REGIONAL LEARNING RESOURCES

Vulnerability in Babies

NORTHUMBERLAND

NEWCASTLE UPON TYNE

NORTH TYNESIDE

SOUTH TYNESIDE

GATESHEAD

SUNDERLAND

DURHAM

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1. Introduction

When a child suffers a serious injury or death as a result of child abuse or neglect, understanding not only what happened but also why things happened can help to improve our response in the future. Recognising the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge.

All organisations who work together to safeguard and promote the welfare of children should seek to adopt a culture of continuous learning and improvement in order to ensure that good practice is shared and that when cases have poor outcomes, the lessons can be learnt and actions identified to ensure that services can be improved to reduce the risk of future harm to children.

Safeguarding Board Business Managers across the region have developed a regional learning resource, with a regional theme of Vulnerabilities in Babies.

There are 7 Local Authorities involved:

Durham: The impact of the toxic trio on babies

Gateshead: Risk of Significant Adults with Vulnerabilities

Newcastle: Neglect with Foetal Alcohol Syndrome

North Tyneside: Signs of Safety

Northumberland: Bruising, particularly around the role of fathers/significant males

South Tyneside: Bruising in Immobile Babies

Sunderland: Family Pets

It is hoped that this resource can enhance the current multi-agency training, knowledge and understanding of the topic of Vulnerabilities in Babies.

A glossary of the abbreviations used within this document can be found at page 26.

2. Local Authority: Durham
Theme: The Impact of the Toxic Trio

1. Background

County Durham had a serious case review published in 2017 relating to the death of a seven week old baby

2. Key Themes:

County Durham had a serious case review published in 2017 relating to the death of a seven week old baby.

- Late presentation of pregnancy (concealed / denied)
- Parental substance misuse
- Missed medical appointments
- Domestic abuse
- Poor home conditions
- Concerns from family members not responded to

3. Good Practice

- The use of a range of tools to assess the motivation of parents and their ability to change.
- Sharing information between agencies where there are concerns relating to any of the above issues.

4. What is different now?

(e.g. Policies and Procedures,Resources, Supervision etc)

- Improvement in antenatal risk assessment in respect of both parents and this now includes the use of the Home Environment Assessment Tool (HEAT). Also maternal / paternal ambivalence considered as part of this assessment
- HEAT tool used from universal to specialist services
- Family health assessment tool is now more in depth and includes the role of fathers
- Update and relaunch of threshold documentation
- Raising awareness of disguised compliance through training
- Recording of significant events improved to include parental substance misuse and this to be included on a child's records as well as parents
- Use of non-engagement toolkit
- Health needs assessment implemented by the 0-19 service
- Training on parental risk factors merged into a one day training course to focus on the impact on children
- Neglect training updated in respect of findings

5. The impact issues identified could have on each Local Authority

The actions are monitored on a monthly basis and a process is in place to ensure the actions are processed in line with the recommendations and in a timely manner.

6. Details of Interactive Session

You tube video link provided on the briefing on the subject 'was not brought'

7. Feedback Session (for delegates to provide feedback on what they will do next)

Evaluations can be included following the use of the Seven Minute Briefings

See Also: 7 Minute Briefing Document

'Charlotte and Charlie' Serious Case Review

01 Introduction

- Charlie and Charlotte were 10 and 7 when they were they were placed on the child protection register and then removed from the care of their family and placed into foster care.
- Concerns had been reported to Children and Young People's Service in respect of the care the family were providing.

02 History

- Parents had children previously removed from another authority as a result of concerns regarding neglect.
- There was extensive multi-agency involvement for a significant period of time following the children being born.

03 No Sustained Change

There was lack of any evidence of sustained change in the parent's ability to meet the children's needs resulting in:

- Severe dental decay and failure to ensure appropriate treatment or both children.
- Permanent visual impairment for both children as a result of parental failure to seek treatment.
- Variable home conditions from very poor to just good enough over periods of time.
- Failure to meet a broader range of the children's health needs over a significant period of time.

04 School Concerns

- Extreme behavioural challenges presented in school by Charlotte.
- Very poor routines for the children meaning that Charlotte regularly fell asleep in school.
- Children frequently arrivedat school hungry.
- One child was overweight and the other often refused to eat.
- Poor supervision of the children.

05 Over Optimistic and Unrealistic Assessment

- The lessons learned from this review focus in particular on the 'start again' approach taken when mother became pregnant with Charlie which led to an over optimistic and unrealistic assessment of parents' capacity to care for their children.
- The learning from this review should be used to influence practice and policy where families have previously had children removed from their care.

06 Thresholds and Risk

- Additional learning comes from how professionals recognise, assess and respond to risk when sexual/abuse allegations are made by children and young people but do not proceed to criminal proceedings; specifically the difference between evidential thresholds and actual/probable risk.
- Further learning comes from how practitioners recognise, understand, assess and respond to cases of chronic neglect.

07 'Was Not Brought'

- A recommendation was made for all agencies to consider the terminology used for missed appointments. Rather than using the term 'Did not Attend' they are urged to use the term 'Was not brought'. This highlights that it is not the responsibility of the child to attend appointments but that of their parent or carer.
- Agencies also need to have systems in place to monitor and respond to missed appointments and to understand their significance.cases of chronic neglect.

Serious Case Review Briefing Note for Agencies can be found at: https://tinyurl.com/yca4ls53

Durham
Local Safeguarding Children Board

3. Local Authority: Gateshead

Theme: Risk of Significant Adults with Vulnerabilities

1. Background

Polly's case was reviewed by the LSCB's Learning & Improvement Sub Group following an allegation of rape made by Polly. The criteria for a Serious Case Review was not met. However, it was agreed that additional learning and work should be carried out to learn lessons from Polly's case and apply them to future practice.

Polly is the first-born child to couple H & P born in 1999.

She has an older half-sister born in 1990 and a younger sister, born in 2006.

Family known to health and social care services.

Intimidating household to visit and adults involved in questionable activities.

2005 – 2011

- Polly was seen on a regular basis by the child & family unit. Diagnosed with ADHD. Parents describe extreme behaviours such as pulling out her hair.
- Parents referred to ADHD parenting group. They did not attend.
- Polly referred to play therapy 2008 but she wasn't taken to appointments.
- Polly's mother asked if Polly had autism or schizophrenia or a split personality.
- Had speech & language appointments but discharged 2012 as she wasn't taken to the appointments.
- Given medication for ADHD. Had IQ test which was in the normal range.
- Parents keen to engage with services but would not follow through with advice.
- Between 2006 & 2011 Children's Social care received 9 referrals re Polly.
- Most referrals were from the police re DV incidents between parents and angry outbursts, seemingly because of the children's behaviour, children were present.
- Parents extremely difficult to work with. Lacked insight into each other's behaviours and would blame each other for their inappropriate responses.
- TAF in place 2012 – closed in November 2012
- Parents talked about strategies they used at home, i.e. not arguing, however would argue constantly.
- Intimidating household to visit and adults involved in questionable activities.

January 2012 – April 2014

- Events for this period begin 16/1/13
- Polly was 12 years old and disclosed she was having consensual sex with a boy, when a third party (B) approached and anally raped her.
- Polly was seen by the Forensic Network in the Children and Young People's Clinic RVI on the 17/1/13. She is described as "very vulnerable" and her parents "feel they are overprotective but this is necessary".
- Polly was put on hep b medication following rape – she 'was not brought' to appointments, parents stated did not need to go as they did not believe she had been raped.
- Parents continue to say they cannot cope with Polly's behaviour – pattern of wanting her back then rejecting or harming her (withdrew S20 agreement four times).
- June 2013 - Polly admitted to QE hospital for CAMHS review after threatening to kill her family and jump out of a window.
- Polly described how her parents slapped, punched, pulled her hair and bit her nose.
- Two paediatric assessments supported the view that Polly's injuries were consistent with assault.

November 2013 and February 2014

- There were 2 ICPCs during this period.
- Recommendation was for a CiN plan at first conference - SSchool objected to this as thought this should be a Child Protection Plan.
- At second conference in February 2014 – subject to CP plan under physical abuse.
- Polly made 4 separate allegations of physical abuse by both her parents during this timeframe.
- She also disclosed she'd been sexually abused from the age of 7 by a 17-year-old cousin when mother and aunt were drinking.
- Core Assets said they were withdrawing from the case because of parent's volatility.
- Scored highly at Adolescent Risk Management Group.

- Dad called EDT as he reported Polly was posting nude photos on Facebook.
- Parents continuing to complain about Polly's behaviour and said they couldn't cope. Also made complaints about foster care and social worker. Refused to have Polly in their care and withdrew S20 consent on 4 occasions.
- It emerged father had a caution aged 17 for gross indecency.
- Father asked to leave the family home as a safety measure – mother not happy about this and wanted father back.
- Polly has 5 periods in care from June 2013 (4 under Section 20 and 1 under Police Protection - 28th April 2014). She returned home when her parents withdrew the Section 20 consent.
- She had 8 foster placements and 2 residential placements
- Polly had a number of education placements – she was subject to 16 conduct incidents in year 7, 72 in year 8 and 40 incidents in year 9 prior to her permanent exclusion. She also spent 46 days in the Learning Support Unit.
- Polly was excluded on 3 occasions due to behavioural issues and then permanently excluded from school in March 2013.

April 2014

- Polly disclosed she'd had sex with 10 boys over the last 4 months. Mother is purported to have said the males should not be approached as it was Polly's fault.
- Seen again by forensic network/CYPS clinic RVI. Consultant paediatrician said Polly's disclosure of past sexual abuse is extremely concerning and needs to be investigated thoroughly.
- Polly was involved in a fight with Father watching and on other occasions arrested for criminal damage and assault. YOT involved at this stage.
- Mother was seen to slap Polly (on CCTV outside school) and was given a police caution.
- 28th April 2014 – Police Protection was taken – Polly placed in foster care.

May 2014

- 1 May 2014 – Emergency Protection Order (EPO) granted. Father aggressive with carer.
- 9 May 2014 – Interim Care Order (ICO) granted. External placement panel agreed a residential placement would best suit Polly's needs. LAC reviews held at least every 6 months during this period.

August 2014

- Polly moved into 'The Grange' residential provision.
- Further allegations from Polly that other young people in placement were touching her sexually / having sex with her / threatening rape.
- Polly took photos of her genitals on young person's phone and gave the phone back to him.
- During this period there were at least 13 allegations.

November 2014

- Formally transferred from Safeguarding & Care Planning team to Looked After Children Team.

February 2015

- Plan to proceed to unsupervised contact with parents.

June 2015

- Plan to move Polly to foster placement prior to returning home from care.

August 2015

- Parents said they were unwilling to have contact with Polly.

October 2015

- Parents said they were unwilling to have contact as Polly had sex in the community with a male.
- LAC reviews held regularly throughout this period. One review had to be rescheduled due to family arguments at the meeting.

November 2015

- Recording states CYPS retracted the diagnosis of ADHD – Polly deemed to have attachment and emotional issues instead – there is confusion around whether there was an actual diagnosis of ADHD, CYPS claim no formal diagnosis was ever made.

January 2016

- Polly admitted to A&E after taking legal highs and collapsing

April 2016

- Decision making meeting with a plan to return Polly home from foster care.
- LA solicitor and Safeguarding Representative felt unable to sanction the plan.

February 2017

- Decision making meeting held – LAC team proposed Polly should return home from children's home. LA solicitor opposed the plan.
- Plan was shelved within 24 hours as Polly alleged Father had grabbed her round the throat.

March 2017

- Polly disclosed she wanted to have a baby with her boyfriend
- Polly had a period of time at home, but this broke down and she returned to care

April 2017

- Polly was having overnight contact at her parents and attended a house party. Polly alleged rape by gang of Romanian males whilst at the party.
- Parents continue to blame Polly, minimise the risks and attempt to disrupt placements.
- Interim Secure Order granted.

2. Key Themes:

Team around the Family

- Relies on parent's cooperation – if no progress or significant change is being made, consider escalation to Child in Need or Child Protection.
- CAF/TAF process is not always robust in terms of gathering and analysing information from other sources.

Attention Deficit Hyperactivity Disorder – help or hindrance?

- Children in the child protection system are three times more likely to have a diagnosis of attention deficit hyperactivity disorder (ADHD) than the general population.
- The behaviours we associate with ADHD, such as inattention and difficulty regulating emotions, are very similar to those typically exhibited by young people who have experienced chronic stress and maltreatment.
- Too much focus was put on Polly's 'diagnosis' of ADHD. Parents had financial motivation for diagnosis. Parents used ADHD label to remove responsibility from them and deflect blame onto Polly.

Child abuse and neglect can cause..

- Attachment and inter-personal relationship problems.
- Mental health problems.
- Alcohol and drug use.
- Behaviour problems.
- The earlier the abuse, the more likely the impact in adolescence.
- Consider impact of Adverse Childhood Experiences (ACE's).

Parents

- Parents extremely difficult to work, hostile and uncooperative.
- Parents would seek support but not follow up on advice and Polly 'was not brought' to appointments.
- Parents self-reporting progress and minimising concerns.
- Recognising and working with families who behave in a hostile, aggressive way or display behaviours indicative of disguised compliance - missed appointments; exaggerated co-operation and compliance; attempts to minimise professionals' concerns or denial of the impact of the lived experience of the child; aggressive or threatening behaviour when challenged; Persistent intimidating action such as repeated complaints about workers, unjustified claims of progress being made or actions carried out and a refusal to discuss key issues whilst focussing on others that have less or no impact for the child.

Sexual activity and the issue of consent

- The fact that young people are engaged in what they view as consensual sexual activity does not mean that they are not being exploited or abused.
- Victims of sexual exploitation or abuse may be coerced into sexual activity. They feel unable to say no.
- Some young people may not recognise they are being sexually exploited, believing they are behaving as they wish.
- Sexual activity between young people of the same age is often perceived as being consensual, but exploitation may still be occurring.
- Child sexual abuse causes sexualised behaviour / anti-social behaviour and difficulties in relationships.
- Disagreement about whether Polly should be made subject to CPP was recorded but could have been escalated using LSCB Escalation Policy.
- Allegations concerning mother and fathers physical abuse appeared to be true.

- Polly would make a disclosure but would then withdraw due to parent manipulation. She would also make allegations about every placement she had which meant disclosures seemed to get diluted.

Volatile family relationships

- Cycles of familial reconciliation and rejection have a significant impact on young people's wellbeing and mental health.
- Recognition must be given to the vulnerabilities in the system of handover between teams – information gets lost/diluted and focus is changed (Ref: traps we fall into').

Child Sexual Exploitation

- 16 and 17-year olds are often viewed as being more in control of their own choices and so less vulnerable to exploitation.

Lack of challenge by Independent Reviewing Officer

- Consider impact of adverse childhood experiences – Using Trauma Informed Model changes everyone's mind-set from "What's wrong with you?" to "What happened to you?" - impacting on how we assess & respond to need as well as build and maintain relational interventions and treatments. It also increases the likelihood that the child's account will be believed.
- Concerns about children should always be followed up – do not assume another agency will make referral into Children's Services. Care review and planning meetings should involve all agencies who work directly with the child or their family.

3. Good Practice

- Polly diagnosed with ADHD, and referred for play therapy and speech & language, given medication for ADHD.
- Parents initially keen to engage with services.
- Referrals were received by Children's Social Care from other agencies. Referral process worked.
- Following Polly's allegations of physical and sexual abuse at age 7 she is made subject to CP plan under physical abuse.
- LAC reviews and planning meetings held regularly once Polly in care system.
- Professionals acted on information regarding Fathers "Gross Indecency" police caution.
- 5 periods in care to safeguard Polly followed by a move to residential provision, interim Secure Order granted.

4. What is different now?

(e.g. Policies and Procedures, Resources, Supervision etc)

- Robust Procedure for children returning home – Decision Making Meeting attended by multi-agency partners and IRO. The meeting should agree a detailed support package, monitoring arrangements and contingency plan.
- Recognising the vulnerabilities in the system at the point of handover between social work teams. Adherence to previous plans made on the basis of assessment is crucial.
- Awareness and understanding of escalation processes with regard to Child Protection Conferences.
- New practice guidance - Working with and recognising families who behave in a hostile, aggressive way or display behaviours indicative of disguised compliance.
- Multi-agency training available regarding uncooperative families and disguised compliance.
- Understanding CSE and role of MSET.
- Over reliance on medical diagnosis as a 'quick fix'.
- Trauma-led (ACE) focus needs to be more at the forefront of the minds of professionals.
- The importance of sharing information and working together to safeguard children.

5. The impact issues identified could have on each Local Authority

- Failure to recognise the seriousness of concerns raised about children and young people, parents minimising seriousness of concerns. This can lead to children and young people being left in circumstances which are detrimental to their development.
- Need to recognise the impact of Adverse Childhood Experiences (ACEs) on the developing child and the impact of these in later life. Recognise the need for training on Trauma Led practice.
- Lack of recognition of the impact of working with hostile families on professionals and the need to raise awareness of disguised compliance and how to tackle this.
- Planning meetings need to involve all agencies who work directly with the child or their family to ensure multi-agency working to safeguard and protect.
- Too much focus on medical diagnosis can enable parents to deflect blame onto a child.
- Recognition must be given to the vulnerabilities in the system of handover between teams – information gets lost/diluted and focus is changed.
- Allegations made by children and then withdrawn should be investigated more robustly to ensure children are not being manipulated by adults. Because a child makes several allegations this does not mean that these should be ignored or the information dilute.

6. Details of Interactive Session

Group Discussion:

- Were environmental issues sufficiently explored as a reason for medical and behavioural symptoms such as ADHD?
- Do we have evidence of abuse of neglect?
- Sharing of all of this information, is there evidence to show we could have worked together to address the issues at an earlier point?
- Would we do anything differently now?

Group Discussion:

- Was sufficient weight given to what Polly was reporting, both verbally and by her behaviour?
- Was there any exploration of why she was so sexualised?
- Was she believed?
- Was it appropriate that Polly was placed back in her parents care on 4 separate occasions and why was that so?
- Disagreement with conference outcomes – escalation policy – are you aware?

Further Discussion – Large Group:

- Children returning home from care - 1SCIE report that returning to live with a parent is the least successful 'Permanence Option' for maltreated children.
- NSPCC report 50% of children suffer further abuse.
- Parents exhibiting hostile and uncooperative behaviour– involuntary recipients of social work intervention.
- Social workers having 'misplaced optimism' – over estimating parent's ability to make necessary changes.

Over to you:

- Are there any lessons for the system as a whole?
- Are there any lessons for your organisation?
- What do we need to do to change as a result of what we've learned today?
- How can any learning be disseminated?

7. Feedback Session (for delegates to provide feedback on what they will do next)

Over to you:

- Are there any lessons for the system as a whole?
- Are there any lessons for your organisation?
- What do we need to do to change as a result of what we've learned today?
- How can any learning be disseminated?

See Also:

7 Minute Briefing Document
LSCB multi-agency safeguarding procedures and practice guidance
Child Sexual Exploitation
CSE Framework – Screening and Risk Assessment (MSET)
LSCB Escalation Protocol
Child Protection Conferences / Child Protection Plans
LSCB multi-agency training programme
LSCB website
Gateshead Children's Services Procedure Manual

Moving Forward

- Robust Procedure for children returning home – Decision Making Meeting attended by multi-agency partners and IRO. The meeting should agree a detailed support package, monitoring arrangements and contingency plan
- Recognising the vulnerabilities in the system at the point of handover between social work teams. Adherence to previous plans made on the basis of assessment is crucial
- Awareness and understanding of escalation processes with regard to Child Protection Conferences.
- New practice guidance - Working with and recognising families who behave in a hostile, aggressive way or display behavioursindicative of disguised compliance.
- Multi-agency training available regarding uncooperative families and disguised compliance.
- Understanding CSE and role of MSET.
- Over reliance on medical diagnosis as a 'quick fix'.
- Trauma-led (ACE) focus needs to be more at the forefront of the minds of professionals.
- The importance of sharing information and working together to safeguard children

Key Learning

- Concerns about children should always be followed up.
- Care review and planning meetings should involve all agencies who work directly with the child or their family.
- Cycles of familial reconciliation and rejection have a significant impact on young people's wellbeing and mental health.
- Multi-agency chronologies are important to share information and inform decision making and care planning.
- Recognising & working with disguised compliance.
- Sexual activity & consent: Sexual activity under the age of 13 is illegal under any circumstances.
- Young people engaging in 'consensual' sex could still be abuse or CSE.
- The earlier the abuse, the more likely the impact in adolescence .
- CAF/TAF process relies on consent & cooperation .
- ADHD – Too much focus put on ADHD. Parents had financial motivation for diagnosis. Parents used ADHD label to remove responsibility from themselves and deflect blame onto Polly.
- Practice implications: Recognition must be given to the vulnerabilities in the system of handover between teams – information gets lost/diluted and focus is changed.
- Allegations concerning mother and fathers physical abuse appeared to be true. Polly would make disclosures but would then withdraw, possibly due to parent manipulation. She would also make allegations about every placement she had which meant disclosures lost their impact.

Further Information & Training

LSCB multi-agency safeguarding procedures and practice guidance

Child Sexual Exploitation

CSE Framework – Screening and Risk Assessment (MSET)

LSCB Escalation Protocol

Child Protection Conferences / Child Protection Plans

LSCB multi-agency training programme

LSCB website

Gateshead Children's Services Procedure Manual

'Polly Chapman' Case Review

07 06 05 04 03 02 01

Introduction

Polly's case was reviewed by the LSCB's Learning & Improvement Sub Group following an allegation of rape made by Polly. The criteria for a Serious Case Review was not met However, it was agreed that additional learning and work should be carried out to learn lessons from Polly's case and apply them to future practice.

- Polly is the first born child to couple H & P born in 1999.
- She has an older half-sister born in 1990 and a younger sister, born in 2006.
- Family known to health and social care services.
- Intimidating household to visit and adults involved in questionable activities.

Timeline

2005 – 2011 (6 to 12 years old):

- Polly diagnosed with ADHD, Parents describe extreme behaviours such as pulling out her hair, Parents referred to ADHD parenting group - they did not attend
- Polly's mother asked if Polly had autism or schizophrenia or a split personality
- Polly referred to play therapy and speech & language but was discharged from both services as wasn't taken to appointments.
- Given medication for ADHD. Had IQ test which was in the normal range
- Parents keen to engage with services but would not follow through with advice.
- Children's Social Care received 9 referrals re: Polly, most of which were from the police re: DA incidents between parents.
- 'Was not brought' - Polly & younger sibling were not taken to a number of appointments, parents described as hostile','uncooperative' & 'difficult to work with'.

Timeline

2012 – 2014
(12 to 14 years old):

- Polly discloses she was having 'consensual' sex with boy, when a third party approached & anally raped her. Polly put on Hep B medication following rape but was not brought to appointments as parents did not believe she had been raped
- Polly permanently excluded from school
- Polly's parents holiday with a third party - Polly is left at home with her older sibling.
- Polly admitted to hospital for CAMHS review after making threats to kill her family & disclosing physical abuse
- Polly makes 4 separate allegations of physical abuse & discloses sexual abuse at age of 7 by 17 year old cousin – Polly is made subject to CP plan under physical abuse
- 5 periods in care : June 2013 – April 2014. 4 under S20 & 1 under police protection
- Polly discloses sex with multiple partners (10 over 4 months)

Timeline

2014 – 2017
(14 – 17 years old):

- Polly moved into residential provision. Further allegations of sexual assault were made by Pollyduring this time.
- Parents continue to minimise the risks & to blame Polly.
- Recording states CYPS retracted the diagnosis of ADHD & claim no formal diagnosis was ever made.
- Interim Secure Order granted.

Gateshead local safeguarding children board

3. Local Authority: Newcastle Upon Tyne

Theme: Neglect with Foetal Alcohol Syndrome

1. Background

Unexpected death of Baby J when she was 15 weeks old. She and her siblings had been subjects of Child Protection Plans for neglect for 5 months. J was born prematurely and with suspected foetal alcohol syndrome. A month prior to her birth, she and her 3 siblings (all under 5) had been made subjects of Child Protection Plans for neglect, primarily due to concerns about their young mother's lifestyle and the continued disputes between her and the father of J's 3 siblings.

https://www.nscb.org.uk/sites/default/files/Child%20J%20SCR%20Report%20May%202016_0.pdf

2. Key Themes

- Recording systems did not include chronology templates that were fit for purpose, hampering practitioners attempts to understand families' history; particularly significant in the context of intergenerational neglect.
- The process for inviting people to key meetings did not consistently ensure that that right people would be there.
- The link between completion of assessment as a pre-requisite for case transfer encouraged more superficial assessments on the most complex and highest risk cases.
- The overwhelming reliance on social workers to lead, manage and administer Core Groups diminished the effectiveness of these multi-agency meetings.
- Routine processes for agreeing bail conditions contain a loophole that omits checks being made about risks an offender presents to children.
- The way that medical staff presented their diagnosis of types of injury was confusing to non-medical practitioners, who interpreted lack of evidence as meaning an injury is accidental.
- It is currently more difficult to coordinate a multi-agency response to unexpected child deaths at weekends and Bank Holidays, with potential to affect the timely diagnosis of likely cause of death.
- Standardised tasks and Contracts of Expectation are used too routinely and without consequence, making them ineffective when addressing deep-rooted learned behaviour through child protection plans.
- Despite all child protection cases being high risk by definition, practitioners juggle priorities by deciding which is riskier than another, leaving the less obvious neglect cases more vulnerable.
- A tendency to focus too much on the nuclear family in isolation from any wider networks, even when extended family members are known to professionals, is limiting the effectiveness of interventions with families that have been subject to child protection measures over generations.
- The attendance of an appropriate range of professionals at CP Conferences is inadvertently being limited by too narrow a definition of family, thereby undermining the effectiveness of planning and the best interests of children.

3. Good Practice

- The Conference agreed that all children, including unborn J, should be made subjects of Child Protection Plans for neglect. This was an appropriate decision given the known and potential risks to the children and the unborn child arising from mother's lifestyle.
- Core group members effectively supported the family over August and communicated well with each other.
- The Family Intervention Project (FiP) worker (who had been temporarily seconded to work with mother to support her move to a new tenancy and was also a qualified SW) provided intensive support for mother. She built a relationship with her at this time that was both supportive and appropriately challenging.
- The school too were in regular contact with both parents, acting as intermediary to resolve conflict over contact and monitoring the appearance and behaviour of the children, two of whom attended regularly over the summer holidays. That they were able to do this over a holiday period was an exceptionally high level of service.

4. What is different now? (e.g. Policies and Procedures, Resources, Supervision etc)

- In order to strengthen the system CSC implemented a new recording process for capturing significant life events in chronologies. All social work staff across the service have been trained in using the new system and all new cases coming into the Initial Response Service must have a current and comprehensive chronology, which supports the single assessment process.
- Further consideration will be given to how we can improve the sharing of single agency chronologies at key points and also the use of multi-agency.
- Chronologies in certain complex cases.
- To ensure that open cases to CSC receive the same level of response and assessment when a new incident occurs CSC has revised its internal procedure, which provides clear expectations about when further multi-agency meetings are to be held in the light of new concerns and triggers for reassessment.
- To strengthen the invitation process for child protection conferences a whole system review of the process was undertaken. The review was expanded to include other safeguarding meetings. The review considered exploration of other mechanisms to provide secure transfer of information required for invitations.
- Full implementation of a single assessment system by CSC was achieved in June 2015. This will help to mitigate against the risk of more superficial assessments being undertaken on some of the higher risk cases as it allows for the continuation of assessment post ICPC to the long term social work teams.
- A decision has been made by the Assistant Director of Children's Social Care for practitioners to stop using Contracts of Expectations, which can detract from the purpose and focus of a Child Protection Plan [or Child in Need Plan] outcomes and actions. Where there is no plan yet in place, for example following an initial referral, practitioners will prepare a Danger Statement and put in place with the parents or carers a robust Safety Plan until an assessment is completed. All Safety Plans will include detailed contingency plans.
- In considering the finding NSCB partner organisations unanimously agreed that the management and administration of Core Group meetings should be the responsibility of CSC in order to ensure that: the meetings are formally chaired and minuted; records are uploaded into the CSC system in a consistent and timely way; a record of the meeting is distributed to the core group members; and minutes are provided to the IROs for Child Protection Conferences.
- Northumbria Police presented the learning from Finding 7 **(The routine processes for agreeing bail conditions contain a loophole that omits checks being made about risks an offender presents to children)** to 200 magistrates in November 2015. Whilst the magistrates acknowledged that they are constrained by bail powers, they embraced the learning and have since raised issues about the kinds of information being submitted to them at court and reflected in files. This includes all relevant safeguarding information and references to appropriate or inappropriate bail addresses. They also have raised the need to tighten up on checking mechanisms at court.
- The standardised Child Protection Medical proforma has been updated to include a page summarising the findings of the assessment and giving a scaled opinion about the likelihood of non-accidental injury.
- Since the onset of the Serious Case review in January 2014 there has been a number of innovation projects implemented with a focus on specific vulnerability areas, e.g. neglect and provide additional capacity to provide specialised, targeted and intensive support to those children and families who need it.
- The Trust Board has agreed to appoint more general paediatric consultants in order to cover the full range of paediatric work including child death at peak times which include weekends and Bank Holidays.
- The doctor for Child Death has discussed with key partners the out of hours information sharing meetings and it has been reiterated to all partners how important attendance at these meetings is.
- A Neglect Practice Group is being established to support workers in decision making relating to neglect cases and threshold around early intervention/help.

5. The impact issues identified could have on each Local Authority

The lack of understanding of complex family history is a recurrent problem that often emerges as learning from Serious Case Reviews nationally. It also is at the root of the 'start again syndrome' described in Brandon et al's biennial reviews of serious case reviews that were commissioned by the government up to 2010:
'In families where children suffered long term neglect, children's social care often failed to take account of past history and adopted the **'start again syndrome'**.

The circumstances of this family were like many others referred to Children's Social Care (CSC) at the time and not specific to Newcastle; a recently single, young mother with three young children, well known to the system and with intermittent crisis points relating to domestic violence and drinking alcohol.

Similarly, capacity and case load levels can lead to practitioners unofficially prioritising 'riskier' cases and the often-cumulative nature of neglect, can mean these are the children who can be inadvertently given less scrutiny until a serious incident occurs or longer term significant impact is likely.

There was also evidence of 'disguised compliance' from mother and a willingness from practitioners to believe her without sufficient scrutiny of the reality in which Baby J was living (hidden male). Contracts of expectations were unrealistic and almost encouraged deceit and disengagement with services. Hidden males and a willingness to believe a given version of events are recurrent themes in SCRs.

6. Details of Interactive Session

https://www.nscb.org.uk/sites/default/files/Learning%20from%20Practice%20Child%20J%20SCR.pdf

7. Feedback Session

(for delegates to provide feedback on what they will do next)

Discussion on how the learning will impact on practice is undertaken after each presentation (embedded below) and is also a standard question on the NSCB evaluation form

See Also:

7 Minute Briefing Document
Vulnerable Babies Brief
Neglect Special Interest Group Annual
The Solution Focused Reflecting Team Technical
Neglect Strategy on a page 2018
L5 Shorter Version
PHE-LGA Frame for Supporting Teens
Neglect 2018 Updat

'Baby J' Serious Case Review

01

Introduction

- This relates to the unexpected death of Baby J when she was 15 weeks old. She and her siblings had been subjects of Child Protection Plans for neglect for five months.
- An initial post-mortem concluded that her death was caused by a head injury.
- Further tests confirmed that this was likely to have been as a result of shaking.

02

History

- J was born prematurely and with suspected foetal alcohol syndrome. A month prior to her birth, she and her three siblings (all under 5) had been made subjects of Child Protection Plans for neglect, primarily due to concerns about young mother's lifestyle and the continued disputes between her and the father of J's three siblings.

03

Role of Partner

- Mother's partner had been living with J, her mother and siblings for three months although her mother denies that she was in a relationship prior to him moving in. She became less available to professionals after he moved into the home. A Review Child Protection Conference held two months before J's death had been generally positive in its prognosis for the future.

04

Key Learning Themes

- While individual professionals were reacting with appropriate urgency, what was missing at this stage was an authoritative and considered multi-agency strategy. This would have best been achieved by consultation with the IRO and either child Protection Conference or, at the very least holding an extraordinary core group meeting.

05

Key Learning Themes

- If the 'system' designed to support families to overcome difficulties has not worked well enough, they are likely to have developed strategies to cope with this that are challenging to work with constructively.
- Professionals are facing an impossible task if their work does not build in enough time for reflection, individually, jointly and if necessary without family present.
- This case highlights the danger of becoming too procedurally task-driven.
- Processes designed to facilitate thinking (assessments) can become rushed and lose much of their original purpose.

06

Key Learning Themes

- The lack of a 'fit for purpose' chronology as part of the work flow undermines the critical importance such a tool has for practitioners in understanding the past and its implications for the present, as part of any assessment.
- Where families have been known to the Child Protection system over long periods of time this acquires particular relevance; to identify patterns of behaviour and to understand and avoid the repetition of risk management strategies that have been unsuccessful.

07

Key Learning Themes

- Because 'risk in neglect cases is not always obvious until symptoms become more serious it requires the 'system' to be more vigilant.
- Neglect can mistakenly be perceived as more benign than other forms of abuse, with the result that risks to the safety of some children can be judged as less of a high priority for action than others.
- Cases involving child neglect require extra vigilance from agencies that are highly attuned to make immediate response to serious incidents, because the warning signs may not be so obvious.

Newcastle Safeguarding Children Board

5. Local Authority: North Tyneside

Theme: Signs of Safety

1. Background

Mother called the emergency services and reported she had fallen asleep on the sofa with Jack (4 weeks) on her lap. When she woke he was limp and unresponsive. Paramedics attempted to resuscitate Jack but he died in hospital.

Jack and his older half sibling age 12 were made subject to child protection plans prior to Jack's birth due to concerns in relation to parents drug use. Similar concern had led to Jack's half sibling being the subject of a child protection plan as a young child and living with family members for a significant period of time.

Mother was on a methadone programme and was caring for both children. As part of the protection plan the child's father agreed to live elsewhere because of his continuing and erratic drug use.

Mother had attended all ante natal appointments, including 2 scans.

Jack was in hospital 3 days following his birth and his mother was reported to be fully involved in his care and attentive to his needs. Her care and handling were described as very good and there had been no concern expressed by staff in relation to her presentation. Records indicate Jack had been unsettled and 'jittery' but currently settled and feeding well.

Jack had not gained weight and it was arranged for him to be reviewed at hospital.

Visits indicate he was alert and well and his feeding was improving. Post-natal checks did not raise any concerns.

Jack's sibling was reluctant to engage in discussions about her family life, however a deficit in care related to two aspects of her life: her school attendance (86%) and her dental care.

2. Key Themes

- There was evidence of 'disguised compliance' from mother and a willingness from practitioners to believe her without sufficient scrutiny. Mother frequently missed appointments with key agencies but was welcoming when practitioners, through perseverance, managed to make contact. It appeared practitioners were reassured by her apparent openness and did not challenge the significant lack of compliance. Jack's father had been staying at the home against the requirement of the protection plan.
- Good quality meaningful supervision that needs to challenge professionals' beliefs about apparent family engagement and to seek evidence of actual progress.
- A system across partner agencies that enables invitations and requests for reports for meetings to be received within the time scales set out in LSCB policies. The process did not consistently ensure that all practitioners were able to attend and contribute.
- All professionals must be aware of and understand the risk to children posed by co sleeping. The National Institute for Health and Care Excellence (NICE) confirmed that although Sudden Infant Death Syndrome (SIDS) is rare, it does happen more often when parents or carers sleep with a baby (on a bed, sofa or chair).
- A clear focus on the needs of all children in the family who are subject to a Child Protection plan.

3. Good Practice

- The ICPC identified the risks to the unborn child and his sibling from parents drug use and associated lifestyle and an appropriate decision was made to make them subject to child protection plans.
- Core group members maintained frequent contact with each other and made numerous phone calls and visits to engage with mother. However this did not lead to any challenge of the effectiveness of the child protection plan when mother was not engaging.

3. Good Practice

- The ICPC identified the risks to the unborn child and his sibling from parents drug use and associated lifestyle and an appropriate decision was made to make them subject to child protection plans.
- Core group members maintained frequent contact with each other and made numerous phone calls and visits to engage with mother. However this did not lead to any challenge of the effectiveness of the child protection plan when mother was not engaging.

4. What is different now? (e.g. Policies and Procedures, Resources, Supervision etc)

- System has been developed to ensure requests for reports and invitations to CP meetings are sent electronically.
- QILP (sub-group of the LSCB) monitors attendance and submission of reports to CP conferences and concern in relation to participation raised with single agencies.
- Awareness raising training delivered to key partners by LSCB Manager.
- Reporting and information sharing template for GPs to promote participation in the Section 47/Initial Conference process, developed and promoted in single agency training for Primary Care.
- Assurance from partners (via section 11) that practitioner supervision is reflective and challenging.
- Multi-agency training includes risks posed by co-sleeping.
- CP plans for unborn babies include an action that staff working with family regularly enquire about sleeping arrangements for baby and remind parents of the risks of co-sleeping.
- Health visitor records are audited to ensure advice and leaflets in relation to co-sleeping are shared with parents.
- Safe Sleeping leaflet updated and incorporated into guidance for professionals/parents/carers on NTSCB website.

5. The impact issues identified could have on each Local Authority

- Systems do not ensure participation of key practitioners and/or agencies at meetings leading to poor information sharing and planning.
- CP plans to consider a range of formal and informal support available to the mother (particularly if a plan removes one of the parents from the care of the children).

6. Details of Interactive Session

In groups – based on the case study, consider the following:

- What is the impact on the parent/s of the child's death?
- What is the impact on the other children and other family members?
- What is the impact on the professionals who worked with this family?
- Make three recommendations to professionals to help prevent this situation happening again. Present your recommendations.

7. Feedback Session

(for delegates to provide feedback on what they will do next)

Provide three flip chart papers around the room and post-it notes for delegates. Delegates write on the post-it notes and put onto the relevant flip chart paper:-

- What are you doing already that is working well?
- What could you/your organisation do better?
- What is the first step you will take to make this happen?

See Also:

Safer Sleep for Babies leaflet
https://www.lullabytrust.org.uk/wp-content/uploads/safer-sleep-for-parents.pdf

Videos on safe sleeping from Lullaby Trust
https://www.lullabytrust.org.uk/safer-sleep-advice/sleeping-position/

NICE Guidance on Co-sleeping
https://www.rcm.org.uk/news-views-and-analysis/news/nice-updates-guidance-on-co-sleeping

North of Tyne Procedure for Child Death Review Process
https://www.northtynesidelscb.org.uk/wp-content/uploads/2017/02/North_of_Tyne_Procedure_for_the_Child_Death_Review_Process1.pdf

Childhood Bereavement Network supports professionals working with bereaved children and young people, with information updates, key resources and networking opportunities.
Find out more about how we can help you.
http://www.childhoodbereavementnetwork.org.uk/

Bereavement counselling after the death of a child
https://www.lullabytrust.org.uk/bereavement-support/seeking-bereavement-counselling/

Introduction

- Mum called the emergency services and reported she had fallen asleep on the sofa with Jack (4 weeks) on her lap.
- When she woke he was limp and unresponsive.
- Paramedics attempted to resuscitate Jack but he died in hospital.

Family Context

- Jack and his older half sibling age 12 were made subject to child protection plans prior to Jack's birth due to concerns in relation to parents drug use.
- Mother was on a methodone programme and was caring for both children.
- The child's father was living at the property against the requirements of the Child Protection plan

The Child's Voice

- Jack had been in hospital for 3 days and his mother was reported to be fully involved in his care and attentive to his needs.
- Her care and handling were described as very good and there had been no concern expressed by staff in relation to her presentation.
- Jack had been unsettled and 'jittery' but currently settled and feeding well.
- Jack had not gained weight. Visits indicate he was alert and well and his feeding was improving.
- Post-natal checks did not raise any concerns.
- There were concerns about Jack's sibling related to her school attendance and her dental care.

Good practice and what was working well

- No injuries were observed and it was noted that Jack had received a good level of physical care prior to his death.
- A police enquiry was initiated and concluded there were no suspicious circumstances in relation to the death.
- There was no evidence Mum was under the influence of substances when she was observed by paramedics or hospital staff.

Lessons Learned

- All professionals must be aware of and understand the risk to children posed by co sleeping.
- The importance of supervision, continuing professional learning, reflective practice and case based discussions.
- A clear focus on needs of all children in the family who are subject to a Child Protection Plan, across partner agencies that enables invitations and requests for reports for meetings to be received within the time scales set out in LSB policies.

Research and evidence

- The National Institute for Health and Care Excellence (NICE) confirmed that although Sudden Infant Death Syndrome (SIDS) is rare, it does happen more often when parents or carers sleep with a baby (on a bed, sofa or chair).Safer Sleep for Babies leaflet https://www.lullabytrust.org.uk/wp-content/uploads/safer-sleep-for-parents.pdf

Recommendations and what needs to happen

- Develop robust recording and reporting systems, including using new technologies
- Develop a strategy for ensuring availability and attendance at meetings
- Develop CP plans to consider a range of formal and informal support available to the mother (particularly if conditions removes one of the parents from the child care
- Child protection plans specify timescales, actions and contingencies due to non-compliance
- Examination of supervision processes, CPD, and reflective practice
- Staff understanding of the risks to children posed by co-sleeping

North Tyneside SAFEGUARDING CHILDREN BOARD

6. Local Authority: Northumberland

Theme: Bruising, particularly around the role of fathers/significant males

1. Background

At 6 weeks old, Kirsty was seen by a health visitor to have a bruise on her cheek. Following referral to Children's Social Care, a skeletal survey showed 10 fractures of varying ages. This was a complex family with mother having a history of domestic abuse, alcohol abuse and mental health issues. Father was believed to be a protective factor but pleaded guilty to causing Kirsty's injuries.

2. Key Themes

Role and invisibility of fathers; toxic trio; information missing from assessments; over-reliance on and acceptance of self-reporting.

3. Good Practice

Response of health visitor when she say the bruise and the Section 47 process which followed referral.

4. What is different now? (e.g. Policies and Procedures, Resources, Supervision etc)

7 minute briefing and learning events highlighted issues and raised awareness of vulnerable babies procedures and guidance.

5. The impact issues identi ed could have on each Local Authority

Themes are similar to other regional and national reviews.

6. Details of Interactive Session

Group discussion slides at end of presentation.

Use 'Coping with Crying' lm in training session https://www.youtube.com/watch?v=NZMh7WyCies

'Kirsty' Serious Case Review

01 Introduction

- During a home visit, when Kirsty was 6 weeks old, the health visitor noticed two small bruises on Kirsty's cheek.
- This triggered immediate referrals to Children's Social Care.
- The full skeletal survey in the paediatric medial assessment showed 10 fractures of varying ages
- When Kirsty was seen the previous day, a GP accepted mother's accidental explanation for the facial bruising.

02 Family Context

- Kirsty lived with her mother and 4 year old sister 'Lydia'.
- Mother was known to services for mental health issues. Father was not known to services.
- Had a history of self-harm, suicidal ideation and depression

03 Lydia

- A child protection investigation was undertaken when 'Lydia was born because of mother's aggressive outbursts on the post-natal ward
- 'Lydia' was taken to A& E twice with bruising and injuries accepted as accidental.

04 Additional Issues

- Mothers disclosure that she was drinking heavily and had hit father at least once.
- Evidence of violence in household.
- Death of maternal grandmother: impact on mother's mental health.
- Revolving door nature of mother's access to services.

05 Outcome

- Father pleaded guilty to causing Kirsty's injuries and was given an 18 month suspended sentence.
- Mother was found to have no case to answer.
- Kirsty and Lydia are thriving in long-term foster care with relatives.

06 Key Lessons

- Focus on mother; father was overlooked in assessments.
- 'Think Child' when dealing with adult issues.
- Gender bias in domestic abuse.
- Lack of effective chronology.
- Over-reliance on self-reporting meant professionals mistakenly believed CSC were aware of significant incidents.

07 Good Practice

Referral of mother to high risk services for both pregnancies.

- Health Visitor following policy relating to bruising on non-mobile babies.
- Speed and rigour of response to that referral, including early involvement of the police.
- Prompt safeguarding of children through care proceedings and foster placement.

N S C B
Northumberland Safeguarding Children

7. Local Authority: South Tyneside

Theme: Bruising in Immobile (Non Independently Mobile) Babies

1. Background

South Tyneside have had two Serious Case Reviews where bruising in babies was the key focus.

A "Bruising in Babies" Learning Event for multi-agency practitioners was delivered as a follow up to the Serious Case Reviews.

The "Bruising in Non-Independently Mobile Babies Protocol" was developed and implemented together with new literature (poster and leaflet)

2. Key Themes

Power Point Presentation attached which covers all aspects of Bruising In Babies.
"Babies who do not cruise do not bruise" strapline.

3. Good Practice

Shared in the Power Point and Seven Minute Briefings (Child B, Child X and Bruising in Babies)

4. What is different now? (e.g. Policies and Procedures, Resources, Supervision etc)

Bruising in non-independently mobile babies protocol introduced and implemented
Updated Policies and Procedures
http://www.southtyneside.gov.uk/article/35872/information/professionals

5. The impact issues identified could have on each Local Authority

If the learning is not implemented effectively, babies could continue to be at risk of significant harm with subsequent Serious Case Reviews being initiated along the same theme.
Further LSCB audit 2018-2019 to ensure that the Protocol is reviewed and amended as appropriate.

6. Details of Interactive Session

Interactive Quiz

7. Feedback Session (for delegates to provide feedback on what they will do next)

Evaluations can be included following the delivery of the Power Point presentation and the Seven Minute Briefings

Bruising in Immobile Babies

01 Background

"THOSE WHO DON'T CRUISE RARELY BRUISE"

- Bruises in active children are common and often are considered "normal" childhood injuries. However, bruises may also be the result of physical abuse or some serious medical conditions
- Bruising occurs after a bump or injury which damages underlying capillaries and causes leaking and collection of blood in the soft tissues under the skin. Usually bluish or purple in colour, bruises gradually fade through shades of green or yellow over a period of two weeks.
- Many factors affect the colour of the bruise including the amount of blood that leaks after injury, the amount of force applied and the amount of tissue damage incurred, the age of the person injured and the underlying colour the injured person's skin.
- The precise age of bruises is impossible to estimate by colour.
- The cases of Baby B and Baby D in South Tyneside stand as a reminder that practitioners must remain alert and seek satisfactory explanation for `bruising on children.

02 Bruising – What we know

- Bruising is the most common presenting feature of physical abuse in children, including babies.
- Bruising has often been noted to be the only feature of early abuse. Bruising is strongly related to mobility. Bruising in a baby / child not yet crawling or not independently mobile is very rare. Only 20% of children who are starting to walk by holding onto furniture will have bruises.
- Once mobile children will sustain bruises from everyday activities and accidents.
- Children who are immobile because of a disability have a significantly increased risk of non-accidental injury and of being physically abused.
- Mongolian blue spots are a type of birthmark. They are flat blue or blue/grey spots with an irregular shape that commonly appear at birth or soon after. Mongolian blue spots are most common at the base of the spine, on the buttocks, and back. They are not to be confused with abusive bruising.

03 Accidental Injury

- Most accidental bruises are seen on the front of the body on bony areas such as the knees and elbows.
- Children who are just starting to walk unsupported may bump and bruise their foreheads,nose, and centre of their chin or back of their head.
- It is common to have fractures, particularly rib or metaphysical fractures without any bruising.
- Accidental bruising in children with a disability will be related to the child's level of mobility, equipment used, muscle tone and learning ability.
- There will be increased bruising over the summer months when children are more frequently playing outside.

04 Non Accidental Injury

- There are some patterns of bruising that may indicate physical abuse has taken place. Abusive bruises are often seen on soft parts of the body such as the abdomen, back and buttocks.
- Bruising to the forearm, face, hands, feet, back of leg, hips, ears are usually a result of defence. Clusters of bruises are a common feature.
- Abusive bruises can often carry the imprint of the implement used or of the hand.
- The bruises are usually larger than accidental bruises.
- The head is by far the most common site of bruising in abuse cases.
- Bruising with Petechial (dots of blood under the skin) around them, co-exist with NAI (non accidental injury) and do not blanch when pressed.

05 Ageing Bruises

- There is no evidence of a proven way to age a bruise accurately. Current estimates are based on an assessment of the colour of the bruise with the naked eye which is no better than 50% accurate.
- There can be multiple bruising across the body at any one time – the bruises can all differ.
- Different colours can appear in the same bruise at the same time. Not all colours appear in every bruise.

06 Implications for Practice

- A bruise should never be interpreted in isolation and should be assessed in the context of the child's medical and social history and development stages.
- Early signs of abuse, such as a bruises that are overlooked or under recognised often result in poor outcomes.
- The Toxic Trio – Domestic Abuse, Substance Misuse and Mental Health are a significant feature in the physical abuse cases in the UK.
- Numerous Serious Case Reviews and reports highlight the number of non-mobile babies who present with bruising prior to a subsequent fatal or near fatal event.

07 Further Information

- "Babies are highly fragile. The first year of life carries the highest risk of a child being killed from abuse"
- The LSCB has produced "Bruising in non-independently mobile Infant" protocol which can be found at:
  http://www.southtyneside.gov.uk/article/35872/information/professionals
  https://www.rcpch.ac.uk/resources/child-protection-evidence-bruising
- Any child who is found to be seriously injured , or in need of urgent treatment of medical investigation in whom abuse is suspected, should be referred. immediately to hospital at the same time as a referral to Childrens Social Care

424 5051 (office hours)

456 2093 (after hours)

STAY SAFE BE HAPPY
South Tyneside Safeguarding Children Board

8. Local Authority: Sunderland

Theme: Family Pets

1. Background

- Sunderland LSCB (SSCB) commenced a Serious Case Review (SCR) in October 2016 following the death of Baby A who died aged 20 days old following an assault by the family pet dog on 20 June 2015.
- The SCR report was published in February 18.
- Criminal proceedings against Baby A's father resulted in him being jailed for 21 months for being in charge of a dangerous dog, and a child neglect charge was ordered to lie on file.
- The SCR highlighted concerns relating to father's long standing problem with alcohol and substance abuse and was under the influence of one or both whilst he had care of Baby A on the night of the incident.
- Mother, who was the usual caregiver for Baby A, was out of the house at a family funeral, returning in the early hours to find baby seriously injured.
- Baby A was taken to hospital by ambulance but died from the severity of the injuries a short while later.

2. Key Themes

- Many families carry vulnerabilities and pressures not known to professionals. It is therefore vitally important to ask the right questions whilst impressing on families the consequences of not addressing issues.
- Death attributed to multiple factors – alcohol misuse, presence of a dog and vulnerable baby, an unforeseen family crisis.
- Professionals need to help families think about the unthinkable.
- Educate parents about the risks of alcohol to the safe care of children.

3. Good Practice

- Health visitor identified and addressed any potential risks , particularly in relation to the dog, as part of a standard health visiting approach.
- Without Mother disclosing risk factor of Father's drinking the outcome could not have been further preventable by professionals.

4. What is different now? (e.g. Policies and Procedures, Resources, Supervision etc)

- SSCB provide guidance on assessing the needs of babies and children when there is a dog in the home.
- SSCB added a procedure in respect of Dangerous Dogs and Safeguarding Children.
- Review of Public Health commissioned 0-19 contract for Sunderland with requirement for antenatal visits to address safe sleeping arrangements and presence of animals within the home.
- During Child Safety Week (week beginning 4th June 2018) , SSCB launched an awareness raising event, publicised both in the local press and across social media with the support of Dogs Trust. 10,000 leaflets are also being distributed by partners to share best practice.

5. The impact issues identified could have on each Local Authority

- The anticipated impact of introducing guidance and procedures is to enable practitioners in conjunction with families to identify and minimise potential risks to children of all ages.
- Ensure findings are shared more widely to inform local strategic planning to reduce the number of preventable deaths.

6. Details of Interactive Session

- SSCB working with key stakeholders and partners to deliver public awareness campaign around dogs who are not properly supervised by their owners or caretakers – this campaign started during Child Safety Week beginning 4th June 2018.
- SSCB and partners ran a campaign to raise awareness of the potential risk to babies of parental use of alcohol compromising their ability to safeguard their children will run in November 2018.
- Awareness raising for taxi-drivers to be vigilant and report concerns when transporting alcohol to adults who may be parents or carers. To be undertaken through annual safeguarding training for Sunderland licensed taxi drivers 2018-2019.

7. Feedback Session (for delegates to provide feedback on what they will do next)

7 Minute Briefing Document

Baby A Serious Case Review

'Baby A' Serious case Review

01 02 03 04 05 06 07

Background

- Sunderland LSCB (SSCB) commenced a Serious Case Review (SCR) in October 2016 following the death of Baby A who died aged 20 days old following an assault by the family pet dog on June 20th 2015.
- The SCR report was published in February 2018.
- Criminal proceedings against Baby A's father resulted in him being jailed for 21 months for being in charge of a dangerous dog, and a child neglect charge was ordered to lie on file.
- The SCR highlighted concerns relating father's long standing problem with alcohol and substance abuse and was under influence of one or both whilst he had care of Baby A on the night of the incident.
- Mother, who was the usual care giver for baby A was out of the house at a family funeral, returning in the early hours to find baby seriously injured.
- Baby A was taken to hospital by ambulance but died from severity of the injuries a short while later.

Key Themes

- Many families carry vulnerabilities and pressures not known to professionals.
- It is therefore vitally important to ask the right questions whilst impressing on families the consequences of not addressing issues.
- Death attributed to multiple factors – alcohol misuse, presence of a dog and vulnerable baby, an unforeseen family crisis
- Professionals need to help families think about the unthinkable.
- Educate parents about the risks of alcohol to the safe care of children.

Good Practice

- Health Visitor identified and addresses any potential risks, particularly in relation to the dog, as part of a standard approach.
- Without mother disclosing risk factor of father's drinking, the outcome could not have been further preventable by professionals.

What is Different Now?

- SSCB provide guidance on assessing the needs of babies and children when there is a dog in the home.
- SSCB added a procedure in respect of Dangerous Dogs and Safeguarding Children.
- Review of Public Health commissioned 0-19 contract for Sunderland with requirement for ante-natal visits to address safe sleeping arrangements and presence of animals in the home.
- During Child Safety Week (week beginning 04/06/2018) SSCB launched an awareness raising event, publicised both in the local press and across social media with the support of Dogs Trust. 10,000 leaflets are also being distributed by partners to share the best practice.

The impact issues identified could have on each Local Authority

- The anticipated impact of introducing guidance and procedures to enable practitioners working with families to identify and minimise potential risks to children.
- Ensure findings are shared to inform local strategic planning in order to reduce the number of preventable deaths.

Interactive Sessions

- SSCB working with key stakeholders and partners to deliver public awareness campaign around dogs who are not properly supervised by their owners or caretakers – this campaign started during Child Safety Week (week beginning 04/06/2018)
- SSCB and partners will start a campaign to raise awareness of the potential risk to children/babies of parental use of alcohol compromising their ability to safeguard their children in November 2018.
- Awareness raising for taxi-drivers to be vigilant and report concerns when transporting alcohol to adults who may be parents or annual safeguarding training for Sunderland licensed taxi drivers 2018-19

Feedback session (for delegates to provide feedback on what they will do next)

- SSCB to undertake a multi-agency audit in July 2018 to evaluate how effectively learning from this review and public awareness has been embedded into frontline practice

sscb
Sunderland Safeguarding Children Board

Glossary of Abbreviations

Acronym	Name
ACEs	Adverse Childhood Experiences
ADHD	Attention Deficit Hyper Activity Disorder
CAF	Common Assessment Framework
CAMHS	Children and Adults Mental Health Service
CIN	Child in Need
CPP	Child Protection Plan
CSC	Childrens Social Care
CSE	Child Sexual Exploitation
CYPS	Children and Young Persons Service
EDT	Emergency Duty Team
EPO	Emergency Protection Order
FIP	Family Intervention Project
GP	General Practitioner
HEAT	Home Environment Assessment Tool
ICO	Interim Care Order
ICPC	Initial Child Protection Conference
IQ	Intelligence Quotient
IRO	Independent Reviewing Officer
LA	Local Authority
LAC	Looked after Child
LSCB	Local Safeguarding Children Board
MSET	Missing, Slavery, Exploitation and Trafficked
NICE	National Institute of Health and Care Excellence
NSCB	Newcastle Safeguarding Board
NSPCC	National Society for the Prevention of Cruelty to Children
NTSCB	North Tyneside Safeguarding Children Board
QILP	Quality, Improvement, Learning and Performance
RVI	Royal Victoria Infirmary
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SIDS	Sudden Infant Death Syndrome
SSCB	Sunderland Safeguarding Children Board
SW	Social Worker
TAF	Team Around the Family
YOT	Youth Offending Team

Compiled and Designed by

South Tyneside Safeguarding Children Board

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