- Professionals should not have unrealistic expectations of parents' capacity to change
- Housing is an issue for vulnerable young adults and may create risk
- All agencies should be consulted when closing cases
- Risks to children must be assessed when having contact with perpetrators of domestic abuse
- Fire safety assessment should be completed as part of **all** assessments
- Children should be adequately prepared when undergoing medical examinations
- The Derbyshire Safeguarding Children Board "Think Family" charter, needs to be embedded in **all** professional practice.

This information, and other advice, is available at

www.derbyshirescb.org.uk

Learning from serious case reviews and serious incident learning reviews

(2013–14)

We're working with partners to keep children and young people in Derbyshire safe and well.

Derbyshire **Safeguarding Children** Board

Safeguarding Children Everybody's Business

Learning from serious case reviews and serious incident learning reviews (2013–14)

These reviews have highlighted **learning** and **themes** that can help our work.

Themes in the SCRs and SILRs:

- Domestic abuse
- Substance misuse
- Vulnerabilities of older children
- Disguised compliance from people agencies are trying to work with
- Difficulties in engaging people agencies are trying to work with
- Suicide/self-harm
- Shaking of babies/youngsters
- Information Sharing

Learning from these SCRs and SILRs includes:

- Supervision Orders should be shared with all agencies and consideration given to whether a child protection plan is also required
- Appropriate representation is vital at key meetings (e.g. case conferences), when a child is at risk
- Children's plans should be SMART and focus on positive outcomes for the child
- Support is needed for older children
- Effective multi-agency working is vital
- Effective information sharing of historical and current information is key to informing assessment
- Disguised compliance and lack of engagement must be discussed in supervision
- Assessments should be completed before an agreement is reached to cease a child protection plan
- Staff should observe safe working practices and be reminded of staff codes of conduct (regarding their contact with young people)
- Professionals need to remain curious and inquisitive
- All babies and children should be registered with a GP – with particular attention/ liaison when families cross borders

(continued overleaf)

In 2013/14 there were two serious case reviews and seven serious incident learning reviews.

The serious case reviews were:

- **ADS13** – a child died due to non-accidental head injuries in 2013
- **ADS14** – a child died following multiple non-accidental injuries in 2014

The serious incident learning reviews were:

- **SILR13A** – a child affected by serious domestic violence by the father on the mother
- **SILR13B** – four children died following a house fire
- **SILR13C** – a child subjected to serious sexual abuse
- **SILR13D** – a School Learning Review, following a series of incidents when staff in different schools have behaved inappropriately towards children
- **SILR13E** – a young person who committed suicide
- **SILR13F** – a disabled child who died from pneumonia, in a case where there had been concerns regarding neglect
- **SILR14A** – two children and two mothers died following a house fire