SSCB Annual Learning Event 2017

Lessons Learned from Case Reviews and Audits

SSCB Annual Learning Event 2017

Simon Westwood
SSCB Independent Chair

Welcome

What is the event about?

- Raising awareness of how the Case Review and Audit Subgroup influences practice in Salford
- Sharing lessons learned from local Case Reviews including Serious Case Reviews (SCR)
- Disseminating multi-agency practice audits findings
- Reflecting on your own practice in light of the learning from these case reviews and audits

Event Programme

- **SSCB Case Review and Audit Subgroup**
- **Child S: Case Review and Recommendations**
- **Child R: SCR and Recommendations**
- **Multi-agency Practice Audits**
    1. Self Harm
    2. Domestic Abuse
- **Group work-** your feedback on how we can embed the lessons learned into practice is vital
- **Additional information, resources & agency stalls**

My perspective – progress over the last three years

- Continuous improvement coupled with…….
- Growing partnership involvement, purpose, and respect.

This has been

- Reflected in positive external inspections of Board partners and
- Positive engagement with frontline staff in learning and developments event such as today.

Children and Social Work Bill 2017 - Proposals for Change

- SCRs will be undertaken by a National Child Safeguarding Practice Review Panel which will be appointed by the Secretary of State.
- Local child safeguarding practice reviews will continue but the arrangements for decision making are yet to be published.

SCR National Panel

- Correspondence with the National Panel
- SCR Panel Reports
- National Case Review Repository

Further information:
www.gov.uk/government/groups/serious-case-review-panel

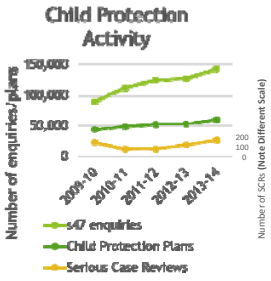
Is the system broken?

No but it is time for change

Prevention and protection

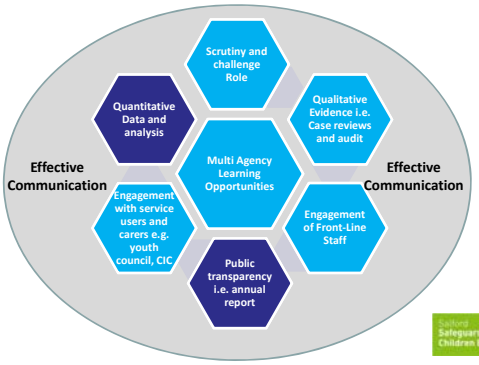
Moving from a culture of failure and blame to one of learning and improvement

- 10 years of SCR studies: huge increase in the volume of child protection work
- **But:** no increase (or drop) in numbers of children suffering fatal or serious harm
- **Instead:** consistent evidence of motivated professionals working extremely hard with emotionally-charged caseloads



Marian Brandon and Peter Bottomley; Triennial Review of SCR's 2016

Building an Effective Learning and Improvement Network



Learning & Improvement Framework

At the heart of this Framework is one simple question

Are we improving our ability to keep children in Salford safe and how do we know?

By understanding why things happened/how they are - we can learn from them

This event is about valuing and developing professional expertise

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Case Review and Audit Subgroup

Sharon Hubber-
Assistant Director: Specialist Services, Salford City Council
Dr Kalpesh Dixit-
Designated Doctor/Community Paediatrician, SRFT

Subgroup Membership

- **SCC Children's Services**- Assistant Director: Specialist Services (**Chair**) Head of Safeguarding, Head of Service CIN, CP & Early Intervention, Head of Social Work and Improvement, Assistant Director for Education and Helping Families and the Principal Manager: Youth Offending Service
- **Health Services-** Salford CCG Designated Nurse, Specialist Nurse: Safeguarding Children and Designated Doctor for Safeguarding Children (**Vice Chair**), CAMH Service Manager Emerge 16-17, GMMH Safeguarding Children Practitioner, SRFT Lead Nurse for Safeguarding Supervision
- **SCC Assistant Director Public Health Nursing**
- **SCC Housing & Strategy Team** - Safeguarding Lead
- **Greater Manchester Police** - Serious Case Review Team
- **National Probation Service** - Senior Managers
- **Salford Safeguarding Children Board** - Business Manager
- **SCC Legal Services**

What Does the Subgroup Do?

Discusses referrals received and determines if:

•An SCR Screening Panel is required

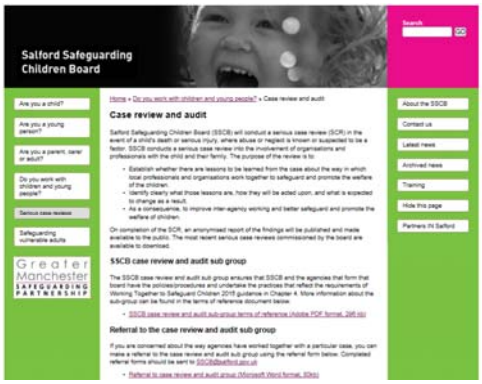
•A case meets the criteria for a Multi-agency Concise Review

•There is learning for a particular agency or agencies

….. continued

- Monitors the implementation of SCR and Case Review recommendations
- Shares the lessons learned
- Undertakes thematic practice audits
- Provides assurance to SSCB

More information please see the subgroup terms of reference



www.partnersinsalford.org/sscb/sscbcasereviews.htm

Case Review Policy

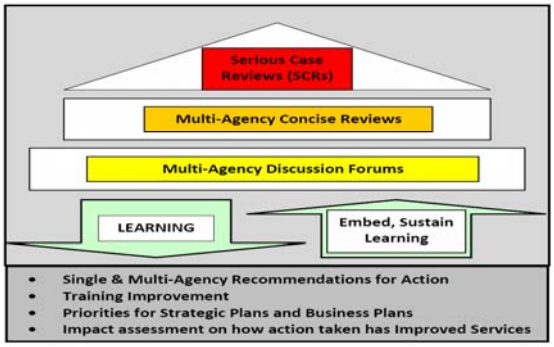
- Reflects Working Together and incorporates the Greater Manchester Case Review guidance
- Systems methodologies- practitioners must be involved in case review processes
- Involvement of families must be considered
- Details the SCR and Multi-agency Concise Review criteria

More information:
www.partnersinsalford.org/sscb/policiesprocedures.htm

What Warrants a Referral?

- If you are concerned about how professionals have worked together with a particular case and exhausted the GM escalation policy, you can make a referral to the SSCB Case Review and Audit Subgroup.
- Email completed referral form to SSCB@salford.gov.uk

Framework of Case Reviews



Serious Case Review Criteria

Working Together 2015 SCR criteria:

(a) abuse or neglect of a child is known or suspected; and
(b) either- (1) the child has died;
or (2) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Multi-agency Concise Review

SSCB Multi-agency Concise Review criteria:

"A child is *harmed* through abuse/neglect or other cause and the case gives rise to concerns about the way in which local practitioners and services work together to safeguard the child/ren in such circumstances. The review should lead to significant and new learning that improves multi-agency communication, procedures, policy and/or practice".

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Child S Case Review

Clare Hyde,
Independent Lead Reviewer

Turning Point Incident

August 2015

Baby Sam (Child S) was found in the street wearing just a nappy. He was aged 2 at the time. Alice; his mother, was asleep in bed and did not know that he had managed to open the door and leave the flat.

Summary: what we knew

- Alice (A) aged 22 at the time
- Lived with serious domestic abuse as a child
- One of three daughters all known to children services from aged 10
- Placed in care at aged 12 with one sister. One Sister placed separately
- Returned to mothers care aged 16
- Mother in a new abusive relationship
- A pregnant within 5 months of returning to mothers. Still on care plan
- A gives birth to baby girl Oct 2009- baby on CPP
- Neglect and ambivalence
- Baby 'removed' from A's care Jan 2013. A's sister now carer for this child.
- By then A is pregnant with Child S- unborn placed on CPP
- Partner D (Child S's father) is violent and abusive to A
- Child S born March 2013- 2months after final court hearing for her first child

System Response

- Child Protection of Child S identified that his father Dan is a protective factor and that Child S must not be left in the sole care of Alice. Plan (CPP) in respect
- CCP in respect of Child S was discharged in December 2013 after 10 months
- At the last child protection meeting it was agreed that the family should be transferred to CIN, however there was a typing error and the case was 'stepped down' to Team Around the Child arrangements. The agency chronologies do not show that this error was identified and rectified by any of the practitioners who had attended the meeting i.e. no one who attended the meeting read the minutes or subsequently challenged this 'decision'.
- When the case was closed at Child Protection/Child in Need level this led to a much diluted focus on safeguarding S.

Reality of Life for Alice and Sam

- Ongoing domestic abuse. One incident of domestic abuse was reported by A's supported lodging provider in December 2013 within 5 days of the final Child Protection Conference.
- Missed medical appointments for Child S in June 2015.
- Repeated missed appointments with the Health Visiting Service and the Early Intervention Service which meant that Child S was not seen by any practitioner at regular intervals between January 2014 and July 2015.
- Concerns were raised in June 2015 by Child S's nursery that his attendance was poor.
- In February 2014 the couple ended their relationship and A's partner left the family home leaving A alone with Child S despite the fact that the Child Protection Plan for Baby S had stipulated that A should not be the lone carer.

Increasing needs and risk

- There were a decreasing number of contacts with the family following the 'step down' arrangements for Child S from a Child Protection Plan to Team Around the Child arrangements
- June 2014, A told the Health Visitor that she wished to end the Team Around the Child arrangements as she said she was coping. It was agreed that she would contact the Health Visiting Service should she need advice or support.
- A and Child S were not seen again until 24th July 2014 when a student Health Visitor raised significant concerns that A was not keeping Child S safe or meeting his basic needs. The student Health Visitor suggested that A access Sure Start services but did not make a safeguarding referral.
- A and Child S were seen by professionals in their home environment 7 times between July 2014 and March 2015. Various concerns; unsafe state of the property; Child S inappropriately dressed and wet and cold on occasion. A was evasive during some of these visits and would not let professionals see the kitchen.

Summary

- Very young parent/s.
- Impact of domestic abuse on Alice as a child-unsafe, neglected, rejected
- Impact of this on her own parenting
- Severe domestic abuse in her own relationship
- Loss of first child –complex, conflicted, unresolved.
- Neglect in all it's manifestations

Methodology

- What did we do and what did we learn?
- Agency chronologies –provide the who did what and when information.
- Learning event with the practitioners who had worked with the family. What was the reality for them?
- Key lines of enquiry
- Focus on what good would have looked like for Alice and Sam (Child S)
- Examine research and good practice to provide analysis and recommendations

Feedback from Practitioners

"It was a totally new experience for me to attend the learning event and there was a lot of information for me to take in. I went as a representative from our department for half of the day.
It was useful to meet with the other professionals who had been involved with the children and I was able to bring some learning back. It highlighted the importance of liaison with other services."

Speech and Language Therapist, SRFT

Feedback from Practitioners

"I was well supported by the lead nurse for safeguarding and we reviewed the case prior to attendance. Seeing the timeline of events was thought provoking and made me question my interventions at the time I was involved. The day went smoothly and there was lots of support. There was no blame. The day was informative and alleviated my anxiety. Overall it was a positive event with lots of key learning points."

Health Visitor/CPT, SRFT

Key lines of Enquiry

- When the CPP was discharged in Dec 2013, were the expectations of the support to be provided by early help and universal services explicit and agreed with the providers?
- Why wasn't the CIN process instigated after the CPP ceased and why did professionals not challenge this at that time?
- Did agencies miss opportunities to escalate the case?
- Between December 2013 and the event which triggered the referral in August 2015; what contact was made with the family, were any concerns raised or referrals for additional intervention made?- If so what was the outcome of these?
- Did practitioners recognise and apply the thresholds of need and response?
- Was there a clear contingency plan?
- Was consideration given to appointing a lead professional or holding a multi-agency meeting?
- Was a Graded Care Profile completed or consideration given to completing one?
- Why was a man who had a history of violence, who was violent and controlling in this relationship and who had no contact with his first child deemed to be a protective factor? Who was he a protective factor for?

The Research

- Factors that are known to be associated with risk to babies and very young children *(Ward et al 2012)* include parents who have experienced abusive childhoods themselves and have not come to terms with the abuse.
- Additional risk factors include domestic abuse and environmental stressors such as housing. Significant protective factors are the presence of a supportive non-partner, wider family and informal support and parent's insight, understanding and capacity to change.
- Severe risk of harm is most likely where there is an absence of protective factors *(Ward, H., Brown, R., and Westlake, D. (2012) Safeguarding Babies and Very Young Children. London: Jessica Kingsley Publishers).*

The Cycle of Neglect and Abuse

- Children who are emotionally or physically neglected can develop many long-lasting problems.
- Intimacy and nurturance skills are typically underdeveloped and can lead these children to have relational problems later in life with other adults and their own children.
- Some children who experience neglect will form quick, over-involved and inappropriate attachments with others. This leaves them vulnerable to abuse.

The Cycle

- Research consistently shows the presence of an intergenerational cycle of care involvement for some families. For example, one study found that adults who were taken into care when they were children are 66 times more likely than their peers to have their own children taken in to care *(Jackson and Smith, 2005).*
- A further study of 63 young parents in and leaving care suggested an intergenerational cycle of care involvement. Of these young parents, five had had their children taken into local authority care, one was attending a child protection conference to retain custody of two children, and another had had her baby temporarily removed *(Chase et al 2006).*

Pregnancy and Loss

A's inability to care for her first child led to that child being removed from her care.

- A study by the *Children's Workforce Development Council* noted there were complex, ethically sensitive, and emotive reasons, why some mothers whose children were removed from their care repeatedly fell pregnant.
- Although contraception, and advice, was seen as important, it was felt to be unlikely that this alone would effect change. Most of the social workers who took part in the study felt that mothers with whom they were working would fall pregnant again.
- In one case the mother was already pregnant and due to give birth to her sixth child.

Pregnancy and Loss continued

- The reasons suggested by the social workers as to why the mothers would get pregnant again were around 'filling the void in their lives,' or related to 'getting into a new relationship with a man.'
- In most cases, the social workers stressed that the parents often had very difficult childhoods themselves, and several parents were care leavers/young parents. *("What can professionals do to support mothers whose previous children have been removed: An exploratory study" Emma Blazey and Emma Persson 2010).*

What would good have looked like?

- No one knew what A's thoughts and feelings were about the loss of her first child and her ambivalence about being a mother, her relationship with her sister who is now the carer of this first child, her relationship with her own mother who 'voluntarily' placed her 3 children into care because of domestic abuse and the impact this had and undoubtedly continues to have on her mental and emotional wellbeing.
- In light of A's history, a comprehensive assessment of her parenting capacity would have been warranted and plans put in place to support her in her parenting role.
- These plans would ideally have reflected any therapeutic needs and also have identified that A and therefore her children were at higher risk of domestic and other forms of abuse because of A's own history.

What would good have looked like?

- Informed by the comprehensive assessment and by research and best practice long term support including trauma and gender informed interventions would help to ensure that A and her child were safe and take into account the several significant indicators that her capacity to parent would have been compromised by her own childhood experiences of trauma and abuse.
- Plans would also reflect that A was very young and still developing into adulthood.
- Plans would also reflect that A could become a parent again.

The Recommendations

1.SSCB should consider its future focus on girls and young women who share similar life experiences with Adult A and for example, consider a **multi -agency themed review** to inform how this cohort of **looked after / formerly looked after young mothers and their children are supported in the short, medium and long term**. These life experiences are characterised by multiple and often compounding vulnerabilities such as exposure to domestic abuse, neglect, becoming a looked after child, becoming a victim of domestic abuse and / or sexual exploitation and becoming pregnant at a young age.

Recommendations continued

2. SSCB should consider the **training and awareness** raising required to ensure that practitioners **demonstrate professional curiosity** and **scepticism around father's role** and other males who are associated with high need or complex families particularly where there has been a history of abuse.

3. SSCB partners to ensure that practitioners demonstrate **professional curiosity and scepticism when carrying out robust risk assessments of fathers and other males** where violence has been identified or is an issue which includes historical information about them and the families or partners they are associated with.

Recommendations continued

4. SSCB partners should ensure that **family history and genograms** are routinely used at the earliest assessment opportunity to identify patterns of risk.

5. SSCB partners should **review** how Child in Need and Child Protection Plans reflect best practice in relation to children and **families living with domestic abuse**. E.g. audit how plans reflect assessment of risk to each individual adult and child and detail actions focused specifically on the perpetrator.

6. SSCB partners ensure that the **'child's voice and daily lived experience**' are the primary focus of practice and supervision across the thresholds of need.

Recommendations continued

7. SSCB partners to provide assurance that **supervision and management oversight** ensures that the **thresholds of need and response are consistently applied** by all practitioners.

8. All practitioners and their practice managers who attend any multi agency meetings should **review the meeting minutes challenging inaccuracies** to the meeting Chair in a timely manner e.g. within 14 working days of receipt.

9. SSCB partners should issue regular briefing to relevant practitioners regarding **police and housing powers** where safeguarding concerns about a child and are unable to **gain access to a home**

Group work

How could we better support LAC/formerly LAC mothers and their children in the short, medium and long term?

Consider:

- Children who have experienced neglect and other forms of abuse may themselves have difficulties as they become parents –what might this mean for our practice?
- What might we need to think about in assessing need and risk with the families we are already working with who have experienced inter-generational neglect and other forms of abuse?
- What might we need to do differently with children and young people before they become parents/when they are parents?

Relevant Information

- Thresholds of Need and Response in Salford
- Strengthening families
- 0-25 pilot
- Family Nurse Partnership
- Young parents' advice website
- Children and Young People's Participation Strategy
- Greater Manchester Escalation Policy
- Self Neglect Guidance (Appendix 2: Legal Options – Powers of Entry)
- SSCB Training - Working with Dad's
  - Domestic Abuse
  - Neglect, Graded Care Profile (MARAM Tools)
  - Assessment Skills
  - Culturagrams
  - Communicating with Children

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Child R Serious Case Review

Nicki Walker-Hall,
Independent Lead Reviewer

Why a serious case review?

- Concerns Child R had been harmed
- Admitted in a state of collapse
- Prima-facie evidence of medical and nutritional neglect
- History of high level of professional involvement
- Both parents were arrested for neglect

Family Context

- Parents were born and brought up in neighbouring Manchester
- Both parents in LA care at a young age
- Parents met in care, pregnant aged 15
- 3 children aged 8, 6 and 3 years 9 months old (October 2015)
- Child R born prematurely in January 2012 requiring resuscitation
- Parents isolated with little family support and few friends

What happened?

- SCR period is 46 months- birth of Child R to the incident
- Admitted to NICU with prematurity, suspected sepsis and respiratory disease of the newborn
- Found to have a Grade 2 Intraventricular Haemorrhage
- Child R developed Necrotising Enterocolitis (NEC), requiring emergency bowel surgery/resection/short bowel syndrome
- Child R remained in Hospital for much of his first year of life
- Adult B took on a significant caring role for Child R
- Adult B trained to administer Gastrostomy Feeds, Parental Nutrition and Intravenous Antibiotics
- Initial Assessment by Children's Services (Child B)
- Child R acute collapse

Issues

- **Multiple periods of hospitalisation**
  - Central line infections
  - Electrolyte imbalance/ hydration
- **Lack of coordination**
  - No Lead Professional
  - Housing issues – single parent application for housing
  - Absenteeism of Child A and Child B
- **Adult B challenging of professionals**
- **Mixed picture of compliance with treatment**
- **Parents instigate litigation against a Trust**
- **Reluctance to accept CAF/misunderstanding of CAF**
  - No holistic assessment

FINDINGS

Could not have been predicted by professionals
and no certainty that any findings
would have made any difference to outcome

Complexity of health needs overshadowed his developmental needs inhibiting recognition as a Disabled Child

- No assessment of support needs of Child R and his family's needs following notification of prolonged hospital admission
  - Including finance, counselling, advice and advocacy
- Cascade referral system from Tertiary through Secondary services to Primary Care/Community Services is not robust
- Developmental assessments not completed as per the Health Child Programme and delay in involving the Community Paediatricians

CAF- The Impact of and Reasons behind lack of Consent

- Parents did not understand CAF believing it to always be Social Care led and with no understanding of the benefits until Starting Life Well became involved
- Parents mixed experiences as Looked After Children and a desire to prove themselves independently capable of caring for their children made them resistant to further Social Care involvement
- There is an inconsistent message to staff regarding the actions that should be taken. SSCB threshold of need guidance indicates a meeting should be held in such circumstances, however the CAF working with resistant families flow chart does not.

There lacked a supportive multi-agency network around the family

- Professionals were working in silos, limiting awareness of Child R's condition and care needs, parental compliance
- Child A and Child B's school had no knowledge of Child R's condition and the impact of this on the family

Lack of a Lead Professional impacted on co-ordination/delivery of services

- No single point of contact for the family
- No plan of action and as a consequence:
  - poor co-ordination of the delivery of actions and review of impact
  - reduced clarity for parents on what to do in when the child is acutely unwell
- Overlap of appointments making it impossible for the parents to comply and reliant on over-stretched parents notifying the professionals

Recommendations

- 13 recommendations
- Some single agency, some for Salford SCB alone and others spanning across the boundary into Manchester
- Recommendations no longer have to be specific: *(work of SCIE and Brandon et al)*
- SSCB response covers specific actions that will be undertaken

Feedback from Practitioners

"The Learning Event I attended was very supportive from the outset. The chair set the scene at the beginning and this was very reassuring as there was a nervousness from staff who attended, including myself. As I had not attended one before, I was concerned there would be blame attached to staff/managers and this was not the case.
The multi-agency chronology was very powerful and this has taught me as a manager to ensure chronologies are updated as well as reviewed. You can see patterns forming and can see the 'journey' for the young person and the family. Perspectives/agendas form each service was taken into account. The session was fun and empowering by creating a 'wish' list and highlighting some wishes which could be realistic. You were listened to!"
Early Help Locality Manager (0-25 Pilot)

Feedback from Practitioners

"I attended and was apprehensive as to what was involved and what questions would be asked. Whilst in the meeting, it became apparent by listening to other professionals involved they knew little about what other services provided.
When asked to provide a chronology, it highlighted we had several no accesses.
We were not aware that she sometimes struggled with Child R's medical cares and the other children. We have been into school to teach support staff to use feeding device in the stomach. We have had an opportunity to rebuild a relationship with mum and now have more regular contact."

Children's Community Nursing, SRFT

Feedback from Parents

Mum was able to see changes brought about by the recommendations contained within the review. She indicated they had been contacted recently by the GP with regards to prescribing of medication. They also noted that health staff caring for another family whose child is receiving TPN have approached a second family member to be trained to deliver the TPN.
Both mum and this child's mother have discussed the positive effects of this as they no longer feel they carry the full responsibility 24/7 when their children are at home.
Mum indicated she hadn't realised how much this had affected her until she could rely on dad. She can now go and enjoy some downtime without worrying.

Group Work

'Lead Professional'

What does it mean to you?

Relevant Information

- Child R Report and SSCB Action Plan (Published 29/3/2017)
- Children with Disabilities Policy
- Hospital discharge Guidelines for Vulnerable Children
- Emotional Health and Wellbeing Directory
- Multi-Agency Training - Children with disabilities
  - Family Assessment
- Lead Professional
- Carers Assessment
- Local Offer: for children and young people with SEN or disabilities
- Support for carers
- Support Services

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Multi-Agency Practice Audits

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Self-Harm Practice Audit

13th October 2016

Helen Williamson,
Safeguarding Children Practitioner, GMMH

What is self-harm?

Self-harm as an individual act is hard to define. However in general self harm (also known as self injury or self mutilation) is the act of deliberately causing harm to oneself either by causing a physical injury, by putting oneself in dangerous situations and/or self neglect.

The National Institute for Clinical Excellence describes self harm as *"Intentional self poisoning or injury, irrespective of the apparent purpose of the act "*

Some forms that self harm can take include:

- Cutting, burning, biting, picking and scratching, pulling out hair, Substance abuse, Head banging and hitting
- Taking personal risks, neglecting oneself, eating disorders,
- Over dosing and self-poisoning

What is self-harm?

Is it a mental health issue or a sign of distress and a way to cope…?

- Those who self harm find it difficult to cope with problems and are more likely to blame themselves, get angry, abuse substances or isolate themselves.
- They are more likely to suffer from anxiety, depression and have low self esteem.
- Young people say it gives 'relief from a terrible situation'.
- Young people are far more likely to turn to friends for help, few turned to family or professionals.

Youth and Self Harm perspectives, Samaritans in collaboration with University of Oxford Centre for Suicide Research

What is self-harm?

- Whilst a proportion of young people who self-harm have a strong desire to kill themselves, for the majority of young people, there are many other factors that motivate them to self-harm, including a desire to escape an unbearable situation or intolerable emotional pain, to reduce tension, to express hostility, or to increase caring from others;
- *"People self-harm to release stress, to feel something, when they try to outweigh mental pain with physical pain, when they are not getting the help/support they need, punishment. Overall it's a coping mechanism" Young Person*
- Self– harming may express a powerful sense of despair and needs to be taken seriously

Prevalence

In 2012 (in Salford = 10% of teenagers, girls 4x more likely) In 2014 (nationally)

- 26% of young women said they self-harmed, 10% of young men.
- However, boys are more likely to engage in behaviours such as punching a wall or hitting themselves for example. As such, it could look as if they have had an accident, a fight or have been attacked. *This isn't always identified or recognised as self-harm,* and doesn't necessarily come to the attention of hospitals.
- **Salford: In 2014:** self-harm cases leading to hospitalisation was slightly higher than national average - higher prevalence rate in areas of known deprivation

Childline Statistics

- In 2014, self-harm was the fourth most common concern that children and young people contact Childline about. There were over 19,000 Childline counselling sessions about self-harm in 2014/15.
- **In 2015** they received 3.5 million visits to their website.
- **The top issues concerning children and young people who contacted them were:**
- Low self-esteem/ unhappiness
- Family relationships
- Bullying (including online)
- There was a 19% increase in low self-esteem and unhappiness from the previous year (2014) replacing family concerns at the top.
- Counselling provided in relation to suicidal thoughts reached the highest number ever in 2015

Themes

- Historical and or current abuse or neglect
- Sexuality and relationships
- Trauma, adverse life events, bereavement,
- Risk of CSE, and risky behaviour.
- Children who go missing and LAC children.
- Unmet needs, poor or disorganised attachments, a lack of stability and resilience. Parents who are struggling or not managing
- The impact of parental substance misuse and/ or mental health issues

Cases

15 years old, White British girl

- Long history of DV/A within the family
- Bereavement issues: father died and grandmother became terminally ill
- 4 children living at home, mum = single parent, alcohol problems … "struggling with children's behaviour/ caring for them all"
- Self harmed 6x within a 3 month period, concerns she would take her own life. 2nd overdose = referred to CSC, but stayed at TAC level, took too long to get to CP level
- Self Harmed = 3x overdoses, 3x ligaturing
- Admitted to J17 2x. Self harm increased – learnt to ligature
- Home leave, return home…CRISIS
- Moved in to residential care/ LAC
- Her mum had a history of not engaging with services
- Focus tended to be on key episodes rather than overall picture of family history and functioning

Cases

17 years old White British: Sexuality and gender were issues

- Long history of trauma/ loss/ attachments issues.
- Unplanned pregnancy, mum left when s/he was 6 (brother and 3 half siblings)
- Allegations against family members
- Admitted to Junction 17 - 2x (crisis admissions)
- Described the mother as neglectful, but travelled to find her
- S/he became LAC soon after
- Reported she was struggling in care because she missed/ couldn't see her sisters
- Just after Christmas 2015 she went to A and E in crisis
- She would attend to see staff at A and E – frequent, sometimes daily presentations
- Sexually harmful behaviours, Risk of CSE Risk to self and others
- Referred to Tavistock clinic
- Encouragement re positive activities

Learning and Recommendations

Early Help: what to do if a parent doesn't engage? Need to ask why
Implications for children…
Thresholds set too high? Complex families may refuse early help….Do these cases provide a compelling argument that the threshold for parental consent or engagement is set too high?

Complexity of needs/ thresholds and resources

- Higher level of vulnerability amongst many who self harm
- Professionals need to ask the young person about their lives, what's happening, why and what is the function of the self harm
- Where do they sit on the thresholds of need? Who is going to lead on the case? **Don't wait to intervene**
- Concern that = services are being cut. Stretched beyond capacity.

What did we learn?

Those seen in A and E

- Under 16s- wait a long time to see CAMHS consultant, Those 16-17 risk being seen and treated as adults(Salford pathway after child N)
- Struggle to find inpatient beds where appropriate
- **Sexuality and Gender**
- A common issue in self-harm cases, gender as fluid – Child B
- These are issues that staff need to feel confident and competent in addressing.
- **Siblings - How do issues impact on siblings, how do they impact on each other?**
- Parenting support needs to be geared towards older children too
- Must assess the impact of older siblings, self-harm, distress on younger children (Child A)

Learning and Recommendations

The Child's Voice

The 2012 audit: Of the eight young people that self-harmed only three were asked about why they had self-harmed.

- Understanding self harm, individuality and reasons, listening, asking what's happening for that young person, **avoid phrase "attention seeking"**
- It isn't necessarily "mental illness" **but it is a sign of distress**
- Keep safeguarding central
- See potential, offer hope, focus on other things, strengthen protective factors
- 42nd street offer advice for professionals
- *"Remember young people don't just self-harm for one reason, it is more complicated than that. We are human beings, don't just see us as 'self-harmers'/a problem/a patient. Be sensitive towards us because self-harm is difficult to talk about"*

Learning and Recommendations

Understanding agency roles and service provision

- Misunderstanding of the role of Junction 17 - "safe place"
- Inappropriate referrals - Inpatient unit must not be the default
- Distress and trauma, social care needs, safeguarding

Evidence not optimism:

Child A home visits, return home – escalation self harm and distress, mum said she didn't think she could cope…

Resourcing and Service Provision

- Services absent or stretched beyond capacity
- A new approach is required to support the emotional health and well-being of children and young people

Emotional Health and Well-Being Directory

Transition to adult services: risk and vulnerability

- Without a formal Mental Health diagnosis?
- To adult safeguarding?

Learning and Recommendations

How can professionals assess parenting capacity and explore the issues around engagement? Assessment needs to be detailed and to take into account different aspects of the parenting role e.g. Stan Houston (2014)

- **Parental behaviour, belief systems, and constitution**
- **Problem solving**
- **Communication**
- **Roles:** and patterns of care giving,
- **The parent's capacity to react to the child** with the appropriate level and type of feelings.
- **Behavioural control:** The manner in which the children are socialised, level of adult supervision, the impact of parenting styles

Learning and Recommendations

Learning Events and Training

- Early Help training to include how professionals can work with older children/ young people.
- Training for staff in relation to: self-harm, and all aspects
- Training/ briefings/ learning events in relation to sexuality, gender issues
- The provision of regular, themed learning events to enable professionals *to learn from each other.* There were a lot of very experienced professionals at the self-harm audit event and a lot of learning was achieved by discussion of the 2 cases.
- **Joint training** between the safeguarding children and adult boards to look at transition for those reaching their 18th birthday.

What happens next?

Recommendations and actions plans for those agencies involved

- The Case Review and Audit Sub-group approved the report and the recommendations and were responsible for ensuring an action plan was developed to address learns learnt and monitor implementation.
- The Emotional Health Wellbeing Board Partnership will drive forward any actions/learning arising from this through the 0-25 and CAMHS Transformation work
- 42nd Street to present the findings to their service user group

Relevant information

- Emotional Health and Wellbeing Strategy
- Emotional Health Directory of Services
- Useful websites
- Online resources & tools
- MindEd – overview and links to free online training
- SSCB Seminar - Supporting Young People to Cope with Emotional Health Issues
- Young people and Self Harm Policy
- Salford LGBT YP Report
- Multi-Agency Risk Assessment Model Tools

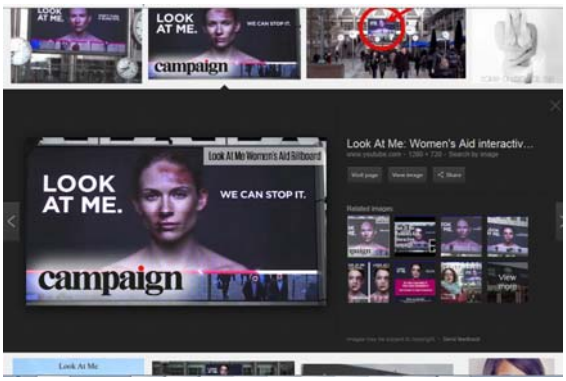
Let's Talk about Domestic Abuse

Lisa Hughes
Child Protection Co-ordinator

Marie Francis
Quality Assurance Officer

Rachel Ashurst
Quality Assurance Officer

Safeguarding Children & Quality Assurance Unit



Clare

Becky

Rania

Linzi

Purpose of Interventions

•Protect the children, including unborn children.

•Empower the non-abusing parent to protect the children.

•Identify the abuser and hold them accountable for the abuse.

•Provide opportunities to change.

Practice Evaluation

- Domestic Abuse Thematic Practice Audit 2016
- Salford JTAI Inspection (September 2016)

Lets Celebrate Good Practice

- Evidence of effective interventions and work undertaken by highly skilled practitioners.
- Indications that some agencies/practitioners within Salford are confident in their dealings with perpetrators of domestic violence.
- Records of open and honest dialogue with the family and clarity about expectations.

Lets Celebrate Good Practice

- There was evidence of robust risk assessment and regularly updated SMART plans.
- Children were provided with support which enabled them to contribute directly to the risk assessment and child protection plan.
- Children's thoughts and feelings on what needed to happen/change to make them feel safe was recorded following direct work then shared with the victim and the perpetrator.

Areas Where We Could Be Better

- Professionals do not always recognise that the abuse does not end when people stop living together and may in fact escalate.
- A failure to recognise the increasing or escalating impact of repeated incidents of domestic abuse, leading to an incomplete assessment
- All professionals who are working with families should be accessing the SSCB domestic abuse training courses. This would enable professional to gain a strong knowledge base to assess domestic violence and the associated risks factors .

Areas Where We Could Be Better

- Limited evidence of work taking place with perpetrators to help them understand the impact of the abuse on their children.
- Some cases also showed an unrealistic view of the capacity of victims and perpetrators to comply with written agreements. For example victims being expected to 'police' perpetrators' contact with their children.

Coercive Control

"Controlling or coercive behaviour does not relate to a single incident, it is **a purposeful pattern of behaviour** which takes place over time in order for one individual **to exert power, control or coercion over another**." (Home Office 2015

- Also referred to as ''intimate terrorism''
- Behaviours *in isolation* may not be criminal offences but Coercive Control is now a crime (December 2015)

Defining Coercive Control

- Difficult to detect – not often reported to the police
- Does not only happen in the home – stalking and micro-surveillance
- Link with domestic homicide (Stark 2007)
- Under-researched in LGBT community

Group Work: Myth or Fact?

- **Domestic Abuse is caused by excessive alcohol or the use of drugs.**
- **MYTH**
- **Domestic abuse is usually just a one-off incident.**
- **MYTH**
- **Perpetrators have a problem expressing anger and need Anger Management courses to learn how to resolve disputes.**
- **MYTH**

Group Work: Myth or Fact?

- **Domestic Abuse is not such a big problem – very few women are actually badly hurt.**
- **MYTH**
- **Victims would leave if the abuse was that bad.**
- **MYTH**
- **Perpetrators are unpleasant, violent people and easily identified.**
- **MYTH**

Group Work: Myth or Fact?

- **Young children will not understand or remember the domestic abuse they have heard or witnessed.**
- **MYTH**
- **Children who witness DA become victims or perpetrators of DA.**
- **MYTH**
- **Children dealing with DA often struggle to achieve in school.**
- **FACT**

Relevant information

- SSCB Children's Domestic Abuse Subgroup
- Young Person's Domestic Abuse Meeting (YPDAM)
- Policies and Procedures
- Supporting Local Pathways
- DASH Risk Assessment Checklist- Young Peoples Version
- SSCB Multi-agency Training – Domestic Abuse
- DASH – Adult Version
- Tackling Domestic Abuse Board
- Disrespect Nobody Campaign
- www.endthefear.co.uk/
- www.sittingrightwithyou.co.uk/

Questions for the Panel

Closing Summary

Summary

- Safeguarding in Salford is good amongst practitioners- something to be proud of with effective supportive networking
- Multi-agency working is good in most cases
- Learning should be to not only continue but to improve the standards further
- Take home messages relate to this
- Note adverse childhood experiences increase the risk for issues in adult life e.g. suicide.

Take Home Messages

- Safeguarding should be proactive, and include protection, prevention and prosecution.
- Have a healthy scepticism on information being given to you.
- Observe not only family members and surrounding but look at interaction, expressions and non-verbal cues.
- Be child focussed, listen to the child.
- Challenge not only reported information but also yourselves
- If the picture is unclear, seek information from multi-agency teams involved with families.

Take Home Messages

- Step back and see what you are receiving to enable you to analyse the information without bias.
- Discuss with colleague or line manager if concerned.
- Challenge another agency/opinion if your concerns about the family/situation/event are not answered satisfactorily.
- Use the Escalation Policy

Take Home Messages

- For complex needs consider a lead professional to co-ordinate services.
- Refer to Case Review and Audit Subgroup if you are concerned about how professionals have worked together
- Remember we are not here to blame someone else- we are here to improve the way we work to support and safeguard children.
- We need to do this now not only for children of today but for these children who will be adults and the next generation of families tomorrow.

Themes to reflect on…..

- The importance of **seeing the whole picture**
  - State the obvious
  - Adverse childhood experience
  - Use tools e.g. genogram, chronology
- **Need for coordination**
  - To help family and professionals understand who is doing what, expectations and the impact on the wider family

Themes to reflect on…..

- **Promoting aspirations** – strengths based approaches
- **Learning from parents and young people's experience**
  - Parent to parent/peer support
  - Independent Advocate
- **Learning about healthy relationships**
  - Schools role/PHSE
  - Children and Social Work Bill

Themes to reflect on…..

- **Looked After Children are likely to need support** when they become adults/parents
  - How do they access this when there are no criteria, role of voluntary sector and peer support?
- **Engagement**
  - Working with challenging parents, are parents the experts? Are professionals the experts?
  - Who has an effective relationship with the child and family?

Useful SSCB Information

- Practitioners Forum
- Policies & Procedures
- Training courses, seminars & e-learning
- 7 minute briefings
- Latest news and lessons learnt e-bulletin
- Case reviews /Serious Case Reviews
- Multi-agency Practice Audits

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SSCB Annual Learning Event 2017

Close

Please complete the post event evaluations and collect your certificates

Thank you for your participation