

- 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.

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**

This information, and other advice, is available at
www.derbyshirescb.org.uk

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Everybody's Business

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

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

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)