Knowsley Safeguarding Children Board

Learning from Serious Case Reviews in Knowsley

January 2017

Between 1st April 2015 to 31st March 2016, a total of five cases were commissioned by Knowsley's Safeguarding Board. Learning from the serious case reviews has improved both our understanding and has led to action on specific areas of work. This bulletin is designed to remind practitioners of the learning from the reviews.

The main themes identified from the Serious Case Reviews were neglect, domestic abuse, child sexual exploitation, adult mental health, substance misuse, safe sleeping.

Responses to the learning identified include:

- **The neglect strategy** has been reviewed and amended. A multi-agency working group was established to strengthen our strategic and operational response to dealing with child neglect within the Borough. Furthermore the Board has promoted the use of **the graded care profile across all agencies**, a nationally recognised assessment tool of children who may be exposed to neglect.

- **A multi-agency domestic abuse action plan** has been developed and is being delivered with a clear emphasis on supporting victims and taking positive action against perpetrators.

- A new policy and procedure has been developed to assist practitioners when dealing with cases of **children with sexually harmful behaviour.**

- To reflect the Board's commitment to listen to **the voices of children**, a focus group has been commissioned to explore how we can engage and respond to children's concerns.

- **Targeted training** has continued to be delivered to a wide range of professionals across the agencies. The focus of the training has been aimed at the priorities of the Board and reflects the lessons that are identified within serious case reviews. For example CSE domestic abuse, sexually harmful behavior.

- The training has been delivered through a number of mediums, including personal briefings, 'e-learning' and seminars. **In excess of 2,000 allocated places** have been filled.

Brief Summary of Serious Case Reviews

Child O

This case relates to a child who took their own life. The child was part of a large family and was known to a range of agencies in respect of previous neglect and domestic violence issues. The Serious Case Review did not identify any connections between any agencies involvement and the child taking his own life. The Independent Author did highlight the need for a number of agencies to improve work with families and focus on the child or children, particularly in large families where high levels of neglect feature over a prolonged period of time.

Child R

This case concerned the unexplained death of a baby. While there had been historical involvement with Children's Social Care due to concerns about mental health, substance misuse and domestic violence, there was no social work involvement following the birth of the child or at the time of the child's death. Amongst its recommendations, the review highlighted the impact on children of domestic abuse, drug misuse and mental health (the

Toxic Trio) and the need for it to be understood by practitioners in all agencies and taken into account in all assessments and referrals.

Child Q and Child S

This review centres on two looked after children who were placed out of the Borough (individually) and were subsequently sexually exploited. The cases are not linked, however the Serious Incident Review Group decided that the circumstances of the cases and potential learning from each case were similar and that there would therefore be more merit in undertaking a thematic review of these cases together. The review highlighted some good practice and concluded that the possibility of Child Q becoming a victim of CSE was potentially predictable but at the time not preventable. The review concluded that the possibility of Child S becoming a victim of CSE was potentially predictable but at the time not preventable.

Amongst its recommendations the review highlighted the need to encourage the full participation of all relevant multi-agency partners in safeguarding work and highlighted that there is a range of multi-agency, independent, statutory, voluntary services and adult services involved in the provision of services to children and families with complex safeguarding issues.

Child N

Was convicted of a serious sexual assault on another child. A lack of understanding of how to identify, assess and intervene in the area of sexually harmful behaviour when it is displayed was evident in this case. Due to vulnerabilities of the victim and the perpetrator the Board decided not to publish the findings. This decision was ratified by the national panel.