Safeguarding Adults Board LEICESTERSHIRE & RUTLAND
Safeguarding Children Board LEICESTERSHIRE & RUTLAND
Issue 5 | April 2014

Safeguarding MATTERS

SCR Special Edition -

This special edition of the Safeguarding Boards' Publication 'Safeguarding Matters' has been produced to share the important messages from National Serious Case Reviews.

These cases involve the death or serious injury of a child or adult. In each case gaps in the practice of individual practitioners and multi agency working have been identified. The details of the cases are upsetting but it is important we understand the context so we can continue to learn and develop confidence in best practice to promote and protect those who are vulnerable. Use this special edition in supervision, team or unit meeting, or learning event to prompt discussion and develop practice.

Building confidence and developing best practice

We need to continually develop our understanding of the complexities of safeguarding children and adults.

'R' for remember (and much more)

Ask yourself the following questions:

Recognition – Do you know what abuse looks like? What are the thresholds for concern?

Report – Do you know who to share this information with? Do you feel confident to talk to that person? What will you do if you are not listened to? Do you know how to escalate concern? Do you know how to whistle blow?

Risk – Do you know what makes some situations more risky? If not do you feel confident to ask? Do you know what 'safe' looks like? Acknowledge the resiliant factors.

Relevance – Do you understand the relevance of the information you have? Does it matter if you don't? It may be relevant to the bigger picture and another agency may think it is critically relevant.

Resistance – Do you feel confident to challenge families or colleagues? Can you recognise when people are being evasive?

Relationships – Are you clear about the boundaries of your relationship with children, adults, families and carers? How do you avoid collusion? Are you clear what your Role is?

Recording – Is your recording clear, evidenced based, with agreed actions and timescales? Can you state 'in my professional judgement' with confidence?

Representing – Is the voice of the child or adult heard? How do you ensure they have every opportunity to be part of the process? Can you 'walk in their shoes'?

Review – What are your contingency plans? How do you cope with change?

Responsive - How do you manage optimism and pessimism as completely natural human responses to complex situations?

Reflection - Do you have space personally and professionally to learn? How do you challenge your own judgements?

All underpinned by CLEAR CREATIVE ACCESSIBLE COMMUNICATION

The Underwear Rule – NSPCC Campaign Launch 13 January 2014

Last year the NSPCC ran a campaign to encourage parents and carers of 5-11 year olds to talk to their children about keeping safe from sexual abuse and to build their confidence by encouraging them to use the Underwear Rule. This puts across the message that the areas covered by your underwear are yours and private to you. If anyone touches those areas you should tell a parent or someone you trust. We wish to maintain and improve levels of awareness of the importance to talking to children.

The NSPCC have developed materials and a booklet for parents to support the campaign and you can view these on the NSPCC website: www.nspcc.org.uk/news-and-views/our-campaigns/current-campaigns/underwear-rule/the-underwear-rule_wda97129.html

Safeguarding is Everyone's Responsibility

20 Things to consider

A tool to prompt discussion and identify areas for development

	Barriers to Recognising, Responding and Reporting	
	Organisational Responsibilities	
1	Providing safeguarding training opportunities.	
2	All staff and managers understanding their responsibility to undertake supervision as outlined in a Supervision Policy.	
3	Developing a culture where fellow professionals offer supervision.	
4	Changing the way organisations manage frontline staff will have an impact on how they interact with children and families. There is evidence that workers tend to treat the service user in the same way as they themselves are treated by their managers.	
Practitioner Responsibilities and Self Assessment Questions (not an exhaustive list)		**Notes**
1	How do I get through the front door and create a relationship where the family/parent is willing to tell me about the child and family?	
2	How do I ask challenging questions about very sensitive matters?	
3	How do I develop the expertise to sense that the child or parent or adult is being evasive? Do you reflect on the times when they have been evasive?	
4	How do I work directly with children and young people, vulnerable adults and their families, to understand their experiences, worries, hopes and dreams, and to help them change?	
5	Do I recognise my intuitive skills (essentially derived from experience) 'Gut feelings are neither stupid nor perfect? They take advantage of the evolved capacities of the brain and are based on rules of thumb that enable us to act fast'. Gut instinct or feelings are part of your tool kit.	
6	Have I had time to reflect to mull over the experience and learning from it, in supervision, for example, or in discussions with colleagues?	
7	Do I have the necessary skills to communicate with children and vulnerable adults with communication difficulties?	
8	Do I have knowledge of the development of children aged 0-18 years?	
9	How do I assess the level of communication and engagement with the men in the family?	

Continued on next page

Practitioner Responsibilities and Self Assessment Questions (not an exhaustive list)		Notes
10	Are the men associated with the family 'visible'? Is their impact being assessed? Look for signs of 'hidden' partners, big shoes, coats etc. Ask the children! Talk to neighbours.	
11	What is life really like for the children or vulnerable adult in this family?	
12	Am I putting the needs, views and wishes of the vulnerable adult or children at the forefront of interaction and enquiry, or is the adult agenda dominating?	
13	Am I recognising barriers that inhibit engagement and implications for practice?	
14	Has my caseload repeatedly exposed me to intractable and long term problems contributing to a normalisation in my response? Is this a barrier to me recognising/understanding the significance of deviant or risky behaviour?	
15	Has my caseload not exposed me to intractable and long term problems contributing to a possible lack of recognition in my response? Is this a barrier to me recognising understanding the significance of deviant or risky behaviour?	
16	Do I have the knowledge and skills to recognise bruising that may be indicative of a non-accidental injury?	
17	Do I understand my role and responsibilities within the child/adult improvement protection plan?	
18	Do I understand the responsibilities of other members of the core/ multi agency group?	
19	Have I communicated with all other agencies involved in delivering the plan?	
20	Am I feeling confident and comfortable working with this family? If not why not? Is this a gut instinct telling you something?	
Based on the learning and recommendations from Serious Case Reviews 2010-2013		

Safeguarding Adults Board LEICESTERSHIRE & RUTLAND

Safeguarding Children Board LEICESTERSHIRE & RUTLAND

The Leicestershire and Rutland LSCB and SAB have a new Website. **www.lrsb.org.uk**

For the first time, the Leicestershire and Rutland Safeguarding Children Board and the Safeguarding Adult Board have developed a joint website. Do take the time to have a look as it brings together all the key elements across both Boards. You can access safeguarding procedures, leaflets and resources, information on both Boards and of course our key publication Safeguarding Matters.

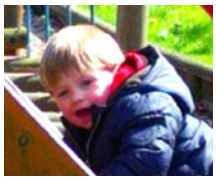
Substance Misuse and Mental Health

December 2013 - Derbyshire - BDS12

Death of a 2-year-old boy in March 2013 from cardiac arrest. BDS swallowed his mother's methadone, which was in a child's beaker. Mother and father were convicted of manslaughter and received custodial sentences. Issues identified include: overreliance by universal health services on specialist health professionals to inform them of child protection concerns; and lack of recognition of thresholds for referral to children's services.

For more information see Derbyshire – SCR BDS12

December 2013 – Wolverhampton – Daniel Jones



Death of a 23-month-old boy in May 2012, as a result of ingesting heroin. Father was convicted of manslaughter and mother was convicted of causing or allowing the death of a child. Maternal history of drug and alcohol misuse and offending; she had one older child who did not live with the family. Paternal history of prolific offending and drug misuse. Family was well known to children's services. Issues identified include: lack of focus on the child; professional optimism; insufficient management and supervision; insufficient information sharing; and working with resistance and avoidance.

For more information see Wolverhampton – Daniel Jones

July 2013 - Lancashire - Baby E

Death of a 4-month-old baby boy from a serious head injury in December 2011. Both parents had been looked after children, had experienced childhood abuse and were chronic substance users. Identifies themes for learning including: establishing a professional lead in multi-agency processes; acquiring comprehensive social histories from parents; recognising unemployment and poverty as risk factors; recognising disguised compliance and maintaining a sufficient level of professional scepticism; impact of coercive relationships on vulnerable women; and engaging with men and fathers. Sets out key findings using systems based typology developed by SCIE.

For more information see Lancashire - Baby E

February 2013 – Manchester – Child U

Death of a 4 year old girl in September 2011 who was subject to a child protection plan. Mother pleaded guilty to manslaughter on the grounds of diminished responsibility and was detained in a secure mental health facility. History of inappropriate sexual behaviour by mother towards her daughter and parental mental health issues. Identifies themes including mentally ill parents, substance misuse, child sexual abuse and hostile behaviour.

For more information see Manchester – Child U

Child Sexual Exploitation

December 2013 - East Sussex - Child G

Abduction of a 15-year-old girl in 2012, by her teacher, Mr K. Child G was involved in a sexual relationship with Mr K, which began around her 15th birthday. Mr K was found guilty of abduction and admitted a number of charges of sexual activity with a child under 16 years; he received a custodial sentence of 5 years. Identifies serious concerns relating to school's actions, including: failure to identify the abuse and exploitation of Child G; fixed thinking; failure to hear concerns raised by students; failure to involve Child G's mother; concerns about LADO response; insufficient recognition of Mr K's inappropriate use of Twitter to communicate with Child G; and serious concerns with the ways in which information was recorded, stored, retrieved and provided for the review.

For more information see East Sussex - Child G

December 2013 - Rochdale Young People 1, 2, 3, 4, 5 and 6

Serious and prolonged sexual exploitation of 6 adolescent girls at the hands of a number of men, who subsequently received criminal convictions. Issues identified include: frequent incidences of young people missing from home; recurrent attendances at A&E; optimistic thinking; unqualified staff; and inadequate supervision. Contains multi-agency and single agency recommendations covering: placing young people at risk of sexual exploitation with specialist foster carers rather than semi-independent living accommodation; and having a twin safeguarding focus when working with teenage parents and their children.

For more information see Rochdale - Young People 1, 2, 3, 4, 5 and 6

Neglect

Hamzah Khan
November 2013 - Bradford - Hamzah Khan

Death of a 4-year-old boy in December 2009, as a result of chronic neglect; Hamzah's body was discovered by police during a search of the family home in September 2011. Mother was convicted of manslaughter and child cruelty in October 2013. Maternal history of: chronic alcohol dependency; depression; social isolation; domestic abuse; and reluctance to engage with services, including registering children for health and education services. Issues identified include: invisibility of children to education and health services; failure to take into account the impact on children of living with domestic abuse; absence of enquiry into the cultural and religious complexity of the family; insufficient significance given to disclosure by adolescents; lack of professional curiosity.

For more information see Bradford - Hamzah Khan

Physical and Emotional Abuse

September 2013 - Coventry - Daniel Pelka

The death of 4 year Daniel on 3 March 2012 as the result of an acute subdural haematoma. Daniel's mother and step father were convicted of murder in August 2013 and sentenced to 30 years' imprisonment. For a period of at least six months prior to his death, Daniel had been starved, assaulted, neglected and abused. History of incidents of serious domestic abuse and violence, chaotic lifestyle with multiple house moves and alcohol misuse by mother and various partners. Issues identified include: deception of agencies and services by mother; impact of witnessing violence on children; impact of culture, race and language; and Daniel's isolation and 'invisibility'.

For more information see Coventry - Daniel Pelka

October 2013 - Birmingham - Keanu Williams

Death of a 2-year-old boy in January 2011 from multiple injuries. The mother was convicted of Keanu's murder and of 'cruelty to a child' in respect of one of his older half siblings; she was sentenced to 18 years imprisonment. Mother spent periods of time in foster care subject to care orders throughout her own childhood. History of: frequent house moves and periods of homelessness and frequent changes in maternal relationships. Issues identified include: focus on the child; professional curiosity in relation to injuries. Recommendations include: multi-agency audits to track records across agencies; critical review of the interagency protocol for child protection medical assessments.

For more information see Birmingham - Keanu Williams

Sexual Abuse

August 2013 - Birmingham - Case No.2010-11/3

Serious sexual assault of a toddler by an early years student and staff member at a nursery in Birmingham in 2010. Knowledge of the incident came to light following an accusation by a 13-year-old girl of online grooming in January 2011. Issues identified include: recruitment and screening procedures; management and team culture; inspection and complaints procedures; and early identification of online sex offenders by police. Recommendations include: effective recruitment processes; balancing physical environments in nursery settings between a respect for privacy and reducing opportunities to abuse; rigorous inspections of early years settings that examine the implementation of safeguarding policies and procedures.

For more information see Birmingham - Case No.2010-11/3

Domestic Homicides and Child Deaths

May 2013 - Surrey - Children U and V

Death of a 7-year-old boy (Child U) and his 6-year-old sister (Child V) on 30 September 2012. Children were found on a bridleway with their father who was also deceased. Police evidence later revealed that father stabbed both children before taking his own life. Mother had disclosed domestic abuse (verbal/emotional) to GP in October 2011. Lessons learned include: domestic abuse is a child protection issue; children should be actively spoken to, engaged with and observed by professionals; and violent acts that lead to the death of children can occur without any prior indication.

For more information see Surrey - Children U and V

February 2013 - Stoke-on-Trent - Case No.SOT12(1)

Death of a pre-school aged child in January 2012. Mother's partner was charged with murder and received a life sentence. Child lived with mother, father and three elder half siblings. Father was physically abusive and controlling towards mother, misused alcohol and was verbally abusive toward one of the subject child's siblings. Children witnessed significant domestic violence and experienced multiple moves before father was convicted of assault against mother. Issues identified include: lack of professional curiosity; lack of focus on the children during domestic abuse risk assessments; lack of assessment of mother's ability to protect and care for her children.

For more information see Stoke-on-Trent - Case No.SOT12(1)

January 2013 – Wirral – Child G

Death of a 17-year-old girl in May 2012, by strangulation. Her boyfriend at the time of her death was charged with her murder. Child G had learning difficulties, ADHD and behavioural problems and had been the subject of a child protection plan for neglect when she was younger. She was living independently in specialist accommodation at the time of her death.

Makes recommendations for developing professional understanding of the effects on child development and social presentation of moderate learning difficulties; working with young people who are sexually active from a young age; and safeguarding young people who are 16 and 17 years old.

For more information see Wirral – Child G

Adult Serious Case Reviews

October 2011 - Rugby - Gemma Hayter

Gemma Hayter's body was found on 9 August 2010 on a disused railway line in Rugby. Her murder and the abuse that she suffered beforehand were truly abhorrent, committed by people she believed to be her friends. Five people caused her death: three are serving sentences for murder and two for manslaughter. Gemma was a vulnerable young woman with lifelong difficulties who highly valued her independence. Though there was evidence that she was regularly exploited by people who knew her and she was known to many agencies, no single agency had a full picture of her life and the level of risk she was exposed to. Like all of us, Gemma wanted friends and a social life and this case raises wider issues nationally about community safety for single adults who may be vulnerable to disability based harassment, hate or mate crime and exploitation.

For more information see Gemma Hayter

September 2013 – Surrey - Gloria Foster

Mrs Foster did not receive care after her care agency, CareFirst4, had been shut down following a raid by UK Borders Agency. She was found several days later in a very poor state during a routine visit by a nurse. Mrs Foster was taken to hospital but died a few days later. Issues identified included: communication, data and information; service closure; care coordination; use of assisted living technology; access to people's homes; care packages – people with complex long term conditions; self-funding and social work.

For more information see Gloria Foster

August 2012 – Birmingham – Mr J Kent

A review was held following the admission to hospital of an elderly man, Mr Kent, where there were longstanding concerns about possible self-neglect/neglect by others and possible financial abuse. Following admission to hospital in November 2011 Mr Kent was assessed as needing nursing care. He was cared for in a nursing home prior to admission to a palliative care unit. He died in April 2012 as a result of longstanding health conditions. This case highlighted issues relating to working with an individual who is reluctant to accept health and social care services. Practioners need to understand the application of safeguarding policies and procedures and use of the Mental Capacity Act 2005 in risk assessment.

For more information see Mr J Kent

The Francis Report

Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013. It told a story of appalling suffering of many patients within a culture of secrecy and defensiveness. The inquiry highlighted a whole system failure. A system which should have had checks and balances in place; and working to ensure that patients were treated with dignity and suffered no harm. The 1,782 page report had 290 recommendations with major implications for all levels of the health service across England. It called for a whole service, patient centred focus. The detailed recommendations did not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that this does not happen again.

For more information see Francis report

Hard Truths: The Government response to Francis

On 19 November 2013, the Secretary of State for Health issued his response to the Francis report, in which the Government undertook to fully implement 204 of the 290 recommendations. Some of the Government's pledges which have workforce implications, include:

- Safe staffing: from April 2014, all hospitals will publish staffing levels on a ward-by-ward basis together with the percentage of shifts meeting safe staffing guidelines. This will be mandatory on a monthly basis. By the end of next year this will be done using models approved independently by NICE. Access the new National Quality Board (NQB) guidance on safer staffing.

- A new national patient safety programme across England will spread best practice and build safety skills across the country. NHS England will start the programme in April 2014.

- 5000 patient safety fellows will be trained and appointed by NHS England within five years, to be champions, experts, leaders and motivators in patient safety.

- Complaints reporting and better complaints information: Trusts will report quarterly on complaints data and lessons learned and the Health Service Ombudsman will increase significantly the number of cases she considers. In addition, all hospitals will be required to set out clearly how patients and their families can raise concerns or complain, with independent support available from their Healthwatch or alternative organisations.

- A new criminal offence for wilful neglect: the Government will legislate at the earliest available opportunity to make it an offence to wilfully neglect patients - so that organisations and staff, whether managers or clinicians, responsible for the very worst failures in care are held accountable.

- A new Fit and Proper Person's Test which will enable the Care Quality Commission to bar unsuitable senior managers who have failed in the past from taking up individual posts elsewhere in the system.
- A new Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the fundamental training and skills needed to give good personal care to patients and service users. The Chief Inspectors will ensure that employers are using the Disclosure and Barring Service to prevent unsuitable staff from being re-employed elsewhere.
- Every hospital patient should have the names of a responsible consultant and nurse above their bed. As part of the agreement with GPs, starting with over-75s from April, there will be a named accountable clinician for out-of-hospital care for all vulnerable older people.

Download the Government's full response, *Hard Truths: The journey to putting patients first*, and its response to each recommendation.

Subsequent reports and reviews

Following publication of the Francis report, the Government commissioned a number of national reviews to explore in detail what needs to happen to help organisations improve the quality of patient care across the NHS.

The reports listed below and their authors are acknowledged in the Government response *Hard Truths: The journey to putting patients first:*

- Challenging Bureacracy: a review of the bureaucratic burdens on providers of NHS care from national bodies - NHS Confederation (19 November 2013)
- A review of the NHS hospitals complaints system: putting patients back in the picture (28 October 2013) - Tricia Hart and Ann Clwyd
- Improving the Safety of Patients in England (6 August 2013) - Don Berwick
- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report - Bruce Keogh (16 July 2013) and NHS Employers response (16 July 2013).
- An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings (10 July 2013) - Camilla Cavendish

Keep Safe Places:

What does this mean?

A Keep Safe Place is a temporary safe place a person can go to when they feel unsafe, vulnerable or upset. People can sometimes become targets for bullying and harassment and can feel intimidated, scared and frightened whilst they are in their community. In some cases this can prevent them from going out.

The venues are in a town centre or city centre setting, with staff who:

- Are able to offer reassurance
- Offer the person a place to calm down
- Offer support with making a call or to make a call on their behalf, to either a relative or relevant service
- Make an emergency call on the person's behalf to the Police or for an Ambulance

Keep Safe Places is a nationally recognised scheme which helps people to deal with incidents that take place while they are out and about in the community. The scheme is aimed at helping people feel confident and safe when in their community, knowing that assistance is available if required.

Currently there are 51 Keep Safe Places across Leicestershire and Leicester City. For details of all of the Keep Safe Places go to www.leics.gov.uk/keepsafeplaceschemes

For more information about the schemes please email Damion.nickerson@leics.gov.uk

Contact us

Leicestershire and Rutland Safeguarding Children Board and Safeguarding Adults Board

The Safeguarding Boards Business Office
Room 600, County Hall, Glenfield, Leicestershire, LE3 8RA.
Telephone: 0116 305 7130 • Email: SBBO@leics.gov.uk

SIGN UP FOR Safeguarding MATTERS

If you would like to receive copies of future publications please email SBBO@leics.gov.uk or call 0116 305 7130