# LSCB
# Learning from Reviews

November 2017

# About the briefing

- Subject matter is sensitive and can be distressing
- Hindsight bias
- Learning to inform and improve practice

# Triennial analysis of SCRs 2011-14

- Why is a serious case review undertaken?
- Report suggests unhelpful focus on predictability and preventability
- Many cases were identified by the review to be unpredictable but not unpreventable
- Need to move to a systems approach

# Numbers

- Numbers of child deaths
- Numbers of SCRs 2011-14
- Average annual rates of SCRs by age group
- Numbers previously known to children's social care

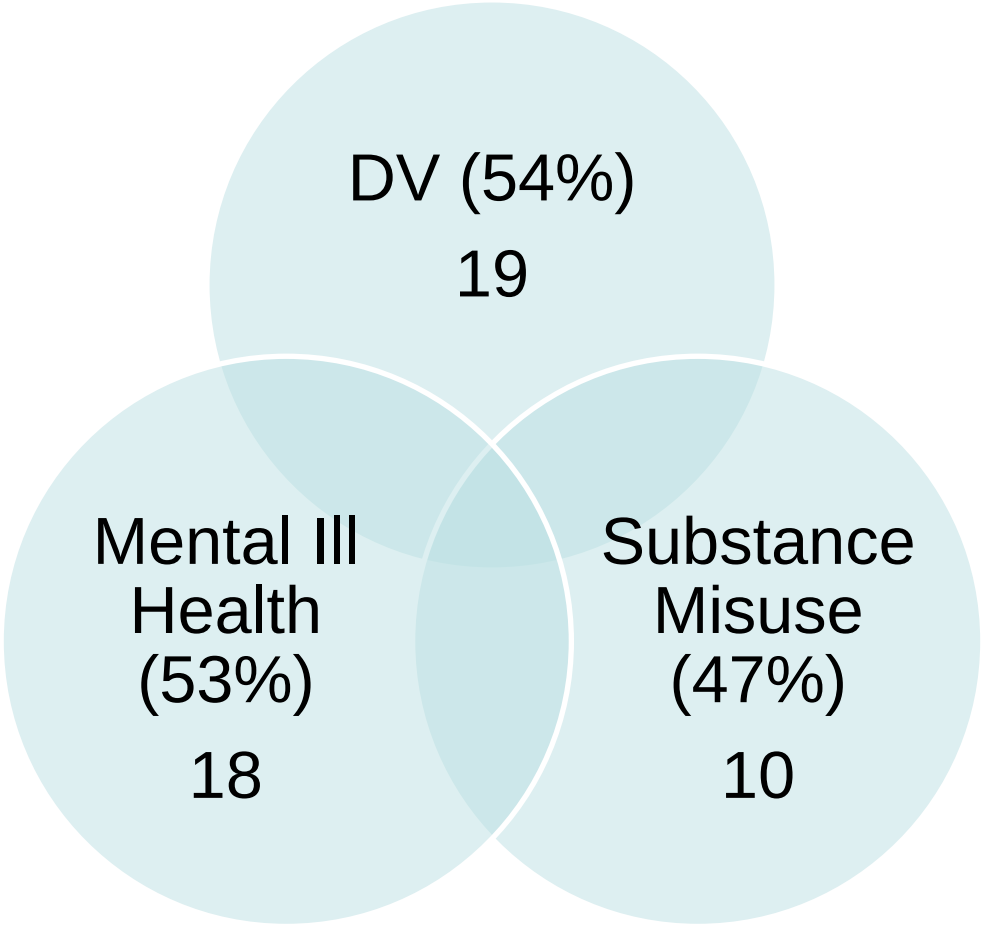
# Vulnerabilities

- Child vulnerability
- Disabled children
- Adolescent vulnerability

# Cumulative and interacting risk of harm: Parents

- DA, mental health, drug and alcohol misuse (combined or singly)
- Maternal ambivalence
- Adverse childhood experiences
- History of crime
- Multiple consecutive partners or acrimonious separation

# Cumulative risk of harm



# Domestic Violence

- Domestic violence/abuse is ALWAYS harmful to children

- DV should not be seen solely in terms of violent incidents, but in the on going contexts of coercive control

# East Sussex Reviews 2014-17

- 3 Serious Case Review (SCR)
  - 2 SCRs in progress

# SCR Child M

- 17 year old Looked After Child who died of a drugs overdose whilst in the company of her “boyfriend” who was 7 years older

- The boyfriend was subsequently convicted of supplying a class one drug in connection with the death of Child M

# SCR Child M

- At 13 years of age Child M found unconscious in the street having consumed a litre of vodka
- By age of 15 years using Ketamine with alcohol and injecting drugs including Heroin by 16
- Subsequent history of continuing substance misuse, drugs overdose, mental health issues, continued relationship with older drug abusing male and concerns of under age sexual activity

# SCR Child M

- Child M embraced drug misuse and believed it added to the quality of her life. She engaged with professionals on her terms and to her own advantage

- Although Child M spent her childhood is Surrey she later moved several times to be in the company of her boyfriend. At the time of her death she was residing in Surrey, was an East Sussex LAC but died in the Thames Valley area

# SCR Child M
# Key Learning

- The difficulties of professionals working within the legal frameworks applying to 16 and 17 year olds who are in effect regarded as adults

- The conflict that existed between professionals wanting to protect Child M from the risks posed by her behaviour and Child M's own wish to live with the male who exposed her to risk

# SCR Child M
# Key Learning

- Following her first overdose, the underestimation by CSC of the serious risk posed to Child M which in turn led to CSC not taking action to bring agencies together to manage the risks posed to Child M

- The difficulties for professionals working across areas when Child M moved between local authorities

- The ineffective use of Child Abduction Warning Notices to prevent contact between Child M and her boyfriend and lack of national policy

# SCR Child M
# Summary of Recommendations

- Reminder that child protection arrangements should apply equally to all children under 18, and that 16 & 17 years olds may need to be subject of a CPP

- Need for drugs services to tailor their provision to the needs of young people

- Adult mental health and substance misuse services to ascertain details of children who may be effected by the behaviour of adult service users

# SCR Child M
# Summary of Recommendations

- LSCBs to consider how to improve continuity of health care for LACs who move placement especially to a different LA area

- All LSCB professionals to consider the vulnerability of children who go missing or who present in different LA areas

- LSCB to raise the issues from this review relating to Child Abduction Warning Notices with CEOP and DFE

# SCR Child K

- 6 week old baby admitted to hospital, the father claimed to have suffered a fit whilst holding the baby and ended up on top of the child causing suffocation and other serious physical injuries.
- Further medical examinations revealed fractures of different ages.
- Child K died 5 days after admission as a result of these injuries. Medical expert opinion subsequently concluded the pattern of injury was consistent with inflicted injury of the shaking/impact type

# SCR Child K

- The father pleaded guilty to manslaughter and was sentenced to 8 years imprisonment.
- Given the constraints of skills, knowledge and authority attributed to relevant professionals at the time, it is the view of the SCR Author and of the SCR Panel that the tragic death of Child K was neither predictable nor preventable.

# SCR Child K – Conclusions

- **Communication** – commonly held view at the time of the incident that communication between GPs, midwives and health visitors had been affected by staff shortages, recruitment difficulties, changes in service delivery and use of locum practitioners.
- During times of change and pressure, good communication is essential to the maintenance of effective services and thereby keeping children safe.

# SCR Child K – Conclusions

- There was also evidence that some of the tools designed to facilitate that communication were;
  - Not used: e.g. the Children's index not being accessed by the GP practices involved
  - Not fit for purpose: e.g. Additional Support Form (used by midwifery/health visiting) did not have a review date and did not enable new information to be added without the risking the loss of previous information.
  - Not universally known and understood: e.g. GP stating they were not aware of the form available for providing information when women book their pregnancy through midwives.

# SCR Child K – Conclusions

- **Epilepsy/Non-Epileptic Seizures**
  - The criminal trial concluded father suffered from functional non-epileptic attack disorder (FNEAD) and had been referred for neuro-psychiatric assessment that he failed to attend.
  - The presence of poorly controlled non-epileptic seizures should have prompted further enquiries about father's health and potential impact on parenting capacity.

# SCR Child K – Conclusions

- **Management Support/Accountability**
  - Frontline professionals across health agencies were working with high caseloads, erosion of early support services and increasing expectations of being able to provide early help services.
  - Evidence of high caseloads and high level of sickness and low moral.
  - The need for effective and challenging supervision, both clinical and safeguarding. The need is most acute when services are under pressure.

# SCR Child K – Conclusions

- **Services Under Pressure**
  - In the current economic climate it is inevitable that public services come under enormous pressure, both efficiency demands and addressing escalation in level of need and vulnerability in the community.
  - Services working in the community must be transparent with each other and assess and share the impact of resource issues

# SCR Child K – Key Recommendations

- All families where epilepsy and/or non-epileptic seizures are present must be given the British Epilepsy Association guidelines on safety.
- A risk assessment must be completed by health professionals when there is evidence of uncontrolled epilepsy or fits where the parent has sole care of the child.
- LSCB should ensure ESHT audits the quality of supervision given to midwives and health visitors and provides evidenced assurance to the LSCB

# SCR Child K – Key Recommendations

- The LSCB should ensure that all partner agencies when they withdraw, reconfigure or reduce services which might impact on safeguarding to report;
  - The communication strategy in regard to withdrawal/reconfiguration/reduction
  - The risk assessment and risk management action plan
  - The plan to monitor the impact

# SCR Child K – Key Recommendations

- The ASFs to be reviewed to ensure that all updates are easy to identify and there is adequate space to do this.
- Practices' access to the Children's Index to be facilitated and Practice Leads to be helped develop a policy on the use of the Index

# SCR Child P

- 7 year old child shot and killed by her father who subsequently took his own life.
- The family had been known to agencies with safeguarding responsibilities as a result of concerns about domestic abuse and violence since 2008, firstly in Brighton and Hove and after 2011 in East Sussex.
- Private law proceedings in relation to residence and contact arrangements began in September 2009 and remained active at the time of Child P's death.

# SCR Child P

- Child P lived with her mother and older adult sibling at the time of her death and did not have direct contact with her father at that time.
- The criminal investigation into the killing of Child P has established that in the early part of 2014 the father used a variety of covert and illicit means to secure details of the family address and details of Child P's routine.

# SCR Child P – Findings

- Child P's father planned and carried out the killing in a secretive way, using the internet and a range of covert and possibly illegal methods to trace the family and obtain the means to carry out the killing.
- There is no evidence that any professional was aware of this activity, nor did he make any threat to harm Child P or give any indication that he might do so. The review has concluded that no professional working with the family could have prevented him acting as he did.

# SCR Child P – Findings

- Often such killings take place in the context of a custody dispute about a child and in a high proportion there has been a documented history of domestic abuse. The killing is then sometimes, though not always, followed by the suicide of the perpetrator.
- The review has identified learning in relation to the management of risk when a victim of domestic abuse and violence moves across local authority boundaries and weaknesses in the functioning of the MARAC arrangements.

# SCR Child P – Findings

- On three occasions while the family was living in East Sussex there is evidence or a strong suspicion that details of the mother's addresses or identity were disclosed to the father inadvertently or in error. Although there is no evidence that these actions led the father to know where the family was living, they might have.
- At the same time the review has identified that, given the existence of social media and very powerful search engines, it is increasingly difficult for families fleeing violence to rely on their whereabouts remaining secret. It cannot therefore provide the sole basis for safety planning.

# SCR Child P – Findings

- The court proceedings in this case became protracted. The repeated attempts to promote contact in various forms between the father and Child P met with no success. As a result Child P experienced considerable uncertainty for more than half her life about where she would live and whether or not she would see her father.
- In such lengthy proceedings there is a danger that significant information revealed and established at an early point may become lost, or parties may choose not to remind the court of its existence.

# SCR Child P - Recommendations

- The East Sussex Domestic and Sexual Abuse Management Oversight Group (DSAMOG) working with the LSCB, should seek to ensure that strategy, policy, training and practice reflect the complexity of a victim's experience, including an understanding of the challenges and barriers.
- The DSAMOG should ensure that professionals understand that the assessment of risk is a process, rather than a one off event, and that risk assessments are updated when there are significant changes in circumstances. Referrals for services should be made before a woman is discharged from the relevant service

# SCR Child P – Recommendations

- DSAMOG should develop effective arrangements for the transfer of cases and sharing of information from MARAC to MARAC both within local (Sussex and Brighton & Hove) networks and when families move more widely.
- Policy, procedures and training convey a good understanding of the impact on safety planning of current use of technology by the public and organisations, including social media and powerful modern search engines

# SCR Child P- Recommendations

- East Sussex LSCB should seek assurance from member agencies that they have systems in place which identify information about vulnerable service users that should not be disclosed, that staff understand the significance of this issue and are trained to use the agency's system.
- The Independent Chair of LSCB should submit a copy of the SCR report to the Designated Family Judge for Sussex and to the Sussex Family Justice Board for their respective consideration.

# SCR Child P – Recommendations

- DSAMOG, working with the LSCB, should secure feedback from victims of domestic violence and abuse who have had contact with services over their children so that recent experiences of service use – good and bad – inform policy and practice

# Key previous SCR Recommendations

- Improve links between adult and children's services
- Communication between CAMHS and CMHT
- View of the child at the forefront of any assessment
- Need for composite chronologies by agencies referring to CSC
- Need for robust family support arrangements when CPP ends

# Key previous SCR Recommendations

- Impact of drug abusing parents on their children
- Working with avoidant and resistant families
- Need for improved procedures for unexplained injuries to infants and young children
- Police to speak to alleged perpetrators of domestic abuse in person

# Themes from Reviews

- Promoting Professional Curiosity
- Effectiveness of Strategy Discussions; inter-agency communication and understanding of roles and responsibilities
- Understanding of ‘unexplained injury’ within investigations
- Role of men within the child protection process
- Elective Home Education

# Themes from Reviews

- The need for practitioners to have critical challenge and reflective supervision
- Use of composite chronologies to assist assessment
- Importance of seeing the child in all assessments and ensuring the views, wishes and feelings of the child are represented
- Professional challenge and escalation
- The need to consider verifying information in cases where domestic abuse is totally self reported