tensions and issues bonding with the baby. She was receiving workplace counselling and the health visitor offered the maternal early childhood sustained home visiting (MECSH) programme. Both Mother and Father were diagnosed with post-natal depression. Baby F was seen at hospital twice prior to his life-changing injuries. On the second occasion, he was not seen by a senior doctor and was discharged with advice to Father.	***Uses Partnership Learning Review model.*** **Findings include:** • it is important to seek engagement with both parents to assess their mental health; • supervisors need to be vigilant to ensure the most vulnerable families are discussed at supervision; • when parents have their own needs, there is a risk that focus on the child will be lost. **Identifies considerations including:** • guidance on the detection and management of unusual medical presentations in non-mobile babies should be applied consistently by all agencies and counsellors should follow guidelines on safeguarding children.

	On the day of Baby F's life-changing injuries, Mother reported that Father had accidentally banged Baby F's head to workplace counsellor. The counsellor discussed this with a supervisor, but no further action was taken. Baby F was taken to hospital where he was found to have life-threatening head injuries, intra-cranial haemorrhage and rib fracture. Baby F is of African/European heritage. Read full overview (PDF)	
Jun 2021 – Sefton Council – Beatrice Injuries to an 8-week-old girl in 2019.	Beatrice was taken to a walk-in centre concerning a rash and was found to have unexplained bruising. An ambulance was called, and Beatrice was taken to hospital where scans showed 13 fractures to ribs and legs of differing ages. Beatrice's parents did not live together. Father suffered from depression, had anger issues and was diagnosed as having Asperger's Syndrome. Mother had made allegations of sexual abuse against her father and had a history of self-harm and suicidal ideation. Father had attempted suicide previously and Mother had a history of risk taking. Concerns over both parents not taking prescription medication. Family proceedings and criminal investigation were in progress at the time of writing the review. Ethnicity and nationality not stated. Read review online (PDF)	**Learning:** • local authorities should liaise around support to care leavers living across boundaries; • where there is a history as a care leaver, background information should be sought from the responsible authority; • police should take a more holistic view of a person's circumstances and consider information sharing to protect a child, even in cases where the child is not yet born. **Recommendations:** • agencies working with care leavers must be aware of the right for care leavers for service provision up to the age of 25-years-old; • request guidance on information sharing between local authorities where care leavers are not living in the area of the responsible authority; • ensure information sharing policies are in place and include all cases, not just those managed under formal child protection procedures.

Jun 2021 – Warwickshire County Council **Child K** Injury of a 12-week-old girl, taken to hospital in January 2017 with a skull fracture.	Parents stated that Mother dropped Child K during a domestic abuse incident. Police attended the family home one day prior to Child K's hospitalisation, where Sibling disclosed physical and domestic abuse by Father. Parents and Sibling were interviewed by police and children's services. Following Child K's injury, parents were convicted of 'causing injury to a child' and given community sentences; Child K and her Sibling were made the subject of care proceedings. Parents had a history of contact with children's services and police due to domestic abuse and physical abuse by the Father. Child K's ethnicity or nationality are not stated. Read full overview (PDF)	**Learning:** • although guidance and procedures do not differentiate between day time and out of hours child protection situations, in practice out of hours services cannot fully replicate daytime services; • inter-agency strategy discussions should be held whatever the circumstances for child protection enquiries; • clarify in emergency situations if children are protected and accommodated under Section 20 or Section 46 of the Children Act 1989; • written agreements, asking that one parent ensures there is no contact between another parent and their children, may not be realistic and may provide false assurance in cases of domestic abuse. **Recommendations:** • consider how effective current police structure is in ensuring that Warwickshire Police can fulfil their roles as stated in Working Together 2015; • Warwickshire Police to consider whether officers involved in child protection investigations have sufficient participation in interagency safeguarding training.
Jul 2021 – Bradford City Council – Emily Potentially life-threatening non-accidental head injuries to a 6-week-old girl in August 2019. A criminal investigation into the injuries was ongoing at the time of this review.	Emily lived with her mother and her five siblings and half-siblings. Her mother and father separated in April 2019. Throughout the period covered by this review, there were several referrals to children's social	**Learning:** • inconsistencies around attendance at meetings meant that there was never a clear, shared understanding of the children's lived experiences;

	care expressing concerns about the care the mother was providing. There were also a number of domestic abuse incidents between Emily's mother and father. The children in this family were the subjects of child in need plans from June 2018 for 12 months and child protection plans from June 2019. Between July and August 2019, when Emily sustained her injuries, there were regular visits from social workers and health visitors, who reported that children appeared happy and settled. Ethnicity/nationality of family not stated. Read full overview (PDF)	• key people were missing from child in need meetings, child protection conferences and core group meetings; • possible indications of neglect were missed. **Recommendations:** • child in need plans should clearly describe areas of concern, actions to be taken and measures of success; • changes in the composition of a household where there is a child in need or child protection plan should lead to an updated social work assessment; • schools should put arrangements in place so they can contribute to conferences and meetings during school holidays.

Jul 2021 – Nottingham City Council – Child R Serious injuries to a 6-year-old child in 2018.	History of domestic abuse between Child R's parents, resulting in a Child in Need Plan and Child Protection Plans until parents separated. Child R had experienced 13 injuries over a nine-month period, mainly in the form of bruises to his face. In 2017 and 2018 Child R made disclosures about being hurt by mother's partner. Child protection medical examination found that one injury was non-accidental and caused by someone hurting him, but no protective action was not taken. Injuries were attributed to poor parental supervision, but this was not in line with the medical findings. In October 2018, Child R attended the emergency department with a serious head injury and significant bruising, which later required neurosurgery. Mother's partner was sentenced to nine years for grievous bodily harm against Child R; Mother charged with neglect. Ethnicity or nationality not stated. Read full overview (PDF)	**Learning:** • compliance with child protection procedures and the arrangements for the child protection medical examinations; • assessment of risk, the impact of confirmatory bias and misunderstanding of terminology; • the transfer of cases. **Recommendations:** • ensure that multiagency child protection procedures are effective in respect of strategy discussions and child protection medicals; • chronologies should be completed as part of the referral to Social Care to highlight patterns of physical injury; • consider an awareness raising campaign within the wider children's workforce focused on physical harm in children and consider whether the terminology around non-accidental injuries should be changed.
Jul 2021 – Unnamed LA – PS Serious assault of a child in care by an adult in 2019, resulting in life-changing injuries.	The perpetrator was the son of a member of the residential unit staff where PS lived. PS experienced many adverse childhood experiences (ACEs), including physical and emotional abuse. At 7-years-old he was removed from Mother's care and lived with his paternal grandparents under a Special Guardianship Order (SGO).	**Learning:** • it's critical that families involved in SGO placements receive information, advice and training on ACEs and the strategies they need to adopt to maintain the placement; • agencies should have acted as responsible adults and asked for a previous assault of PS to be investigated. Victims of crime often are fearful of retribution.

	PS was described as a troubled child, and in 2017 his grandparents felt unable to cope with his aggressive behaviour. Following several placements in foster care and in a residential care home, PS was placed in the residential unit where he stayed until the assault. Ethnicity or nationality not stated. Read practice review (PDF)	**Recommendations**: • ensure that the 'voice of the child' is routinely captured during assessments; • ensure that measures used to determine suitability of residential settings for placing children are fit for purpose; • ensure that newly qualified social workers and practitioners working directly with children and families receive formal monthly supervision; • staff working with children such as PS should be trained to spot and respond to early signs of exploitation, such as cash in hand work; • staff and managers should know and be able to apply the principles of trauma-informed practice.
Jul 2021 – Sandwell Metropolitan Borough Council - JS Serious physical harm and neglect of a 6-month-old baby by their parents in January 2017.	JS was born prematurely to teenage parents supported through the Family Nurse Programme. Pre-birth, Mother moved to independent living with Father when JS was nearly 3 months old. Concerns about neglect and parents disengaged with services; no referral was made. JS had five hospital admissions; at the last admission morphine was found in J's system. Maternal history of: involvement with safeguarding services; depression; missed appointments. Father was convicted of wilful neglect in January 2019. Ethnicity or nationality not stated. Read full overview (PDF)	***Uses a systems review methodology*** **Learning:** • need for all professionals to: recognise when a multi-agency approach is needed and what support may be needed; • consider whether their service is best placed to deal with the presenting issue; • follow guidance, protocols and procedures; • share information; • be able to recognise a safeguarding concern and access supervision from safeguarding lead; • challenge robustly when parents do not listen to advice and instructions or administer medication not approved for a child;

		• consider whether all children who attend A&E with excessive drowsiness without an immediately identifiable cause should have their urines sent for toxicology. **Recommendations:** • ensure that pre-birth protocol is embedded and used in all appropriate cases; • ensure that thresholds are properly understood; • ensure that health partners have in place robust provisions for supervision and "Did not attend' (DNA) policies; • roll out a neglect identification tool; • launch a prevention campaign aimed at parents/carers about the safe handling and storage of drugs.
Aug 2021 – Dudley Metropolitan Borough Council – Children Q&R Serious injuries to two unrelated children; Child Q aged 4-years-old and Child R aged 7-weeks-old, whilst in their parents' care in December 2020.	In both these cases there was some professional disagreement about whether the injuries sustained were non-accidental, with paediatricians believing that the injuries in both cases were likely to be non-accidental. The families involved in these cases were both known to children's social care prior to the children's injuries. Professionals made several referrals to children's social care, but these often did not meet the threshold for statutory intervention. Both cases featured recent and historic domestic abuse and historic safeguarding concerns. Mothers had experienced adverse childhood experiences and mental health problems. Disguised compliance and a lack of professional	**Learning:** • there was a lack of clarity about the men involved in the children's lives; • domestic abuse didn't appear to have been considered by professionals; • there was disagreement between medical and children's social care professionals about the cause of the injuries. **Recommendations:** • decision making at strategy meetings should include all appropriate agencies; • the children's workforce should feel confident recognising potential non-accidental injuries;

	curiosity were also featured in these cases, as well as issues around hidden men. Child Q was of a mixed background. Child R was mixed Black and White ethnicity. Read full overview (PDF)	• the development of a practitioner forum should be considered, where medical and social care staff can gain an understanding of each other's roles.
June 2021 **London Borough of Merton Council** **'Jason'** 16-year-old Jason sustaining serious stab injuries in April 2019.	Jason had been missing for the first two weeks of April 2019, during which time he was involved in selling drugs (county lines) in a large town many miles from his home. On his return he presented as traumatised and disclosed that he had been assaulted and threatened that he would lose his life by those organising the drug-selling. He was highly anxious about his safety. The day after, Jason was taken to hospital after being stabbed in his leg and back. On 13 June 2019, MSCP decided that these events met the Working Together 2018 criteria for a local child safeguarding practice review. This decision was agreed by the Child Safeguarding Practice Review Panel. Jason is Black British, born in the UK, his parents are Black Caribbean (Jamaican) and separated before his birth. Jason always lived with his mother although her immigration status of No Recourse to Public Funds (NRPF) has been a pervasive issue throughout his childhood. The family lived with uncertainty; they had no home of their own and depended on help from wider family and friends. His mother told Youth	

	Justice Service (YJS) staff that they were reliant upon their charity to meet the family needs. She did not have the right to work or claim any benefits. It is understood that mother undertook casual work, which would entail working long hours . Her NRPF status was settled in late 2018, when she finally gained the right to work and remain until 2021, when Jason will reach maturity. Read full overview (PDF)	

NEGLECT		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
May 2021 - City & Hackney London Borough Council – Child B Neglect of a 10-year-old child over a number of years.	Child B was born with a disability and needed significant support from health specialists. They lived with mother, father and older siblings. In May 2015, Child B was admitted to hospital to have a toe amputated. Concerns were raised that the infection that led to the amputation was preventable. Child B was not brought to a significant number of health appointments. Further concerns were raised and formally escalated in 2018. In February 2019, Child B was made subject of a child protection plan. Nationality or ethnicity not stated. Read full overview (PDF)	**Learning:** • children not being brought to appointments is an indicator of potential neglect; • effective and child focused safeguarding practice with disabled children ensures they are seen, heard and helped; • the focus on engaging parents and carers to support disabled children is key, but this should not dilute professional challenge; • multi-agency working, information sharing and understanding the responsibilities of others can be complex; • the need for professionals to think family and think fathers. **Recommendations:** • ensure that all services have access to and use a 'Was Not Brought" policy across the local health system;

		• the Disabled Children's Service should ensure that meetings that they convene include an analysis of a child's attendance at appointments; • ensure that recording systems are sufficient to identify repeating patterns of children not being brought to appointments; • ensure that guidance for safeguarding children with disabilities is sufficient in terms of setting out the importance of communication and hearing the voice of the child.
Jun 2021 – London Borough of Bexley Council – Child O Serious and potentially life-threatening incident to a 4-year-old boy in July 2019.	Child O was taken to hospital after accidentally swallowing Gamma-ButryoLactone (GBL) he found in his mother's handbag. Child O lived with extended family under a Special Guardianship Order (SGO). Child O was alone with Mother when the incident happened, contrary to the SGO agreement. Concerns raised about neglect due to parents' misuse of drugs. A Child Protection Plan was made for Child O but was unsuccessful in reducing risks. Father was convicted of child neglect in 2015 when he was found in-charge of Child O under the influence of drugs. Child O was accommodated under section 20 of the Children Act 1989 and placed with his grandmother. A police investigation was underway but not concluded. Care proceedings were initiated for Child O and sibling which concluded in 2020.	**Learning:** • the support offered to the family under the SGO and the quality of the support plan; • robustness of the communication between local authorities (LAs) including how safeguarding referrals were raised; • adult mental health; • domestic abuse and MARAC involvement; • issues arising from management oversight and supervision information. **Recommendations:** • review training programs about the legislations, governing and meaning of different types of placements such as SGOs, Children Looked After (CLA) and adoptive placements that are open to LAs when considering the future of children who are unable to live with their birth parents;

	Ethnicity and nationality not stated. Read practice review (PDF)	• oversee a multi-agency review of current arrangements for Children in Need that are also subject to SGOs.
Aug 2021 – Wandsworth Borough Council **Child A** Injury and acute illness of a 6-month-old boy, taken to hospital in March 2018	Hospital staff found that Child A had a fractured rib and was seriously underweight and malnourished with a throat abscess. Following hospital admission, Child A became the subject of a child protection enquiry and was put on a child protection plan for neglect. Child A was made the subject of an interim care order and was placed in foster care once discharged from hospital. A police enquiry was started but was concluded due to insufficient evidence for a conviction for Child A's injury. Mother and father had traumatic and abusive childhoods; both had an autistic spectrum disorder and mental health issues. Child A's ethnicity or nationality are not stated. Read full overview (PDF)	**Learning:** • professionals should be able assess when to explore parental backgrounds, indicators of vulnerability, and adverse childhood experiences; • training for practitioners in neurodiversity; • how professionals should use feelings of unease or discomfort to inform assessment and decision making; • the role of early help services in working with and supporting vulnerable families. **Recommendations:** • strengthening professional training and screening on autistic spectrum disorder, ADHD and anxiety disorders, and what such difficulties mean for parents' understanding of information from health agencies; • when children's services check if a child and their family are known to the service, the whole family and household should be included; • reviewing the effectiveness of the mechanism for alerts to community health services of children attending accident and emergency and other urgent care NHS services.

SUDDEN UNEXPECTED DEATHS IN INFANTS AND CHILDREN		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
Feb 2021 – Metropolitan Borough of Dudley **Child A** Death of a boy aged under 3-months-old in June 2019.	Child A was found unconscious on the sofa at home in the morning by Mother; Father was asleep on the sofa. Child A was taken to hospital by ambulance where he was confirmed dead. Child A was born prematurely and spent time on the neonatal unit prior to being discharged home. Mother is a care leaver and had disclosed cannabis usage; Father also known to use cannabis. Concerns that both parents were using cannabis when visiting Child A on the neonatal unit. On the day of Child A's death police and lead nurse for child death visited family home; concerns noted about home environment. Ethnicity or nationality not stated. Read full overview (PDF)	**Learning**: • Mother received consistent support from the Care Leavers Team, but insufficient consideration was given to how she would manage living independently with Father of Child A and her unborn child; • parents should have been challenged about their use of cannabis and they should have been offered Early Help; • there were opportunities for professionals to have visited the family home prior to the discharge of Child A, which may have identified the need for more support. **Recommendations:** • ensure that training of professionals includes the impact which cannabis use can have on parents' ability to care for their children; • promote the feasibility of conducting the antenatal and postnatal visits jointly and ensure that the Graded Care Profile 2 (GCP2) tool is utilised where concerns are raised regarding home conditions and potential neglect.
Mar 2021 – Thurrock Council - Sam and Kyle Death at home of Sam, a 2-year-old boy in January 2018. Cause of death was unascertained.	Sam's older sibling Kyle was placed on a Child Protection Plan after Sam's death, and subsequently placed in foster care. Sam and Kyle's mother was a looked after child, placed in foster care at 10-years-old following sexual abuse by her father.	**Learning:** • the impression is of agencies working in silos rather than developing a shared understanding of the case; • professionals concentrated on their own engagement with parents and their

	She was 18 years old when Kyle was born. Father was known to social services when a child. Kyle was registered as a child in need until May 2015 when the case was stepped down to early offer of help. Concerns about home conditions, the maturity of mother, and father's offending, alcohol misuse and incidents of domestic violence. Evidence of cuts and bruises on Kyle. Kyle's behaviour was seen to be aggressive and destructive at nursery and at school. Family identified as white British. Read full overview (PDF)	compliance, rather than attempting to place the child at the centre. **Recommendations:** • review procedure for the escalation of concerns and for resolving differences of view between professional and agencies; • explore better co-operation between agencies when handling complex or persistent cases; • review interagency procedures for establishing agreement with families of written care plans.
Mar 2021 - – Metropolitan Borough of Dudley Child L Death of an infant girl aged under 3-months-old in September 2018. Cause of death was attributed to airways obstruction in the context of co-sleeping.	Parents were cautioned for child neglect and drug possession offences. Child L was born prematurely and lived with her mother, father and older sibling, Emily. Her older sibling, Beth, lived with maternal grandmother; there was a lack of information about the reasons for this. Child L's father had history of depression and anxiety. Home conditions were reported to be cluttered, chaotic and dirty and subsequently deemed to constitute criminal neglect. Both siblings underwent child protection medicals; Emily was found to be dirty and unkempt. On the day of Child L's death parents provided different accounts in relation to where she had slept the night before. Ethnicity or nationality not stated. Read full overview (PDF)	**Learning:** • importance of enquiries about sleeping arrangements and the number of bedrooms in general. This can provide a clearer indication of where family members are sleeping and counteract disguised compliance when speaking with professionals; • lack of professional curiosity about older sibling living with grandmother; • information about paternal and maternal mental health and substance misuse. **Recommendations:** • ensure the Graded Care Profile 2 (GCP2) tool is utilised in every case where concerns are raised regarding home conditions and potential neglect; • ensure that the Clutter Image Rating Scale (CIRC) is utilised where clutter is identified as a factor;

		• review multi-agency training to ensure that training on neglect includes professional curiosity, disguised parental compliance, and the avoidance of normalising poor conditions is embedded.
Mar 2021 – Nottinghamshire County Council **Child RN19** Death of a 15-year-old child in 2019. Child R became unresponsive at home and died after being taken to hospital.	Child R was found to be emaciated but otherwise well cared for. Concerns from school about poor attendance. Child R had been removed from school and commenced Elective Home Education (EHE) in 2018. Initially planned to be short-term with a place at grammar school which subsequently fell through. Several GP appointments were attended for chest pain from eating fatty food. Contacted NHS 111 and eating disorder charity counselling services days before death. Coroner's inquest returned a narrative verdict which indicated that Child R died of natural causes with Anorexia Nervosa as a causative factor. No criminal charges made by police. Family is White British/Russian. Read practice review (PDF)	**Learning:** • parents and professionals should remain curious about what their children are thinking, feeling and accessing on mobile devices; • social isolation can have a negative impact on emotional and psychological health; school staff should act on healthcare concerns by offering referral to appropriate services; • GPs should use tools to recognise faltering growth and eating disorders are part of the differential diagnosis for this. **Recommendations:** • review material available to parents to help them recognise the signs of Anorexia Nervosa and the importance of early diagnosis in children; • consider requesting a National Review on EHE to change non-statutory guidance to improve opportunity to promote the welfare of children receiving EHE; • raise awareness across the partnership of early recognition of children with eating disorders and professional curiosity and how to promote this within systems.
Apr 2021 – Medway Council **Baby Harris**	Baby Harris had lived with his mother, father and half-sibling (Child A).	**Learning:**

Death of a 15-day-old boy in June 2019. Baby Harris was found dead in the family home, after having been asleep in his parent's bed.	Family were known to children's services and the police due to concerns around potential parental drug misuse and issues around Child A's school attendance. Family had two social work assessments, and police had intervened in domestic abuse incidents between the father and mother. Father had a history of mental health issues, violence, and alcohol and drug misuse. Family was White British and European. Read full overview (PDF)	• lack of professional understanding around Child A's lived experience, which could have alerted professionals to risks and harm; • invisibility of unborn Baby Harris and Child A, partly due to inconsistent parental engagement with services; • a lack of access to and understanding of the family's history by agencies resulting in parental risk factors not being identified; • issues around multi-agency responses to domestic abuse, including issues with information sharing; • safer sleep messages provided to the family were difficult to put into practice, due to the family's living arrangements. **Recommendations:** • improving the engagement of children, and an understanding of the lived experience of children; • improving the quality of assessments where children and unborn children are experiencing neglect; • improving the understanding of the cumulative effects of neglect; • ensuring that there is sufficient staff capacity in social work services to offer the conditions for good social work practice.
Apr 2021 – Oxfordshire County Council - Jacob Death of a 16-year-old boy, who was found dead in his bedroom in April 2019.	There was insufficient evidence that Jacob had intended to end his life. Jacob had been criminally exploited by adults operating county lines and exposed to serious levels of youth violence.	**Findings:** • issues with professional knowledge, skills and safeguarding systems for children at risk of criminal exploitation;

	Support for Jacob included: early help pathways, nine inter-agency strategy discussions, a child protection plan under the category of neglect. Jacob was placed in residential care in 2018, eventually returning home under a supervision order. Jacob repeatedly went missing from home and care. There were several police reports and recorded offences against Jacob, mainly relating to violent crimes; there were no investigations or convictions. Jacob missed education for 22 months. Jacob was White British. Read practice review (PDF)	• a single agency approach instead of multi-agency coordination that could have identified contextual risks; • focus on responding to Jacob's behaviours, without enough focus on reducing risks to Jacob in the community; • issues of unconscious gender bias in relation to criminal exploitation; • missing education playing a significant role in levels of risk not being identified; • importance of agencies responding quickly at critical times in a child's life to keep them safe. **Recommendations:** • a review of the effectiveness of the National Referral Mechanism; • statute and guidance on schools who cannot be mandated to accept children on roll; • a national review of placement sufficiency for children who need to be in care or placed under secure arrangements.
Apr 2021 – Unnamed LA – Child E Death of a 6-year-old girl in June 2019. Cause of death is unknown.	Child E had a chromosomal abnormality, a history of having regular epileptic seizures, and significant learning difficulties. On the morning of her death she had suffered two seizures and was kept home from school. Mother left Child E and three younger siblings locked in a bedroom while she went to collect another sibling from school. On her return, she found Child E face down on the bed and unresponsive.	**Learning:** • the practice was insufficiently child focused and tended to be governed by parents' wishes and views; • there was a need for more focus on the quality of Child E's lived experience and on her parents' refusal to consent to potentially lifesaving treatment; • there was insufficient professional curiosity and response about understanding and

	Mother called an ambulance and Child E was pronounced dead at the hospital. Family lived in temporary and overcrowded accommodation. Ethnicity or nationality not stated. Read full overview (PDF)	investigating the children's experience of living in overcrowded accommodation. **Recommendations:** • ensure that professional practice is child focused and considers the lived experience of all children in a family; • review the process and procedure for identifying risks and harm to children when parents or carers are not complying with medical advice; • professionals need to establish whether fathers have parental responsibility for children; • consider the options for improving the coordination of services and information sharing to address the needs of children with disabilities.
Apr 2021 – Portsmouth City Council – Child H Death of a 9-year-old boy in August 2018. Child H was found unresponsive in the family home and later pronounced dead.	A police investigation concluded there was insufficient evidence to pursue a prosecution. Child H had epilepsy and significant disabilities. Family was in receipt of various services in response to Child H's needs. Child H was subject to Child Protection Plans in 2010 and 2018 due to concerns around neglect. Child H's father and mother were known to the police for involvement in drug use and supply and other criminal offences. Ethnicity or nationality is not stated. Read full overview (PDF)	***Uses a model of learning based on a Soft Systems Methodology.*** **Learning:** • a professional focus on managing Child H's disabilities, rather than seeing a child who was disabled and neglected; • the need for information sharing between appropriate agencies when a child has a Child in Need plan; • importance of professionals escalating concerns about parental capacity in a timely manner, particularly when a child has complex needs; • family medicine management should be checked by professionals on a regular basis,

		when prescribed medicines form part of a child's health and safety plan. **Recommendations:** • increasing knowledge across services on how concerns about a child's welfare might be managed; • children's social care reviews their local policy on Child in Need cases, to ensure policy clearly reflects the need to involve partner agencies, particularly in cases involving children with disabilities; • local NHS Trusts review their policies and procedures on recognising and responding to medical neglect.
Apr 2021 – Wandsworth Borough Council **Frankie** Death of a 3-year-old boy in July 2016. Frankie was a hospital inpatient for life threatening asthma leading up to his death and died within 24 hours of discharge.	Parents were professionals and Frankie was cared for by a nanny; his older sibling was home educated. Frankie was seen at home twice post birth but was not immunised and did not attend the two-year developmental check. Frankie had twelve hospital admissions associated with severe asthma from the age of 20-months, until his death. Parents were reluctant to fully comply with medical advice and prescribed medication for Frankie; they feared steroids and declined or reduced numerous medications over various hospital admissions. Ethnicity or nationality not stated. Read full overview (PDF)	**Learning:** • medical neglect is less understood across all agencies and within the health system, which is a weakness in the multiagency children safeguarding system; • impact of parents' social class upon the relationship with health professionals; • parental challenge around medication is common but there is a lack of robust strategies to manage this in the hospital; • absence of other categories of neglect appears to have reassured practitioners **Recommendations:** • hospitals to explore how clinical teams manage parent consent for emergency treatment;

		• hospitals must review how they manage severe illness in children when a parent favours alternative therapy; • GPs and Health Visitors must have an agreed plan when following up issues of concern with families; • all services must be able to evidence how their workforce participates in reflective safeguarding supervision which supports their learning and development.
May 2021 – Blackburn with Darwen Borough Council – Child CD Death of a 13-month-old child in February 2019. Child CD was found head down in a fabric toy box at the bottom of the bed, cold to the touch.	Ambulance services were called but Child CD did not show signs of life and resuscitation was not attempted. Ambulance crew expressed concerns regarding the home environment and circumstances in which Child CD was found. Parents were arrested on suspicion of murder/ neglect, but no charges were levied against them. Family had re-located three times during the review's timeframe. Mother had experienced adverse childhood trauma at home and in school. Both parents had a history of alcohol and drug misuse, depression, and could be non-compliant with their medication regimes. Father had a history of homelessness and Mother did not always engage with services. Ethnicity and nationality not stated. Read executive summary (PDF)	**Learning:** • maternity services should provide assurance that routine domestic abuse enquiry is effective, and not a widespread issue; • Early Help may be indicated when families move frequently; • there should be a robust assessment of family needs when women with a significant history of mental/emotional instability are pregnant and in the post-natal period to support them in caring for infant and their other children. **Recommendations:** • safer sleep and the risks to mobile infants/toddlers should remain a focus of local multiagency activity; • a focussed response and co-ordinated multiagency working with adolescents with complex health and social needs on the edge of statutory intervention; • assessing and working with young fathers (the hidden male) who have or assume childcare responsibilities is crucial.

May 2021 – Sandwell Metropolitan Borough Council – Child NS Death of a 2-month-old child due to asphyxiation.	Mother found Child NS lifeless in the bed beside her after waking up following a night out. At the time of Child NS' death, children's social care was not aware that there was a new baby in the family. The family had older siblings, some of whom had additional needs, who lived with Mother and Child NS. Father lived nearby. In 2018, school staff made a referral to children's services because of changes in the presentation and behaviour of two of the siblings. A subsequent child and family assessment resulted in no further action. Later that year, the eldest sibling received a serious injury and was made subject to a child in need plan following a section 47 enquiry and child protection conference. The needs of Child NS were not considered as part of this process because the parents had only disclosed the pregnancy to the services necessary to receive antenatal care. Read executive summary (PDF)	**Learning:** • information about all members of the family should be sought from GPs during assessments and conferences; • assessments of a child's needs should consider any additional needs of siblings; • practitioners need to bear in mind that parents might not disclose key information. **Recommendations:** • improve the effectiveness of informing parents about the dangers of co-sleeping; • consider how to promote the wellbeing of all immediate family members who have experienced a neonatal death; • consider how to ensure the needs of siblings are considered collectively as well as individually.
Jun 2021 – Rochdale Borough Council – Child A1 Death of a 4-month-old infant in May 2018 whilst in the care of a family member overnight.	Child A1 lived with her parents; Mother and Father were known to Early Help and Health Services in respect of antenatal and postnatal care. At the time of her death, Child A1 was being cared for by her paternal aunt, who placed her on the sofa and then fell asleep after consuming alcohol.	Identifies an area of learning for Children's Services as to the extent to which the Child Protection Plan in respect of Paternal Aunt's household included any risk to other children. **Recommendations:** • ensure that Special Circumstances Forms generated by midwifery services are shared by key agencies, such as general practitioners (GPs) and health visitors;

	When she woke up, she found Child A1 lifeless. An ambulance was called, and Child A1 was confirmed dead at hospital. Paternal Aunt had two children; both were made subject to Child Protection Plans in March 2018 under the category of emotional and physical abuse. There were also concerns about alcohol misuse. Ethnicity or nationality not stated. Read full overview (PDF)	• ensure that information sharing, and discussion take place routinely between midwifery and GP practices where issues are identified, and concerns are raised in order to understand the holistic family circumstances; • where parental alcohol and substance misuse are risk factors, practitioners are able to consider any other caring responsibilities for children including babysitting arrangements.
Jun 2021 – Surrey County Council – Baby KK Death of a 9-month-old infant, from heart failure and chest infection in April 2016.	Baby KK was born prematurely and experienced health problems including bronchiolitis, sepsis and injuries requiring nine hospital admissions during his life. Baby KK's 2- year-old sibling was born when mother was 17 and father was 20 years of age. The family lived in supported accommodation. Mother frequently accessed hospital ante-natal services during her pregnancy with Baby KK. Evidence of domestic abuse which was not disclosed. Involvement of children's social care and concerns, including two referrals to the NSPCC, about unhygienic home conditions and child neglect. Both children were made the subject of child protection plans when Baby KK was 3 months old. Read full overview (PDF)	***Uses the SCIE Learning Together model for case reviews, a systems approach which provides a theory and method for understanding why good and poor practice occur.*** **Key findings:** • need for understanding of roles in partnership working relationships so that opportunities for review and assessment of a child's needs are not missed; • tendency for hospital professionals to focus on the presenting illness or injury and not to consider other explanations; • limited involvement of hospital professionals in safeguarding work; • reluctance of general practitioners to refer directly to children's social care; • the fluctuating nature of neglect and the inconsistent ability of parents may undermine professionals' ability to see and respond to neglectful parenting.

		• Makes no recommendations but poses several considerations for the safeguarding board and partner agencies for the findings identified.
Jun 2021 – Surrey County Council – Baby LL Death of a 4-month-old boy in May 2016. Baby LL was found dead by his father.	The post mortem identified the cause of death as acute pneumonia. Baby LL had lived with his father, mother and sibling. Baby LL and sibling were the subject of child protection plans under the category of neglect, and children's services worked with the family due to concerns around the care of both children. The family had been in contact with the police, accident and emergency services and children's services following referrals due to concerns around the children, and due to injuries to Baby LL's sibling. Father had previously been in prison for failing to protect another of his children from physical abuse, and mother had an older child in care due to emotional abuse and neglect. Child LL's ethnicity or nationality are not stated. Read full overview (PDF)	***Uses the SCIE Learning Together systems model.*** **Findings include:** • issues of professional psychiatric opinion undermining social workers' views on the risks posed by parents; • the need for consistent safeguarding practices in paediatric and accident and emergency teams, so that opportunities to identify hidden injuries are not missed; • professionals sharing information on the presenting evidence, but not always clearly communicating underlying concerns and relevant historical information; • GPs should have access to the records of family members, to understand a family's history and be aware of risk factors and past child protection concerns; • the importance of professionals understanding financial challenges faced by families and identifying risks that financial pressures may pose to children.
Jul 2021 – Wakefield Council – Jason Death of a 3-month-old infant in August 2019. Jason had been co-sleeping with a sibling and his mother	Jason had already died when Mother contacted emergency services and he was taken to hospital. Skeletal surveys found no injuries beyond evidence of attempted resuscitation. Siblings were subject to child protection plans and children in need plans at different points from 2008.	**Learning:** • some parents have difficulty assimilating and consistently following advice and the circumstances under which children's needs are neglected; • the way parents respond to their children's needs is influenced by their own childhood experiences;

	Parents had been looked after children and experienced adverse childhoods. Mother had a history of self-harm, low mood and domestic abuse and was subject of a child protection plan for several years. Mother had difficulties regulating emotions and could be very hostile and aggressive with practitioners and the public. Father was remanded in prison at the time of Jason's death. Parents are White British. Read full overview (PDF)	• parents who have experienced unstable or adverse childhoods can learn to just focus on their own needs because they have learnt not to depend on others. **Recommendations:** • ensure multi-agency training includes curiosity about where children are sleeping as part of assessments; • develop safe sleeping procedures emphasising the importance of ongoing risk assessment about safer sleeping for all services; • consider how the use of the neglect toolkit is used routinely by services; encourage every GP practice to have a written protocol for discussing safeguarding concerns and follow-up.
Jul 2021 – Surrey County Council – Child A Death of a 4-week-old infant in April 2017. Child A was found unresponsive by their mother.	Cause of death was identified as sudden unexpected death in infancy (SUDI) associated with co-sleeping. Police conducted enquiries and passed the case on to the Crown Prosecution Service. No charges were made. Child A lived with their mother and two siblings (Sibling 1 and Sibling 2). The relationship between Mother and Father 1 ended within days of Child A's birth, and Father 2 was absent from the children's lives. The siblings' school had referred the family to children's services, due to concerns around Mother's alcohol use.	**Learning:** • services thinking about children within the context of their family, and being mindful of repeat patterns of behaviour within families; • professionals recognising when parental deflection may create risk for a child; • professionals being aware of indicators of abuse, and understanding when to share information about these indicators. **Recommendations:** • ensure school staff have training on indicators of abuse, and have the competencies to safeguard children; • information sharing training should include the directive that when parents do not give

	Children's services had conducted a child and family assessment, which resulted in a child in need plan for support around Sibling 1's behaviours. Child A's ethnicity or nationality are not stated. Read executive summary (PDF)	permission to share information staff consider if a child is at risk of harm, before a decision to not share information is made; • when there is disparity between parent's views and those of their children, professionals should maintain focus on the child.
Aug 2021 - City & Hackney London Borough Council – Child I Death of a 16-year-old child from natural causes whilst in custody at a Young Offender Institution.	Review does not consider the circumstances of Child I's death. Child I lived with his mother, father and older sibling. For much of his childhood there were no known concerns but after transition to secondary school difficulties rapidly emerged. History of school exclusions, violence, theft, carrying weapons; arrested several times in possession of Class A drugs. Child I was placed in foster care and later entered Local Authority care under a voluntary section 20 agreement. At the time of his death, Child I was on remand for murder. Child I was a Black child. Read full overview (PDF)	**Learning:** • practitioners need to recognise 'subtle moments' that might present clear opportunities to help and protect a child; • where children are identified as needing early help, it is important that parents and carers fully understand what this involves in respect of a coordinated, multi-agency approach to help and protection. **Recommendations:** • ensure that policy, procedure and practice relating to critical moments (both well established and those less obvious) is sufficiently robust to ensure effective safety planning; • work with schools to ensure that they are able to identify children who show persistent behavioural difficulties; • ensure that a multi-agency response to the persistent disruptive behaviour of children is sufficiently described in threshold tools; • explore with primary and secondary schools how multi-agency involvement could be improved both prior to and at the point decisions are being made about permanent exclusions.

Aug 2021 – Thurrock Council – Leo Death of a 9-year-old boy in June 2019. Leo was found unresponsive in the family home and taken to hospital where he was pronounced dead.	Leo died from bacterial meningitis and orbital cellulitis and had been unwell for six days prior to his death. A police investigation for neglect concluded that the cause of death was due to natural causes. Leo and Sibling 1 were subject to a child in need plan, due to concerns regarding neglect and unsatisfactory home conditions. The family were receiving support from several services and the children's school. Leo and his father had a history of physical health issues and Mother had mental health issues. Leo was of White British and American heritage. Read practice review (PDF)	**Learning:** • social workers should take the "think wider family approach", considering all members of the family or household to assess their impact on the whole family; • professionals should be involved in multi-agency meetings, including healthcare professionals, to ensure effective plans are in place; • when families are living in poverty focus needs to remain on the cause and impact of poverty on the children, and professionals should escalate cases where families' access to funds and services is not sufficient; • children's services and partners should use specialist assessment tools in cases of neglect to quantify need and measure perceived improvements or deteriorations; • when an adult or child is recognised as a carer, the full extent of their role and its impact should be clearly articulated in assessments and shared with partners. Makes no formal recommendations.
Aug 2021 – Cornwall and Isle of Scilly Councils Child C Death of a 16-year-old girl in 2018, assumed to be suicide.	Child C had experienced adverse childhood experiences, including sexual abuse, and was believed to be at risk of exploitation. History of self-harm and had spoken about ending her life from time-to-time since 8-years-old. Child C was known to the universal services, Police, Children's Social Care, Child and Adolescent Mental Health Service (CAMHS) and local voluntary agencies.	**Learning:** • it's essential that practitioners understand parental capacity, strengths and attitudes to increase the effectiveness of interventions and avoid placing additional stress on children and their families; • child sexual exploitation (CSE) requires a different focus from other forms of child abuse;

	In July 2016, she was made subject to a child protection plan under the category of sexual abuse which includes sexual exploitation, until March 2017. In 2018, she stayed in a specialist facility for young people with mental health problems. Diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) at 15-years-old. Ethnicity or nationality not stated. Read practice review (PDF)	• adolescents can be exposed to a wider range of risks than younger children and concentrating on a single issue may lead to an over optimistic assessment of risk; • assessments should include listening and responding to children's views. **Recommendations:** • develop a research-based risk management strategy designed to address the specific features of adolescent risk taking and suicidal ideation; • promote the concept of "contextual safeguarding" and ensure that it is adopted by practitioners and managers working within the child protection process.
Aug 2021 – London Borough of Waltham Forest Council – Khalsa Unexpected death from bronchial asthma of Khalsa, a 14-year-old boy, in October 2019	Khalsa had received medical care for acute asthma since he was 3-4 years old and was admitted to hospital three times in the two years prior to his death. Khalsa was raised by his father following the death of his mother when he was 7 years old. He lived with his father and three older adult siblings. Concerns raised by Khalsa's general practitioner about the management of his asthma and his father's understanding of how to support his son led to Khalsa being made the subject of a Child in Need Plan. A pattern of cancelling and rescheduling appointments by Khalsa's father was noted, however he was otherwise well cared for. Khalsa was raised within the Sikh faith.	**Key findings:** • communication between multiple medical services and trusts did not allow practitioners to understand and contribute to the risk discussion; • the need to create systems that enable young people to have a voice to participate in their health plans, specifically when this may be overridden by parental influence; • the perception of asthma as not being potentially life threatening can impact on how some professionals engage in professional curiosity. **Recommendations:** • ensure timely information sharing between multiple universal services and acute hospital trusts;

	Read practice review (PDF)	• increase awareness of asthma and its management across agencies and communities.
May 2021 – Borough A and Borough B **Child E** Child E was born with no brain activity on 16 September 2020 at Borough B Royal Infirmary Maternity Unit, after a breeched labour and delay in the parents accessing medical care.	Child E was the fifth child born to the parents. Their oldest child was removed as a baby and is in long-term foster care. Their 3 younger children are Looked After by Borough A. Child E was put on life support immediately after the birth, and the life support was switched off. Child E died 6 minutes later. Child E's parents are understood to have fled from London to Borough B having attempted to conceal the pregnancy because the unborn baby had been placed on a pre-birth Child Protection Plan. The Mother attempted to give birth in the Bed and Breakfast accommodation where the couple were staying in Borough B, however ended up calling an ambulance and attended hospital when mother was in distress. Due to the parents' irregular presentation of events, borough B hospital promptly worked with County B Police force colleagues and identified that the parents had given a false identity and determined their true names. Read LCSPR Practice review (PDF)	

SEXUAL ABUSE and CSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
Feb **2021 – Surrey County Council – Family M** Serious harm and sexual abuse of children whilst living with a relative under a Special Guardianship Order.	The review concerns six children, of whom four were removed from one situation where they were likely to suffer significant harm to another where they experienced severe abuse. The children had moved from another local authority area and were placed with the perpetrator and his wife. Behavioural problems were attributed to early trauma; this was magnified by the perpetrator's ability to create a narrative that he and his wife were "courageous and brave" in taking on the children. Read full overview (PDF)	**Findings:** • the need to share information across the multi-agency network; • practitioners need to be equipped to undertake assessments which include hearing the voice of the child, understanding the meaning of a child's behaviour, and maintaining professional curiosity; • friends and family assessments should always include consideration of the impact of placement on all children in the household. **Recommendations:** • ensure that there is a focus on the voice and lived experience of children in assessments and interventions; consider the child's history, the history of their care givers and the motivation underlying their application to look after the child; • the Safeguarding Children Partnership should work with partner agencies to develop a strategy on recognising and working with child sexual abuse within the family; • agencies should evaluate their supervision systems and provide an opportunity for practitioners to analyse in complex family situations.

Mar 2021 – Dudley – Child D *(Learning Review Theme -"if you take me home, I'll just go missing again")* Placement of a 12-year-old girl in secure accommodation in May 2019.	Child D and her family were well-known to services and there was a history of criminality, mental health issues and drug and alcohol misuse in the family. There were concerns about previous neglect and non-protective behaviour from her mother and sexualised behaviour from her sibling and a section 47 enquiry was undertaken in respect of both children. Children's social care received a multi-agency referral form in May 2017 raising concerns that Child D was a victim of child sexual exploitation. By March 2019, Child D was frequently going missing, was involved in criminality and reported misusing substances. Throughout her life, Child D disclosed several instances of rape and sexual abuse. In May 2019, Child D was found almost unconscious and intoxicated in a local park. She was admitted to hospital and children's social care were informed. Following this, Child D was accommodated in a secure residential placement where she remains under section 20. Ethnicity and nationality not stated. Read learning review (PDF)	**Findings:** • Child D's aggressive behaviour may have impacted on professionals' perspective and response to the case; • despite being on a child protection plan, outcomes did not improve for Child D; • there appears to have been a lack of cohesion in care planning. **Recommendations:** • analyse themes and trends from return home interviews to inform service provision; • consider developing a strategy to manage highly complex and high-risk cases; • review escalation around the legal gateway process
Mar 2021 – St Helens Borough Council **Child B** Disclosure by a 14-year-old girl in January 2019 of four offences of rape by an adult male.	Concerns that Child B was at risk of sexual exploitation had arisen a year earlier when Child B had travelled to a hotel to meet a man she had been in contact with over Facebook. Child B had been supported as a Child in Need and was later the subject of a Child Protection	**Findings:** • the multi-agency sexual exploitation process; • child in need/child protection; • the significance of neglect as a factor which underlies adolescent vulnerability; • bullying;

	Plan, as well as being referred to CAMHS, Catch-22, and Barnardo's. There were concerns at school about bullying and Child B had moved to an Alternative Education placement. Further concerns about disguised compliance from Mother and Father's lack of engagement. Child B made several disclosures of grooming and sexual exploitation which resulted in Section 47 enquiries and was accommodated under Section 20. Ethnicity and nationality not stated. Read summary online (PDF)	• early intervention to prevent child sexual exploitation; • information sharing; • school nurse involvement; • safeguarding roles and responsibilities; • public awareness of child exploitation; • the voice of Child B. **Recommendations:** • ensure that children and young people assessed as at high or medium risk of sexual exploitation are immediately flagged on the information systems of all agencies who are in contact with the child or young person; • ensure that the support provided to children and young people at risk of sexual exploitation also considers the current and future needs of younger siblings living in the same household.
Apr 2021 – Unnamed LA – Anonymous Family Chronic neglect, physical and sexual abuse of eight siblings and three older half siblings perpetrated by their parents and one sibling.	Both parents and the oldest sibling of their relationship were convicted and sentenced for sexual offences and neglect. Initial case review commissioned in 2016 and covered a period of 26 years involving six Local Authority areas; reviewed in 2019 to focus on home area partner agencies and services responsible for the family from 2005-2015. Children were removed on Care Orders in 2007 but sexual abuse continued to be perpetrated by their parents and an older sibling. Two criminal investigations - the first in 2007 did not progress; the second concluded with charges and a trial in 2017. Ethnicity or nationality not stated.	**Learning:** • the impact of securing evidence in criminal proceedings and safeguarding children; • mothers as sexual abusers of their children and the impact of disguised compliance by parents; • the level of knowledge, skills and training available to practitioners on child sexual abuse within the family; • the continuing need for escalation and professional challenge by practitioners; • the historical and current issues around the retention of records; • the central role of the Independent Reviewing Officer (IRO) needs to be recognised when

	Read full overview (PDF)	there are a number of children within a family in different placements; • children "not brought" to medical appointments. **Recommendations are provided under the following themes:** • child sexual abuse investigation processes and management oversight; • professional escalation and challenge; • training and professional development for front line practitioners; • information sharing.
May 2021 – Medway Council – Faith Historical sexual abuse of an adolescent girl	In 2016, prior to Faith's 18th birthday, Faith disclosed that she had been sexually abused for several years by a neighbour, and that her mother had been aware this was happening. There were several domestic incidents involving police and neighbours at the family home. Faith's stepfather was violent and Mother had issues with alcohol. Faith was excluded from school and looked after by two foster parents, before moving to residential care. A retrospective health review identified that as a child Faith had been seen by health practitioners with symptoms suggestive of sexual abuse. Ethnicity and nationality not stated. Read full overview (PDF)	**Findings:** • over many years the signs and indicators that Faith had been sexually abused were not recognised and acted upon and her voice was not heard; • assessments and plans were limited in their analysis of the history of both parents, the dynamics of relationships within the family and relevant health information; • there was no clear plan to give Faith a permanent safe home and the legal framework was not used effectively Recommendations: • develop a multi-agency whole family approach to work with complex families; • seek evidence from Children's Services that the cause of placement breakdown is analysed and that findings are incorporated into ongoing planning for the child;

		• ensure that all practitioners have the required knowledge and skills and confidence to recognise and respond to child sexual abuse within the family including hearing the "voice" and lived experience of the child.
Jun 2021 – Unnamed LA – Anonymous Victims Sexual abuse of several children by their foster carer between 2007 and 2019.	Foster carer (FC1) and his wife (FC2) were registered with a private fostering agency and had fostered forty children from five different local authorities between 2007 and 2020, usually as mother and baby placements. They had never been approved as local authority foster carers but had worked for three private fostering agencies. Early in 2020 FC1 told police that he was a paedophile and had sexually abused several children in his care. FC1 was charged with offences of oral rape and sexual assault on children under 13-years-old relating to four of the children, and sexual activity in the presence of a child which covered unidentified victims. He received a lengthy prison sentence. Ethnicity or nationality not stated. Read review (PDF)	**Learning:** • while there were no obvious physical injuries to the young children victimised by FC1 there will be potential long-term impacts on their health and wellbeing; • training about the "invisible male" should also be used to consider situations where foster carers and other professionals are providing care and support in their own homes; • the identification of child sexual abuse in particular with regard to children who are pre-language or have significant language or communication difficulties. **Makes no recommendations but sets out actions including:** regional event to be developed to share learning on: • understanding and avoiding the impact of professional bias; • ensuring neither foster carer is an "invisible party"; • understanding perpetrator profiles; • sexual abuse of babies and pre-verbal infants.
Jul 2021 – Surrey County Council – Child G Review of the support received by Child G in the period 2014-2019 including her allegation of sexual abuse in August 2018.	In 2018. Child G lived with Mr A, her maternal great uncle, and his wife, who were Child G's Special Guardians.	**Learning:** • communication challenges across partnerships working with a family with multi-faceted needs;

	Child G alleged she was sexually abused by Mr A. A police investigation concluded there was not sufficient evidence to proceed with a prosecution. Mr A had historical allegations of sexual abuse made against him. Child G was born in 2011; parents separated during the pregnancy. She has two older and one younger half siblings. Child G's mother had mental health needs and was inconsistent in engaging with professionals. Evidence of incidents of domestic abuse. Children's social care were involved with the family since 1995. In October 2015 Child G was subject to a Child Protection Plan under the category of neglect before moving to live with special guardians in February 2018. Subsequent evidence of distressing and sexualised behaviour led to an urgent GP referral to Child and Adolescent Mental Health Services (CAMHS) in August 2018. Family is White British. Read full overview (PDF)	• the Special Guardianship Order report and recommendation was not subject to sufficient scrutiny; • the need for professionals to be aware of the possibility of trauma and current abuse, in children presenting with distress and high levels of disturbance; • delays to accessing of therapeutic support. **Recommendations:** • ensure that family support is consistently applied and not stepped back due to resource pressures; • ensure there are mechanisms to review caseload size, and social work shortages; • review of processes for undertaking Special Guardianship assessments; • review training on trauma informed practice and sexual abuse.

Aug 2021 – Richmond upon Thames Council Keeping Children Safe in Schools	Review commissioned in April 2017 following five convictions for sexual offences of adults who had previously worked at St Paul's School London. Allegations had also been made against 32 ex-staff members and there had been recent involvement from the police, local authority, health professionals and Local Safeguarding Children Board (LSCB) with the school. Alleged offences had taken place from early 1960s onwards with many relating to the 1970s and 1980s. Sixteen of the alleged perpetrators were deceased. Fifty-nine ex-pupils were seen by the lead reviewers. Attendance at the school ranged from pupils who started in 1953 through to those who left in 2015. Six of the 59 ex-pupils seen were victims of perpetrators who stood trial. Ethnicity and nationality not stated. View report online:	**Findings:** • accepting responsibility for past abuse must be a foundation for moving forward and developing an effective safeguarding culture; • schools face difficulties in balancing a response to allegations of abuse that takes account of employment law, education legislation and good safeguarding practice; • there are gaps in the national safeguarding system in relation to the recruitment and regulation of teachers, the Disclosure and Barring Service and the way in which information is shared across national organisations. **Recommendations:** • Charity Commission should make explicit their expectations regarding best practice at times of crisis and specifically that protecting the reputation of the charity includes openness and honesty about any poor practice; • Home Office should establish a system of advocacy and support for complainants in child sexual abuse cases both pre and post-trial to ensure consistency between areas.
Aug 2021 – Surrey County Council – 3 children; HH, II and JJ Sexual assault of a child and possession of indecent images in August 2015.	One of Child HH, II and JJ who were 6, 3 and 1-years-old respectively, were sexually assaulted by their father Mr A. In 2008 Mr A was sentenced to prison for the possession of indecent photographs and videos and was ordered to register as a sex offender for ten years.	**Learning :** • the lack of certainty in the assessment of those who access indecent images of children; • the danger of relying on earlier assessments without reviewing them with agencies involved; • the importance of identifying what changes in an offender or their situation might lead to

	At this time Mr and Mrs A did not have children. Six months later Child HH was born and made subject to a child protection plan. Mr A was considered a High-Risk Offender and monitoring software was installed on his laptop. In August 2015, police received intelligence that Mr A was using an online chat room dedicated to child sexual abuse. He was convicted for this behaviour and a serious contact offence against one of his children. Ethnicity and nationality not stated. Read executive summary (PDF)	that offender being assessed as presenting a greater risk of carrying out harmful behaviour. **Recommendations:** • work with other bodies to review the approach to families in which a member has committed offences in relation to online indecent images of children; • ensure that professional staff have sufficient skills and knowledge to work with those who access indecent images of children online and their families.
May 2021 **Wiltshire Children's Safeguarding Board** **Family N** Following a 999 call to Police in June 2020, a male adult was found holding a knife to his partner's throat. She had arrived home and witnessed Adult A sexually abusing Child A.	Child B had called the Police. Following Adult A's arrest, Child A disclosed that she had been sexually abused by Adult A on more than one occasion. All of the children were subject to a Supervision Order at the time. **FAMILY MAKE UP** Child A aged 13 at the time of incident Child B aged 12 at the time of incident Child C aged 6 at the time of incident Child D aged 1 at the time of incident UBB E Unborn at the time of the incident Mother - Mother of all the children Adult A Mother's Partner and Father of Child D and UBB E Adult B Ex-husband of Mother and Father to Child A and Child B: Deceased Adult C Father to Child C Adult D Mother's Former Partner Child J Older sibling, now 18, son of Adult B and sister to the two eldest girls who lived with his	

	grandmother throughout this period and is not part of this review. View report online:	

BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**

HOMICIDE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
Feb 2021 – City & Hackney London Borough Council - Child C Death of a 15-year-old boy in May 2019 as a result of being stabbed.	A 15-year-old boy was found guilty of Child C's murder, and a 16-year-old boy and 18-year-old male were convicted of manslaughter. Child C had been permanently excluded from school and had been injured in another stabbing three months before his death. Increasing police contacts and concerns about behaviour and escalating risk prior to incident. Child C was going missing with concerns about criminal exploitation and county lines involvement. Parents had separated and Mother lived with new partner. Two referrals to children's services and concerns over Child C's cannabis use. Child C was from a Black and minority ethnic background. Read full overview (PDF)	**Findings:** • exclusion from mainstream school can heighten risk; • education settings need access to local intelligence; • clarity is needed about interventions to mitigate extra-familial risk; • involving and supporting parents is essential to effective safety planning; • inconsistent judgements about risk creates uncertainty; • poor case recording can directly impact on practice. **Recommendations:** • review processes that involve the application of risk gradings for young people at risk of serious youth violence; • exhaust all kinship options as part of a safety plan for children who are at risk of serious youth violence;

		• schools ensure they have a detailed understanding of the potential safeguarding needs of any child at risk of permanent exclusion; • ensure that policy, procedure and guidance is sufficient to ensure the active consideration of racial and cultural identity as part of the safety planning process involving extra familial risks.
Feb 2021 – Thurrock Council – Frankie Death of a 15-year-old boy in the summer of 2018.	Frankie was fatally stabbed when attacked by a group of adolescent males in London. One young person was convicted of murder and four were convicted of conspiracy to cause grievous bodily harm. Frankie lived with his mother and two siblings; his father was in prison from 2016. Family was supported by a Child in Need Plan, following a social work assessment that identified concerns around involvement in crime. Frankie had a Referral Order for theft and knife possession and was permanently excluded from school in 2018. Frankie's social worker had concerns about his associations with gang culture. No evidence to indicate that Frankie's murder was gang related. Ethnicity or nationality are not stated. Read full overview (PDF)	**Learning and recommendations are integrated:** • ensure timely notifications to relevant persons when a child dies outside of the area in which they reside; • improve notification processes for agencies when a child becomes the subject of a Child in Need Plan; • review permanent exclusion processes within schools to reduce the potential for safeguarding risks to children at risk of exclusion; • understand how to incorporate the concept of contextual safeguarding in the assessment of risk to children in the future; • evaluate how partner agencies support families affected by gang association; • assess how partner agencies share intelligence related to gang affiliations. Recommendation made to the National Child Safeguarding Practice Review Panel to consider a national thematic review because of the prevalence of similar incidents across the country.

Apr 2021 – Medway Council – George Death of a 3-year-old boy in February 2018 in Croydon.	George had been in the rear passenger foot well of a car when the front passenger (Mother's partner, 'A') pushed his seat back twice and crushed George. 'A' was imprisoned for manslaughter, perverting the course of justice and witness intimidation, and George's Mother received a custodial sentence for child cruelty, perverting the course of justice and assault. Actions by Children's services for George and Mother included: supported accommodation; a child protection plan on grounds of neglect; a child in need plan and child and family assessments. Mother was considered vulnerable to abuse and exploitation due to adverse childhood experiences, and there were concerns about her cognitive ability. Mother was involved with two men, 'A' and 'B', both of whom were involved in multiple incidents of domestic abuse and criminal activity. When George was 18 months old, he was taken to hospital twice with head injuries, which Mother claimed to be accidental. Mother and George moved address several times. George was White British. Read full overview (PDF)	**Learning:** • the impact on George of witnessing domestic abuse and unpredictable changes of residence was underestimated; • George's presence was not adequately recorded during some incidents; • the need for professionals to record and assess incidents considering information on all individuals present; • the need for professionals to define demonstrable change in the situation of a child at risk or vulnerable adult before concluding sufficient improvement. **Recommendations:** Medway agencies to improve methods of reporting and responding to incidents involving safeguarding issues and vulnerable adults.
May 2021 – London Borough of Merton Council Child D Death of a 7-year-old girl in November 2017.	Child D was murdered by her father in the family home. Father then rang the police and reported what he had done; Child D was resuscitated at the scene but died in hospital the following day.	**Learning points relate to:** • mental health risk assessments; • multi-agency assessments; • thresholds and 'step-up' and 'step-down'; • the use of interpreters and cultural sensitivity in assessments where English is not the first language;

	Father pleaded guilty to Child D's murder and was sentenced to life imprisonment. Family was known to numerous agencies. Father and Mother were experiencing a breakdown in their relationship. Father had attempted suicide on several previous occasions due to stress and depression. Mother was not a fluent English speaker and there were concerns about Father's coercive control of Mother and his continual disguised compliance and deception. Post-mortem discovered semen in Child D's vagina but investigation was unable to establish how it got there. Father denied sexual assault. Child D's father was White British, and mother was from South East Asia. Read full overview (PDF)	• considering and assessing coercive control and disguised compliance; • information sharing; • sexual abuse. **Recommendations:** • seek assurance that in mental health assessments following attempted suicide where the adult has responsibility for children, that risks to them and partners are considered, including where the dependent is seen as part of the patient's perceived 'problem' or 'protective element'; • review multi-agency approaches to assessing for the possibility of sexual abuse of children.
May 2021 – Plymouth City Council – Baby G Death of a 6-month-old baby boy due to a significant head injury attributed to shaking in May 2017.	Father was charged with manslaughter and received a prison sentence. Mother was 18 years old when she became pregnant with Baby G. Maternal history of troubled childhood, being subject a Child Protection Plan, and depression. Father diagnosed with depression; had an older child who lived with their mother. Baby G's parents lived separately; Mother moved into supported accommodation for young parents before the birth. Mother attended antenatal appointments together with Father; no concerns identified. Frequent attendance at GP practice and three attendances at hospital emergency department.	**Learning:** • the need for clear and accurate information sharing and for all agencies to seek information if they believe an assessment is being conducted; • importance of professional curiosity for clinicians when presented with unusual signs and symptoms. **Recommendations:** • ensure that partner agencies recognise that minor presentations can represent injuries which may be a sign of serious abusive trauma; • promote awareness among parents and professionals of the "crying curve" ("purple

	Baby G spent regular nights with Father, and following a brief incident of Mother being unwell, the arrangement became more frequent. Ethnicity or nationality not stated. Read full overview (PDF)	crying") and the impact on parents of coping with inconsolable crying; • reflect on the diagnosis and treatment of depression in new and prospective parents and how this can impact on parenting capacity; • develop a programme of intervention to engage fathers and prospective fathers; • engage, reassure and educate parents about infant crying and strategies for coping and impulse control.
Jun 2021 – London Borough of Ealing Council – James Death of a 10-year-old boy in August 2020.	James died because of restricted airways after his mother gave him an excess dose of Melatonin, prescribed to help him settle at night, and put him to bed with a sponge in his mouth. Mother reported to police that she had "killed her son" and subsequently pleaded guilty to manslaughter with diminished responsibility. James was a boy with severe learning disabilities and a complex range of disorders. James had a degenerative visual impairment and hearing loss. In March 2020 Mother decided to keep James at home due to health risks posed by the Covid-19 pandemic. Mother was concerned about stress related to finances and her divorce; she was diagnosed with depression in 2018. Mother and Father divorced in 2017, and Father moved to Spain. Mother was a Russian national, Father English Read practice review (PDF)	**Learning:** • there was a significant level of contact between the family and agencies, services were maintained and there was multi-agency oversight; • during this contact James's mother was inconsistent in her presentation; • James's mother refused offers of support through Children in Need services; • there was no contact between agencies and James's father. **Recommendations:** • collaborate and co-produce with disabled children and their parents, information about and service delivery of child in need services; • review information provided to parents about the Direct Payment System and their responsibilities to inform funders of situations where family members or partners are employed;

		• review the approach to engagement of fathers as single agencies and as a partnership.
Jul 2021 – London Borough of Richard upon Thames Death of 10-year-old and 7-year-old boys and their mother and father in March 2018 *(Joint domestic homicide review and serious case review: Maria aged 47: Luis aged 10: Carlos aged 7: found murdered by Juan aged 57 who also took his own life)*	The children, Luis and Carlos, and their father, Juan, were found dead at the foot of cliffs in Sussex; their mother, Maria, was found dead at the family home in London. The coroner certified that Luis, Carlos and Maria were unlawfully killed, and that Juan had committed suicide. The family emigrated from Venezuela to the UK in 2016. Prior to the deaths, Juan wrote a document in which he claimed that Luis and Carlos had been sexually and physically abused while at school in Venezuela. The family did not come to the attention of agencies while in the UK, and the review panel were unable to find sources to support the claims of abuse. The review panel concluded that financial issues were a potential motivation for the murders and suicide. The family were Venezuelan with Portuguese heritage. Read full overview (PDF)	**Learning:** • consideration of the financial and homelessness support available to migrant families; and ensuring the link between financial difficulty and suicide is incorporated into safeguarding adults and suicide prevention. **Recommends:** • the London Borough of Richmond upon Thames addresses issues of financial and homelessness difficulties for all communities; • links to domestic abuse are addressed in the development of the borough's violence against women and girl's strategy; • the borough ensures that issues of financial difficulty and links to suicide are incorporated into public health and suicide prevention work.
2021 **Southampton Safeguarding Children Partnership – 'Liam'** Liam was a 17-year-old boy who died on the 19 January 2020 having been stabbed.	Hampshire Police were called to an area of Southampton at 06:15 am on 19 January 2020 after reports of an assault, where on arrival they found Liam with a stab wound to his chest. He was taken to Southampton General Hospital but died later that day from his injuries. A 15-	

	year-old boy was arrested and at the time was missing from his residential care home. After an investigation he was charged with Liam's murder, he stated he was acting in self-defence, which the Jury accepted, and he was found not guilty at the Crown Court trial. He was convicted of being in possession of a bladed weapon for which he received a 12-month referral order. Liam was linked to Child Criminal Exploitation (CCE) from the age of 10 years and indications point towards his involvement with County Lines and drug related offending. Liam was a Looked After Child (LAC) and was subject to several placements in different areas of the country, including periods in secure accommodation, once when he was in custody and also for his own welfare. Liam is of a British white ethnicity. At the time of the incident which led to his death, Liam was living with his mother, who for the purpose of this review is called LM. Little is known of Liam's father as it appears that he stopped having contact when Liam was about 1 year old. Read full overview (PDF)	

National Learning - Adults

ADULT - BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
Sept 2021 -Norfolk Safeguarding Adults Board Joanna, Jon & Ben During April 2019, Norfolk's Safeguarding Adults Board ("NSAB") commissioned a Safeguarding Adults Review (SAR) concerning the deaths of two adults at a private hospital, Cawston Park ("Hospital"). During December 2020, the death of a third patient was added to the review's remit.	The deceased, Joanna, "Jon" and Ben were in their 30s. They had learning disabilities and had been patients at the Hospital for 11, 24 and 17 months respectively. They died between April 2018 and July 2020. Joanna, Jon and Ben were admitted to the hospital under sections of the Mental Health Act (1983). Joanna and Jon originated from London boroughs. Ben was from Norfolk. Their behaviour was known to challenge services and sometimes their families. Joanna and Jon had experienced several out-of-family-home placements. Ben had lived with his mother for most of his life. Their placement at the hospital resulted from personal and family crises. Read full overview here	The review makes 13 recommendations for critical system / strategic change. In addition it contains the following key learning for practitioners; • the critical role for professional curiosity and challenge • the trauma of transition • meaningful support for individuals with behaviours that challenge others • critical responsibility for staff to advocate reporting and openness • where the victim of abuse doesn't want to 'complain' • the importance of meaningful occupations • making sure attention is given to physical health needs • mental capacity
Sept 2021 – Salford Safeguarding Adults Board – 'Matthew' Matthew who had been known to several agencies throughout his adulthood took his own life in November 2020.	Matthew had a long criminal history for a variety of crimes and had a number of personal challenges with drug addiction and managing his mental health and was known to mental health services and had a number of short stays as an inpatient. Matthew had a long term partners who is mother of his 2 children and the couple had been discussed at MARAC.	Key learning points: • better understanding around disguised compliance • challenges around adults having access to suitable property is a national issue due to shortage of social housing • better understand the function of MARAC to help reduce risks

	He tried several attempts to take his own life and experienced a period of homelessness. Matthew took his own life on a railway and died as a result of his injuries. Read full overview here	• recognise the needs of the children but also the needs of the parents equally for both mother and father as part of a whole family approach – Mathews needs were not always recognised • recognising the signs of self-neglect

ADULT - BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
July 2021 – Salford Safeguarding Adults Board – 'Kannu' Kannu died on 20 November 2020 in hospital at the age of 91, cause of death given as old age and frailty, congestive cardiac failure, ischaemic heart disease, hypertension and type 2 diabetes.	Kannu had been known to Adult Social Care for some time and received commissioned services through Continuing Health Care until September 2019 after which private care provider arrangement commenced, commissioned by local authority. This arrangement continued, interspersed with concerns about her physical health, not eating/drinking and refusal of support from her carers, until March 2020, she was admitted to a nursing home. The day after admission she expressed a wish to return home, however this did not happen partly because of repairs being needed in her home. She remained in the nursing home until shortly before her death. She was admitted to hospital the day before she died. Read full overview here	Key learning points: • ensure early referral for advocacy service • practitioners must work through all the options with both the individuals they are working with and their relatives • shortfalls in key legal literacy relating to mental capacity and deprivation of liberty • ensure person centred practice, including professional curiosity • risk assessments must be timely and thorough • importance of supervision to ensure critical reflection • importance of comprehensive assessments • pathways for multi-agency meetings need to be revisited • clearly agreed roles and responsibilities for the review of placements