Lessons Learned Research Digest

Issue 3 – March 2021

Welcome to the third edition of the Darlington Safeguarding Partnership Research Digest bulletin. The bulletin has been produced to share messages from recently published Child Safeguarding Practice Reviews/Safeguarding Adults Reviews /Lessons Learned Reviews and any local lessons learned. The cases identify lessons to be learned to improve learning and develop practice across multi-agencies to safeguard children and young people, and adults with needs for care and support.

This bulletin focuses on reviews published in 2020 and 2021.

Cases highlighted in *italics* indicate those cases where learning may be relevant to reviews undertaken in Darlington;

learning.nspcc.org.uk/case-reviews/recently-published-case-reviews

In addition, the NSPCC provides a thematic briefing highlighting the learning from SCR's which focuses on the different topics;

www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/

Local Learning

CASE	LEARNING
Darlington Safeguarding Partnership	*There have been no Child Safeguarding Practice Reviews published in the past 12 months.*

Regional Learning

CASE	REPORT
January 2021 **Teeswide Safeguarding Adults Board**	**Learning from Regional and National SAR Cases;** May 2020 – Oxfordshire SAB Thematic Review – Homelessness. Read here; Link here to full report;

Reviews undertaken by the National Panel

THEME	LEARNING
Safeguarding children at risk from sudden unexpected infant death	National review into sudden unexpected death in infancy in families where children are considered at risk of significant harm. This review sets out recommendations and findings for government and local safeguarding partners to better protect infants from sudden unexpected death in infancy (SUDI). The aim is to identify what might have been done differently and how to improve approaches to embed safer sleeping advice in families with children considered to be at risk of significant harm through child abuse or neglect. Read full report here;

National Learning

PHYSICAL AND EMOTIONAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Anonymous Authority – Baby L	Baby L was taken to hospital by ambulance. Subsequent medical assessments concluded that some of the injuries had happened prior to the hospital admission. Parents were arrested and bailed pending further criminal enquiries. At the time of the reported injuries, Baby L and their older half-sibling had been subject to Child Protection Plans and to a Public Law Outline (PLO) process. Baby L's parents had lived separately in several other areas of England prior to meeting in 2017. Father had two children from a previous relationship where there had been concerns about neglect and historic injuries. Mother had a child from a previous relationship; contacts made to Children's Services in relation to Baby L's half-sibling. Paternal history of mental health problems and domestic abuse. Ethnicity or nationality not stated. Learning centres around: the effectiveness of pre-birth and post-birth multi-agency assessment, multi-agency case management, inter-agency communication and information sharing; how well practitioners considered the inherent vulnerability of babies to abuse and	**Learning:** • All relevant professionals are invited to Initial Child Protection Conferences, especially those who have extensive knowledge of previous case background. • That all single/pre-birth assessments are completed on time by social workers and include all relevant information, especially parenting and trilogy of risk; and do not over rely on parental self-reporting. • That professionals have the requisite experience, knowledge, capacity and managerial support to effectively carry out their safeguarding responsibilities and roles. • That the Child Protection Review system uses effective case tracking to inform Case Conference Chairs of progress with child protection plans and empowers them to mount robust, timely and effective challenge to professionals when appropriate. • That core groups are effective in challenging agency decisions and (in) actions when required, through the use of the Safeguarding Children Partnership escalation/ professional dispute procedures. • All professionals in contact with non-mobile babies to be familiar with the local

	non-accidental injury, particularly in the context of the trilogy of risk; barriers to recognising and addressing over optimism in parents. Uses the Welsh Model. Read summary report	Safeguarding Children Partnership's guidance. **Recommendations:** • ensure that pre-birth assessments are completed on time by social workers and include all relevant information, and parents' accounts and views are appropriately tested and triangulated by evidence from other sources • ensure that guidance on injuries to non-mobile babies has been widely disseminated to all front-line practitioners and embedded in practice.
2020 – Anonymous Authority – Child N Injuries to a 4-week-old infant in 2016.	Civil court found that the injuries were caused by the father and that the mother failed to protect Child N. A criminal investigation in respect of both parents and the paternal uncle concluded with no further action in 2020. Child N lived with their mother, father and older sibling, Sibling 2. Both siblings were subject of a Child in Need plan at the time of the injuries. Another older sibling, Sibling 1, died when aged 5-months-old. Mother was a teenage parent with a history of self-harm, mental health problems and personality disorder, and substance misuse. Father had experienced a difficult childhood and had anger control issues. Ethnicity or nationality not stated. Read full overview	**Learning:** • when one parent has mental health issues affecting their ability to care for the children, the assessment and plan needs to consider the impact on the other parent/carer • supervision for professionals needs to ensure they are focused on the child and not on the parent's histories and situations • professionals should seek to understand the nature of parenting relationships from the point of view of both parents/adults and the child, and not focus only on the mother • Uses the Significant Incident Learning Process (SILP) methodology. **Recommendations:** • confirm if formal pre-birth assessments are being undertaken in cases where a new baby will be the subject of a child in need or child protection plan at birth

		• consider the benefits and practicalities of requesting that the information that a child is on a child in need plan is shared with all professionals working with the family.
2020 – Anonymous Authority – Child Sam Serious, non-life threatening injuries to an adolescent in a targeted attack in 2019.	Sam was the victim of a targeted attack and admitted to hospital. Sam had been known to services from an early age. Parents had separated; history of domestic abuse, some of which Sam witnessed. Father is in prison custody. Mother had two further children with new partner, one of whom died of natural causes. Police involvement with Sam on several occasions, including being arrested predominately for drug misuse. Sam left education aged 15-years-old with signs he was associating with people involved in organised crime. In 2017 a friend of Sam's was the victim of homicide. Sam was arrested for suspected involvement in a separate murder, for which he remains under investigation. In 2018 Sam was suspected in county lines drug supply. Ethnicity and nationality not stated. Read learning report	**Learning:** • following any high-profile local incident, community tensions and anxiety are likely to be heightened • safeguarding partners need to be assured that they are sharing key information and that they are doing so securely in compliance with regulations • there are potential implications for children and vulnerable people who are 'released under investigation' especially when this is for an extended period. **Recommendations:** • local police should review its 'released under investigation framework' to ensure that professionals conducting reviews take cognisance of a suspect's age, vulnerabilities and safeguarding risks • review the 'Step Up & Step Down' procedure to ensure that a multi-agency approach is taken when making decisions relating to levels of need.
2020 – Cambridgeshire and Peterborough – Jack	Jack lived with his parents; had been subject to a child protection plan because of risk of neglect before birth.	**Learning:** • effectiveness of assessments, consideration and management of risk

Serious harm suffered by a 3-month-old baby boy because of multiple injuries, including fractures and bruising of the brain in May 2017.	At the time of the injuries, he was subject to both a child protection plan and Interim Supervision Order (ISO). Family were known to multiple agencies; older sibling had been taken into care and adopted. Maternal history of: depression, being a looked-after-child, learning disabilities. Following the identification of the injuries, Jack was made the subject of an Interim Care Order (ICO). Ethnicity or nationality of Jack is not stated. Read full overview	• injuries to pre-mobile babies need to be viewed from a perspective of potential risk • consider risk of neglect where a child's weight is varying • need to involve and support fathers • need to share information to allow robust discussion of concerns. **Recommendations:** • ensure procedures on pre-birth assessments are consistent, contain guidance on timescales and ensure sufficient challenge • all agencies should understand legal orders and their implications • ensure child protection plans are SMART using tools to measure progress • review and reissue guidance for parents with mental health problems, on joint working, and on bruising in pre-mobile babies.
2020 – East Riding – Baby B Life-changing injuries to a 10-and-a-half-month-old infant in November 2013 due to shaking.	Mother's partner was convicted of causing grievous bodily harm and was imprisoned. Mother was convicted for neglect and received a suspended sentence. Baby B was the second child in the family. Baby B's parents had separated and both children were living with their mother and her partner. Anonymous report about neglect made to the NSPCC in June 2013; Children's Social Care found no concerns. Baby B was not brought to several health appointments; sibling had high rate of school absenteeism.	**Learning:** • concerns made anonymously should be treated as seriously as those that are not anonymous • health visitors and school nurses provide a useful link between schools and health services • where professionals have personal or professional relationships with a service user, or someone closely involved with the service user there is the potential for professionals' boundaries to become blurred. **Recommendations:**

	Concerns about domestic violence; mother's partner's child had been subject to a child protection plan due to domestic violence in earlier relationship. Family is White British. Case review conducted following an investigation in December 2018 by the Local Government and Social Care Ombudsman into complaints made by Baby B's father against East Riding Council. Read full overview	• practitioners must ensure that they are complying with current legislation, statutory guidance and agency polices relating to information • ensure that the minutes of strategy discussions are included within the case record of all agencies involved in the meeting and include the arrangements for review.

NEGLECT		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Anonymous Authority – Children's Case C Severe neglect and abuse of a large group of siblings by their mother and father over many years.	Care proceedings concluded in 2017 and the children are no longer under parents' care. Six of the siblings are now adults. Evidence of the children suffering significant neglect and abuse by their parents between 2007-2017. Home environment was overcrowded, chaotic, dirty and unsafe. Evidence of physical abuse, domination and coercion, and failure to prevent physical and sexual abuse between siblings. Failure to ensure that the children received medical care or attended school regularly. Parents were uncooperative, aggressive to professionals with some disguised compliance and manipulative behaviour. Several of the children made subject to child protection plans for neglect in 2007-2009; in July	**Learning:** • overwhelming nature of the complexity and scale of the problems and of the oppositional, hostile behaviour of the parents • responses from all agencies to concerns and interventions were generally short-lived and episodic • children's lived experience was not fully appreciated. **Recommendations:** • develop a model for interagency practitioner supervision for complex cases where working together closely and consistently is of paramount importance • ensure that the use of the Public Law Outline is being used effectively to give local authority and social workers sufficient

	2016 police protection was taken on all the children under 18 living with the parents and interim care orders were granted. Ethnicity and nationality not stated. Read full overview	leverage with families which are deliberately obstructive by clarifying their concerns in a 'Letter before Proceedings' or further action.
2020 – Anonymous Authority – Family G Chronic neglect and intrafamilial child sexual abuse of male and female children, aged between 3-to 9-years-old at the time abuse was first reported.	The mother and her male partner were subsequently convicted of multiple offences of sexual abuse. Family were known to multi agency services and had period of child protection planning under the category of neglect, later stepped down to child in need plans. Concerns re-emerged and children were removed from the family home, on an interim basis, into care. Shortly after the children were removed, they made disclosures about their previous home life and of being sexually abused. Ethnicity or nationality not stated. Read executive summary	**Learning:** • information exchange between professionals must be comprehensive and timely • professionals need to recognise the different indicators of possible child sexual abuse so that potential indicators are not misunderstood, dismissed or ignored • professionals need to use curiosity, hypothesising and a critical analytical mindset throughout the risk assessment process • if an agency decides not to implement an important case conference recommendation, the relevant agency professional must notify the case conference chair with reasons. • Uses the Significant Incident Learning Process (SILP). **Recommendations:** • professionals must have knowledge to enable them to identify and respond effectively to children who are or who may be at risk of suffering multiple categories of abuse • professionals must have knowledge of child sexual abuse, including female perpetrator behaviours

		• Achieving Best Evidence (ABE) interviews and medical examinations must be child centred and undertaken in a timely way • effective management and multi-agency oversight must be child focused, analytical and reflective.
2020 – Cumbria – Child CH Death of a 14-year-old girl in June 2018.	In May 2016, Child CH was placed in care due to long-term neglect and emotional abuse. She had three foster placements and two placements in children's homes. Whilst in care, she disclosed previous sexual abuse. Throughout her time in care, Child CH had many missing episodes and was seen at hospitals on several occasions for self-harm and suicidal ideation. She was kept in hospital following tying a ligature around her neck as her placement said they could not manage her safely. From May 2018, Child CH was at a mental health hospital and continued to display ligaturing behaviours. She went missing from the hospital and was found dead four hours later. Ethnicity/nationality not stated. Read full overview	**Learning:** • risk assessments need to be holistic, shared across agencies and reviewed regularly • perceived risk can increase professional anxiety and be a barrier for access to services and placements • when a child in care is particularly vulnerable, there should be a plan for service delivery which takes this vulnerability into consideration. **Recommendations:** • request assurance on the commissioning arrangements for placements for children who require stable and safe care • ensure that information about looked after children is shared with a placement or hospital when a child is moved • write to the Department for Education and Ofsted about the challenge in finding placements for children with significant risks and vulnerabilities. • Model: uses the Significant Incident Learning Process (SILP) model.
2020 – Gloucestershire – Children of Family Y	Mother and father were estranged and had lived apart.	**Learning:**

Significant and chronic neglect of four siblings over many years.	Children were placed on a child protection plan on two occasions under the category of neglect. Several recordings and anonymous referrals regarding the poor living conditions at the mother's home. Mother displayed disguised compliance in telling professionals this would be improved, as well as not bringing children to medical appointments. Two of the children were reported to be soiling themselves daily at school. The eldest sibling committed intra-familial child sexual abuse (CSA) on his three younger siblings on numerous occasions from 2012 to 2016. Both parents were charged with neglect offences. Ethnicity and nationality not stated. Read full overview	• practitioners should improve their awareness and personal knowledge in being able to recognise and identify symptoms of child sexual abuse and neglect • risk assessments must be carried out with the rationale recorded and supervised; 'was not brought' is a more relevant term than 'did not attend' as the emphasis is placed on the parent or carer who does not bring a child to an appointment. **Recommendations:** • all safeguarding partner agencies should ensure that staff are aware of the signs and symptoms of child sexual abuse and know what to do if they are seen or suspected • assure that staff complete background chronologies on their case files on children and families subject to child protection enquiries • ensure that staff capture the voice of the child in safeguarding cases and focus on the experience and impact on children.
2020 – Gloucestershire – Megan Neglect and abuse of a 6-year-old girl over a number of years.	Megan was placed in the care of her paternal grandmother in 2012 via a Special Guardianship Order (SGO). Megan was neglected and physically abused by her father, her paternal grandmother and her grandmother's partner. Megan was brought to hospital 'acutely unwell' and staff found her covered in bruises. Megan was removed from her grandmother's care in 2015.	**Learning:** • need for practitioners to improve their awareness and personal knowledge in being able recognise and identify the signs and symptoms of all child abuse • the voice of the child was not effectively captured at the time considering the subsequent disclosures Megan made • agencies should have robust record keeping and management systems in place

	Her father, grandmother and partner received substantial custodial sentences. An initial case review was carried out by the Social Care Institute for Excellence (SCIE) in 2017. This review reassesses the 2017 report. Ethnicity or nationality not stated. Read full overview	• a consistent lack of professional curiosity and scrutiny displayed in the assessment of child protection concerns • too much optimism when conducting the SGO application of parental grandmother's capacity to care. **Recommendations:** • Gloucestershire County Council Children Social Care to develop a safeguarding pathway for the application of family members for Special Guardianship Orders. The process will include utilising a Family Group Conference and to apply for an interim Kinship Foster Placement to allow safeguarding to remain in place whilst a detailed viability assessment of the prospective guardians' capabilities is conducted.
2020 – Luton – Child G Neglect and sexual abuse of a secondary school aged child.	Legal proceedings took several years, and Child G is now an adult. Child G's school made referral to social work team about Child G's angry behaviours, self-harming and allegations about abuse at home. Strategy meeting and interview with Child G by a police officer and a social worker; core assessment and medical assessment were not carried out. An Interim Care Order was made, and Child G was placed with a foster carer. Ethnicity or nationality not stated. Read full overview	**Learning:** • missed opportunities for a holistic and multi-agency assessment and response to Child G's emotional needs • no evidence of chronologies being maintained, or information being collated to enable a wider understanding of Child G's history • there was a need for better management and supervision • ensure appropriate use of specialists to provide advice on how to engage with the child/adult if they have learning needs

		• practitioners need to be curious about the causal nature of behaviour and seek to explore alternative reasons. **Recommendations:** • ensure that agencies have in place and follow effective safeguarding supervision and management oversight procedures, and remind agencies of the importance of appropriate challenge and escalation • establish clear self-harm procedures and pathways • ensure that effective support is provided to disabled children and their families to enable them to communicate and effectively participate in plans • ensure compliance with the procedures for child protection medicals and the inclusion of consultant paediatricians in strategy discussions or meetings.
2020 – Portsmouth – Child I Death of a 9-week-old infant in 2018**.**	Child I had no identified health concerns and the cause of death was unascertained. Child I was found unresponsive in an unsafe sleeping position co-sleeping with his mother, Mrs I. Resuscitation was attempted and during this Mrs I made statements of guilt to hospital staff and police who identified that Mrs I was under the influence of alcohol. Parents were known to Police for alcohol related incidents.	**Learning:** • practitioners working with families should take every opportunity to remind parents of key safe sleeping messages tailored to their needs • health practitioners are in a key position to identify domestic abuse and to initiate support and safety for victims • good practice was shown by the neonatal doctor in following-up after Child I was not brought for a repeat blood test. **Recommendations:**

	At the time of death there were concerns that Child I had been subject to neglect. Two hours following Child I's death Mrs I was arrested at hospital for driving with excess alcohol. Both parents were arrested the following day for neglect. Ethnicity and nationality not stated. Read full overview	• support professionals working with universal and high-risk families to identify safe-sleep risks, emphasising 'out of routine' events such as going to a party or on holiday • support professionals in discussing alcohol consumption with parents and highlighting what happens on those occasions when they may binge/drink more than usual • Portsmouth hospital should review and improve continuity of carer arrangements, especially when there is staff sickness.
2020 – West Sussex – Family W Significant neglect of two siblings, including neglect of their physical, emotional, social developmental, health and medical needs.	Both children had been the subject of child in need plans since October 2016 and child protection plans under the category of neglect since June 2017. Alcohol use and abuse were present in this family but was not identified as a risk factor and addressed. Ethnicity or nationality of family not stated. Read executive summary	**Learning**: • at times, the focus was on the adults rather than the lived experiences of the children • information sharing within and between agencies was not always consistent • over-optimism about the likelihood of the adult carers improving their care of the children • a lack of challenge to adult family members which led to gaps in information. **Identifies good practice**: • direct work carried out by the school nurse, which allowed the child's voice to be heard and shared • recognition by dentist that one of the children's decayed teeth and bleeding gums were indicative of neglect. **Recommendations:** • highlights the improved outcomes that have been identified and should be addressed, including: multi-agency partners can

		evidence a shared responsibility for the safeguarding and protection of children • multi-agency assessments, risk assessments and effective safety plans are secured and monitored within the child protection conference process, to ensure the best outcomes for children • amending the pathway for capacity assessments of carers with learning difficulties so that they can be undertaken at an earlier stage.

SUDDEN UNEXPECTED DEATHS IN INFANTS AND CHILDREN		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Blackpool – Child CE Death of a 10-week-old infant in March 2019.	Cause of death was confirmed as overlay due to unsafe sleeping arrangements; Police investigation concluded with no further action taken. Child CE lived with their mother, father and siblings. No concerns were observed or identified by professionals during the pregnancy or following the birth; only a small number of universal level services involved with the family. National Probation Service were involved with an adult male who lived with the family, but no association was found with this and the circumstances of Child CE's death. Ethnicity or nationality not stated. Read full overview	**Learning:** • it is important that all professionals understand, and follow, agreed policy and procedures. Failure to do so may place a child or vulnerable adult at risk • being actively curious about members of the household, family dynamics and actual, or potential, risks to children is an important consideration for practitioners • contemporaneous record keeping is an essential requirement following all appointments and contacts • ensuring fathers are given the same advice and support as mothers is important • ensuring new parents think about safer sleeping arrangements for the baby is a core task for all professionals. **Recommendations:**

		• to review the current strategies and initiatives around safer sleeping advice, support and promotional materials and consider any changes which may promote knowledge and understanding.
2020 – Bury – Isabella Death of a 14-month-old girl in August 2019.	Isabella's mother found her unresponsive at home and she was transferred to hospital by ambulance but died after resuscitation failed. Isabella had complex medical needs and global developmental delay. Parents were known to children's services. Mother had been subject to a child protection plan and there were concerns for her around child sexual exploitation. These increased when her relationship with Father became known when she was 16 and he was 21-years-old. Father had issues with alcohol misuse. Isabella was born prematurely and spent 13 weeks in neonatal intensive care, under the care of several consultants with different medical expertise. Concerns were raised about parents' parenting capacity due in part to their young age and missed medical appointments, lack of support, and home environment. Mother gave birth to Isabella's sibling in July 2019. Ethnicity and nationality not stated. Read full overview	**Learning:** • considerations should be given as to how professionals engage with fathers. If a father has not engaged, it should be clearly recorded that he remains an unassessed risk. • if a parent does not consent to local authority support for a child in need, careful consideration should be given to escalating the protection provided • information about avoidant behaviour should be shared with all other professionals involved. **Recommendations:** • ensure that the language change - 'was not brought' is reinforced across partner agencies and that practitioners are trained to realise 'medical neglect' and recognise missed appointments as an indicator. The universal use of the language term will emphasise parents' and carers' responsibility to take a child in their care to health appointments and will deliver a clearer marker to identify neglect.

2020 – Gloucestershire – Liam Sudden unexpected death of a 1-month-old boy in 2019.	During the night Liam's mother awoke to feed him but could not remember the details around this; the following morning she found Liam unresponsive on the sofa. Liam and his half-sibling were subjects of child protection plans for neglect. Half-sibling Emma was subject to a Special Guardianship Order. Mother was known to police as a victim of domestic abuse, and had a history of poor mental health, drug misuse and self-harm as a child, as well as child sexual exploitation. At the time of Liam's death the family was receiving support from health providers, children's social care, psychology service, paediatric and speech and language services. Police were satisfied there were no suspicious circumstances surrounding Liam's death. Inquest concluded that the cause of death was unascertainable. Ethnicity and nationality not stated. Read full overview	**Learning**: • pre-birth planning and assessment is important in ensuring early understanding of possible risks • practitioners should be equipped to recognise possible feigned compliance and to address this in assessments and plans • record keeping was not of sufficient content or quality to know what was happening to the family and what risks were identified. **Recommendations:** • where information is missing and reliant on another practitioner or agency to provide it this should be addressed by practitioners through the Escalation Policy • practitioners should be equipped to assess the significance of substance misuse and poor maternal mental health and its impact on parenting capability and put in place an appropriate plan of support and intervention.
2020 – Hertfordshire – Child K Death of a 16-year-old boy by suicide.	Case review covers the period from January 2012 to December 2017. There were no services involved with Child K at the time of his death apart from school. An initial child protection conference was triggered due to Child K's plans to run away to his family's country of origin and his threats to teachers and other pupils.	**Learning:** • Child K was seen differently by different people • Child K's needs in relation to his autism rarely featured in multi-agency meetings • Child K felt that the involvement of professionals in his family's life was a significant disruption. **Recommendations:**

	School made a referral to the Channel Panel and he was made the subject of a child protection plan. After this, his engagement with professionals declined. Concerns about the effects of domestic abuse in the household. Father was controlling and there were sporadic acts of violence. Child K was diagnosed with an autistic spectrum disorder. Shortly before his death, Child K made a report to the police which suggested his actions may result in risk to himself. Ethnicity/nationality not stated. Read full overview	• consider a trauma-informed relational approach • consider whether practice and service provision are sensitive to the cultural, historic and gender context of families, including those outside of the main Black and Minority Ethnic groups • review cases of domestic abuse before closure to confirm that couples and children have been signposted to counselling or meditation services.
2020 – Sutton – Child T Death by suicide of a 17-year-old child in November 2019.	Child T was diagnosed with autistic spectrum disorder (ASD) in 2012. Child T's behaviour deteriorated at secondary school and they were permanently excluded and transferred to a pupil referral unit (PRU) in 2016. Child T displayed aggressive behaviour on several occasions and admitted to drug misuse. Child T attempted suicide four times and was admitted to hospital twice between December 2017 and September 2018. In the eight months leading up to their death, the only services involved with Child T were a special college and an adult sleep clinic. Family are Catholic but Child T did not hold any faith. Ethnicity/nationality not stated.	**Learning:** • education, health and care (EHC) plans and safeguarding of those with special educational needs and disabilities (SEND) need to be more aligned to ensure safeguarding issues aren't minimised due to SEND • the emergency provision for young people following a suicide does not aid recovery for the young person or the family • when a young person has highly complex needs, the focus can be entirely on the young person without consideration of the impact of issues on the wider family. **Recommendations:** • review the offers of post-diagnostic support for autistic spectrum disorder

	Read practice review	• challenge agencies and partnerships in how they listen to young people around the transition to adult services • ensure a review by the SEND board takes place to address issues holistically before consideration of school exclusion.

SEXUAL ABUSE and CSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Anonymous – Child A and Child B Sexual abuse of two children by a carer whilst in a long-term kinship care placement.	An older sibling living in the same placement witnessed Child A being sexually abused by the carer and informed the mother and then the police. Carer received a custodial sentence for the sexual abuse of Child A and Child B. Prior to entering care, Child A, Child B and Sibling 1 witnessed extensive and serious domestic abuse between their Mother and Father. Initially, the children were placed with Mother under an Interim Care Order, and later placed with Carer 1 and Carer 2 as kinship carers. The carers were subsequently approved as foster carers, and the placement became permanent for the children for 12 years. Uses the Welsh Child Practice Review model. Read overview report	**Learning:** • importance of robust exploration during the approval process for kinship foster carers • placement reviews for looked after children in kinship care placements should identify when national minimum standards are not met to avoid children remaining long term in inadequate accommodation • without consistent, rigorous and child focussed oversight by supervising social workers, shortcomings in the parenting capacity of kinship foster carers may not be identified or challenged. **Recommendations:** • ensure that social workers support children in kinship care to identify a trusted professional who will enable them to get their voice heard in the decisions which impact on their lives • ensure that social workers have access to regular supervision which provides opportunities for reflection and critical challenge with a specific focus on the

		effectiveness of care plans for looked after children.
2020 – Anonymous – Adolescent girl BR19 Child sexual exploitation and neglect of a 15-year-old girl.	An incident of rape and sexual abuse of a 15-year-old girl by teenage males in February 2019 involved other children as victims, perpetrators or witnesses. Review focuses on one child, BR19. Criminal proceedings ongoing at the time of the review; BR19 and her sibling have been taken into care. Maternal history of Adverse Childhood Experiences (ACEs) including sexual exploitation; being in care; and domestic abuse. Mother had BR19 as a teenager; was imprisoned when BR19 was young. BR19 lived with Father until aged 10-years-old, when she returned to Mother. Both BR19 and her sibling were made subject to Child Protection Plan in 2013 for neglect. BR19 was not in school throughout most of an 18-month period; concerns expressed by Mother of possible child sexual exploitation (CSE) of BR19; became subject to a Child Protection Plan in September 2017 and 2019 due to ongoing concerns around CSE and Mother's ability to protect BR19. Ethnicity or nationality of family not stated. Read overview report	**Learning:** • multi-agency planning and analysis of risk • impact of CSE and services for survivors of CSE who are parents • parental engagement and consent • professional challenge and escalation • professional curiosity of the child's lived experience • contextual safeguarding and perception of sexual activity between teenagers being consensual • Identifies good practice from professionals. **Recommendations:** • strengthening multiagency decision making and practice in relation to child protection processes • understanding and responding to the link between adolescent neglect, CSE and contextual safeguarding • understanding the impact of traumatic adverse life experiences on parenting through partnership assessments.
2020 – Coventry - Family S	Several of whom have disabilities including one child with serious physical and learning difficulties.	**Learning:** • the need to hear the voice of the child, and not the louder voice of adults

Serious sexual abuse of eight children between August 2010 and May 2016.	Criminal proceedings resulted in several adults receiving custodial sentences from four years to life imprisonment. The children had all come to the attention of statutory services over a number of years due to neglect by their carers. Evidence of indirect or incomplete disclosures, both verbal and non-verbal. A police investigation into disclosure of sexual abuse made to a foster carer in 2015 was closed within a matter of weeks with no further action. A second police investigation, triggered by information emerging out of Family Court procedures, uncovered repeated abuse of a number of children by members of Family S, a family where sexual abuse of children had become normalised over at least three generations. All of the children are white British. Read full overview	• need to develop knowledge of sexual abuse in relation to disabled children and ways to provide opportunities for non-verbal children to communicate • the impact of gender on the on the response of services. The review followed a systems-based methodology. **Recommendations:** • develop skills and knowledge in communicating with children who disclose sexual abuse • embed understanding of grooming and sexual offending in practice • ensure a clear pathway is in place for identifying and working with complex intra familial sexual abuse. • Model: uses a systems-based methodology.
2020 – Kent – Child I: Carys Death of a 16-year-old girl in 2017 by suicide.	Carys and her sister lived with their mother and stepfather and his two children. Carys experienced anxiety and was in receipt of mental health services. Early in 2017 Carys and her sister disclosed to their mother that their stepfather had been sexually abusing them; he was arrested and has subsequently been convicted for the offences. Following the disclosure and investigation, but	**Learning:** • initial responses to disclosures of child sexual abuse • use of child sexual abuse pathways and associated support • responses to the mental health needs of Carys • education settings being identified as key safeguarding partners • sharing of adult safeguarding information and concerns • accurate record-keeping by professionals

	before the criminal trial, Carys took her own life. Ethnicity or nationality not stated. Read full overview	• follow-up for children not brought to health appointments. **Recommendations:** • to require an audit of strategy meetings to ensure participation from partners is sufficiently inclusive, follow up is occurring as necessary and effective information gathering and sharing is taking place • ensure rigorous promotion of the role of the Sexual Assault Referral Centre to ensure victims of sexual abuse, including non-recent abuse, are being offered holistic support • explore ways to widely promote existing pathways and opportunities to respond to mental health issues in children and young people, including the policy to manage self-harming and suicidal behaviour • request assurance from health partners that missed health appointments for children are subject to robust and consistent follow up.
2020 – Salford – Helen Delay in responding to potential trafficking of a female child in 2019.	Aaron and Helen, both African, presented as homeless, Aaron applied for accommodation. Housing raised concerns with children's social care and police that Helen, 24-years-old according to Aaron, was a child. Helen was removed under Police Protection Powers and placed in foster care in June 2019. An age assessment of Helen resulted in an age of 12-years-old assigned to her. Aaron was arrested for trafficking offences.	**Learning:** • immigration identification documents are not evidence-based • need for professional curiosity • need for professional advice in a timely manner and to escalate concerns to enable a multi-agency approach • need for a multi-agency approach to age assessment and to have a pathway to resolve disputes on the presenting age of an individual

	Read practice review	• consider the child's views at all times. **Recommendations:** • Local Safeguarding Partnership to develop effective multi-agency pathway and deal with risk of child trafficking • UK Visas and Immigration to ensure robust identification procedures and have a consistent approach to directing practitioners with concerns if someone with an adult ID is thought to be a child.
2020 – Southampton – Freddie Sexual abuse of a boy under 8-years-old from January 2014 to October 2016.	Freddie lived with his mother and two older half-siblings who were known to children's services due to concerns including neglect and physical abuse. Evidence of sexual abuse of Freddie's half siblings by their father. Freddie's mother started a relationship with a person posing a risk to children. The children were made subjects of Child Protection Plans under the category of sexual abuse in June 2014. Accounts of Freddie displaying sexually inappropriate behaviours at pre-school; excluded from school in June 2015 for displaying aggressive and sexualised behaviours. In March 2016, Freddie was taken into local authority care due to neglectful parenting. Whilst in care Freddie made statements about sexual abuse that had taken place within the	**Learning:** • importance of management support and supervision when working with intra-familial child sexual abuse • the value of seeking additional input from specialised services in helping professionals remain objective and child focused • not letting biases of professionals towards parents hamper judgements and undermine decision making. **Recommendations:** • ensure that the plans for children subject to Child Protection Plans are fit for purpose and have pace • examine blocks and barriers to effective multi-agency work around the issue of child sexual abuse • increase the knowledge and confidence of practitioners in assessing and working with cases involving child sexual abuse.

	family, and in October 2016 he was made the subject of a final Care Order. Read full overview	
2020 - Waltham Forest – Child C Death of a 14-year-old boy in January 2019	Child C was stabbed by four men, one of whom was sentenced to life imprisonment. Child C was the youngest of three children. His parents separated after he was born, and he was brought up by his mother. Child C was Black British of African Caribbean heritage. Child C's early life was in the East Midlands. He had a troubled time at secondary school and was home educated by his mother from the age of 12. Evidence of access to and threats to use firearms. His mother felt he was being groomed and the family moved to Waltham Forest in April 2018. Child C was arrested in October 2018 in a flat in Bournemouth in possession of Class A drugs. Evidence that Child C had been a victim of criminal exploitation for a considerable time by the time of his death, and that this became significantly greater in the autumn of 2018. Read full overview	**Learning:** • time spent out of school constitutes a significant risk to children who are vulnerable, and the current arrangements governing home education contribute to this risk • failure to capitalise on a 'reachable' moment for a child who was being criminally exploited. **Recommendations:** • the government to review the guidance on home education • the implementation of a national system for responding to exploitation of children by county lines gangs • a review of arrangements for recovering children to ensure they are brought back by adults with skills relevant to working with children who are being criminally exploited.

BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Anonymous – Young Person B Self-harm of a young female in June 2018.	Young Person B took a significant overdose of her prescription medication, alongside over the counter medication, which caused a brain injury. Young Person B was subject to periods of abuse and neglect from an early age. She lived with her family until October 2017, when she moved in with the mother of her boyfriend in an informal arrangement. Disengaged from education early in 2017; prior to the overdose some instances of less serious self-harming. Ethnicity or nationality not stated. Read summary report	**Learning:** • importance of ensuring representation from schools at child protection conferences and in core groups even when the child or young person is not attending school • importance of reviewing the impact of child protection plans • the need to risk assess access to prescribed medication for children and young people who self-harm • importance of understanding the potential adverse impact of private fostering arrangements not being assessed on the young foster person and on other children in the family • persistent fear and anxiety caused by childhood neglect impacts on children's ability to learn, solve problems and relate to others, which undermines their ability to manage further adversity in adolescence. **Recommendations:** • ensure practitioners understand the features of adolescent neglect and review the effectiveness of local approaches in addressing both chronic and acute factors • ensure that the voice of the child is more consistently acted upon • ensure private fostering is more effectively publicised across the partnership and children are identified, assessed and

		supported in their private fostering arrangement.

HOMICIDE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Hillingdon – Child X Death of a 7-year-old boy in December 2016.	Emergency services found Child X and Mother deceased at Mother's home address. Inquest concluded Child X was unlawfully killed, and Mother died by suicide. Family moved to England in 2011 for work. Mother worked as a nurse; history of alcohol dependency and mental health problems. Had contact with Police following a rape allegation in 2015. Mother's hospital employment terminated in 2015. School concerned about Child X's appearance and attendance; referrals made by family and school about Mother's wellbeing. Mother reported to cousin that she was going to take her own life and that of Child X. Father reported Child X as missing after he did not attend school and being unable to contact Mother. Family is Irish. Read full overview	**Learning:** • information sharing within police did not always work well and information about Mother and Child X was lost • information held by friends and family should be taken seriously and support given to help them share information • lack of focus on the potential impact of Mother's alcohol use and mental health on her role as a parent and a nurse. **Recommendations:** • guidance from the College of Policing should be unambiguous that, in cases of sexual assault, a victim care plan should be delivered by the police force where the victim resides • GPs should always ask patients whether they have any dependants when alcohol misuse is a problem • consider with national organisations whether a helpline for families concerned that a child is at risk could be developed.
2020 – Hull – Child H Death of a 9-month-old child in February 2014 as the result of a hypoxic brain injury.	Mother convicted of causing or allowing her child's death; her male partner was convicted of murder.	**Learning:** • need for multi-agency collaboration, assessment, managerial oversight, supervision and challenge

	Mother and her partner both known to health, children's services and the police. Initial assessment by Children's services; no further action taken. Maternal history of premature birth; partner history of domestic violence towards two previous partners. Ethnicity or nationality of Child H is not stated. Read full overview	• if duty officers in children's services do not routinely communicate with the referring practitioner before making decisions about a referral, misunderstandings can occur and this leaves children vulnerable • need for agreements and plans to be monitored, reviewed, checked and shared with other agencies • all family members, especially those living in the household, should be subject to assessments, both to determine risk and to confirm and assess their ability to protect children in the family • need to engage men • unaddressed domestic abuse can leave some children vulnerable and with ineffective help. Makes no recommendations but sets out questions and issues for the safeguarding board to consider around practice, procedures and strategies.
2020 – Manchester – Child U1 Death of child under 3-years-old in January 2018.	A post mortem concluded that the death was a result of internal bleeding caused by significant trauma impact to the abdomen. Partner of Child U1's childminder was found guilty of the child's murder, and the childminder was found guilty of causing or allowing the death of a child. Both received prison sentences.	**Learning:** • a decision that the injuries were due to a medical cause rather than NAI meant professionals did not query an alternative diagnosis • deference to the medical clinicians involved made challenging medical professionals difficult. **Recommendations:**

	Child U1 was born in March 2016 and had an older sibling who was under 4-years-old at the time of their death. Child U1's father had no contact with the family. Child U1 first attended hospital with an episode of minor gastro-intestinal bleeding in April 2016. There were frequent hospital visits in 2016/17 including surgery; initial concern regarding non-accidental injury (NAI) but this was discounted, and a medical cause was thought to be responsible. A strategy meeting concluded that there were no safeguarding concerns in relation to Child U1. Family are Mixed Race British. Read full overview (PDF)	• highlight the need for professional curiosity, professional challenge and information sharing within and between agencies • assessments to include an understanding of care arrangements and an assessment of the carers • an understanding of differential diagnosis, and when bruising is present where NAI should be considered
2020 – Warwickshire – Alice and Beth Death of two sisters aged 3- and 1-years-old in 2018	Alice and Beth died within two weeks of each other. Police investigation revealed the cause of death to be interference with the normal mechanics of breathing. Mother was convicted of murder and imprisoned. Alice and Beth's parents had separated before Beth was born. Mother was in a new relationship before Beth's birth. Alice had attended A&E previously for injuries and seizures. Several accusations of alleged abuse were made by both parents and mother's partner, as well as arguments over contact with Alice and Beth. Numerous reports to Children's Services, the police and the NSPCC were also made.	**Learning:** • where a family moves between areas, the new authority and relevant partners need to be informed • where possible more information should be achieved and explored when referrals come to the multi-agency safeguarding hub (MASH) to better understand the nuances of the referral • when concerns raised about parents can be easily refuted there is a danger that professionals can be prone to dismiss other information in the same vein. **Recommendation:** • encourage professionals to adopt an investigative, questioning and professionally

	Ethnicity and nationality not stated. Read full overview	curious approach when considering the history of a case • seek reassurance that the West Midland Regional Safeguarding Network policy on 'Protecting Children who move across Local Authority borders' is understood and adhered to • be assured that GPs are clear on the pathways and procedures for making timely referrals to Children Services.

ADULT - NEGLECT		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Portsmouth – Mr D	Mr D has a learning disability and at the age of 11 he became a looked after child due to neglect and his parents' inability to support his nutritional needs. He weighed 16 stone 7 lbs and required oxygen at night due to health conditions linked to his obesity. Mr D successfully lost weight and by the age of 17 he was no longer obese and no longer required oxygen at night. As Mr D approached 18, there were instances of unplanned contact with his mother. He showed signs of becoming anxious and distressed and there were instances where he self-harmed and went missing. He remained in foster care until the age of 18 when he was deemed to have the capacity to choose to return to the family home. Foster carers and professionals expressed concerns about his mother's behaviour and her capacity to change. After returning home, Mr D had a significant number of contacts with the Emergency Department, the 111 service Out of Hours GP and the minor injuries unit. His college attendance reduced, and his weight increased significantly. Professionals found it difficult to engage with Mr D and his family, with appointments frequently being missed or cancelled by his mother. Three years after returning home, D was admitted to hospital with back pain. At this time he weighed 29 stone. Pressure areas were noted, and Mr D was not	**Learning:** • Agencies did not help Mr D to express what his desired outcomes were from the support he was offered. He was not empowered to participate in assessments, to make decisions, or to safeguard himself. He was not supported by an advocate at transition or at other times. • There was an apparent lack of recognition of the long-term impact of abuse and neglect on the survivor's physical and mental health and their social functioning. There was no evidence of work being done with Mr D either as a child, during the Transition Process or as an adult to enable him to understand his early experiences of neglect and to be aware of their implications for his future in order to empower him to minimise their impact. • There were obstacles to people with learning disabilities experiencing good health outcomes -the circumstances that led to his removal from his family as a child did not lead to any substantial action when he became an adult, despite a range of agencies being aware of them.

	complying with advice on eating, drinking and mobilising. His mother continued to intervene in Mr D's health care and provide unsuitable food and drinks. Following Mr D's discharge from hospital professionals remained concerned about the home environment. On some occasion's dressings were unavailable and suitable pressure relieving equipment could not be sourced. A number of safeguarding concerns were raised to the Multi-Agency Safeguarding Hub. Three months later, Mr D was admitted to hospital on an emergency basis, with a grade 4 pressure sore and osteomyelitis. It was deemed by all professionals that it was not safe for Mr D to return home. Mr D was judged to lack capacity to make informed decisions about his health needs and was discharged to a residential placement. Mr D Executive Summary	

ADULT - SELF NEGLECT AND HOARDING		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Hampshire – Elizabeth	Elizabeth was known to a number of different agencies since the early 2000s. Elizabeth was sadly found deceased at her home in 2019. The last confirmed sighting of her was around six weeks previously. A post-mortem examination was inconclusive as to the cause of her death and an open verdict was returned at the Inquest.	**Learning (Multi-Agency):** • Agencies making safeguarding referrals to the local authority neither sought nor received feedback of action taken by the local authority. This meant that agencies involved with Elizabeth were unaware of what steps, if any, had been taken in response to the referrals. This issue has been identified in a number of other statutory reviews by the board and may reflect that

	The house where Elizabeth had lived alone for the last thirty plus years, was found to be derelict and subject to an extreme level of hoarding. **Elizabeth SAR 6 Step Briefing – HSAB December 2020**	capacity and workload within the Hampshire multi-agency safeguarding hub prohibits the flow of such information • No agency considered whether or not there were any other individuals living within the home that may have been impacted by the circumstances • There were gaps in knowledge of legal frameworks available to agencies to allow them to respond appropriately • Agencies did not appear to have sought specialist safeguarding advice in relation to hoarding and self-neglect. • Experts from Housing advised of the need to learn from previous cases including the need to think creatively about methods of engagement with individuals away from the home. • There was no structured approach, across the agencies, in managing disengagement. • There were missed opportunities to refer the case to the local Partnership Action Groups (PAG) for consideration of a coordinated response – possibly by utilising the Multi-Agency Risk Management (MARM) process. • Gaps were evident in relation to embedding the Mental Capacity Act as everyday practice. • There appeared to be an absence of professional curiosity when attempting to converse with Elizabeth to explore the underlying reasons for her disengagement and reluctance to resistance to contact. • Elizabeth's family expressed that they wished they had been contacted by agencies as her

		situation deteriorated so they could have had an opportunity to reach out to her to offer support. It is recognised however, that this can be a difficult area for professionals to navigate when the adult has chosen to maintain a distance from family.

ADULT – PHYSICAL ABUSE		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**

ADULT - BEHAVIOURAL/MENTAL HEALTH CONCERNS		
CASE	**KEY ISSUES**	**LEARNING & RECOMMENDATIONS**
2020 – Norfolk – Ms F and Mr G Deaths of a woman (Ms F) and a man (Mr G) who lived in a Norfolk care home.	**Ms F** lived with dementia as did **Mr G**. The two residents were not related to each other in any way, and their cases are quite different. However, there are overlaps in a number of the learning themes, and NSAB agreed it would be beneficial for both cases to be reported in a joint report. **Ms F** lived in a Norfolk care home. She had lived in the care home for a number of years. The focus of this SAR begins in **June 2017** after a male resident (Mr Z) moved into the care home as a private placement. Soon after Mr Z arrived at the care home, he began to demonstrate challenging behaviour, including resistance to personal care, shouting and verbal aggression. Within a short time, this developed to include violence towards staff members, and then to other residents.	**Learning:** • the process of assessment and response to mental capacity • inter-agency working and communication between professionals and organisations • the process by which care needs are assessed in a hospital environment • the need for professional curiosity • the way in which challenging behaviour is assessed and managed • the recording of safeguarding data

	Violent behaviour included hitting or punching residents in the face/head. In **December 2017** he pushed over Ms F who hit her head as she fell to the floor and fractured the neck of her femur. Ms F was taken to hospital for surgery, where she remained over the Christmas period. Mr Z was detained under the Mental Health Act 1983. Ms F returned to the care home in January 2018. By this stage, the incident and subsequent surgery seems to have set in motion a chain of deterioration in Ms F's physical and emotional health. Although it is not for the SAR to consider causation of Ms F's death, it appears important to note Ms F's death occurred some weeks afterwards at the care home on **31 January 2018**. **Mr G** was an elderly man with dementia and a range of other health conditions. In **June 2017** Mr G was admitted to an acute Norfolk hospital following an incident in a previous care home which led to him falling and sustaining an injury (not a fracture). While in hospital his behaviour became more challenging, leading to his detention under the Mental Health Act 1983. Mr G was admitted to a psychiatric hospital outside of Norfolk as there was not a bed available at the time in Norfolk. Shortly after arriving at the psychiatric hospital Mr G was admitted to the local acute hospital with a suspected infection and dehydration. After treatment there was a rapid improvement in the behavioural elements of his presentation.	

	Overall, despite it being an out of area placement, Mr G appears to have had a relatively positive experience of care. In **mid-August 2017** Mr G was transferred back to a Norfolk psychiatric hospital and his experience of this hospital also appeared broadly positive. Hospital staff seemed to understand well Mr G's care needs and demonstrated an ability to develop and implement an appropriate plan for managing his physical health and behaviour. The care home had significant difficulties in effectively managing Mr G and providing him with adequate care. Personal care was often refused by Mr G, or delivered under challenging conditions. The Dementia Intensive Support Team (DIST), who remained in contact with Mr G, noted concerns about the care home's ability to safely manage Mr G but this was not flagged as a safeguarding referral. Despite their concerns, DIST proposed to discharge Mr G to the care of his GP, based on an apparent improvement in his presentation. The relationship between Mr G's family and the care home broke down over the next 3 days regarding Mr G's care. There was significant concern for Mr G's physical health and a paramedic was called who arranged for Mr G to be admitted back to hospital. The ambulance crew who admitted Mr G to hospital were so concerned about Mr G's physical state that they made a safeguarding referral, querying the possibility that Mr G had experienced abuse and neglect. The care home	

	has disputed the concerns documented by the ambulance service, stating that these concerns were simply those relayed by the family**.** Mr G sadly died in hospital 3 days later on 22 November 2017**.** SAR Ms F & Mr G Executive Summary	
2020 – Hampshire – Sasha Fatal overdose of 20 year old	Sasha was 20 years old and had a long history of mental health illness and missing episodes since the age of 15. Before her death, she was under the care of several health services and as a child had been supported by the Child and Adolescent Mental Health Team (CAMHS). On the evening she died, Sasha was found in a serious condition by a lake in a country park close to where she lived. She died shortly afterwards in hospital from a suspected overdose of propranolol. The Coroner confirmed that Sasha died as a result of suicide following a deliberate fatal overdose of propranolol tablets. Sasha had a longstanding difficulty with her mental health and well-being that led to several diagnoses from childhood into adulthood. She found transition from children's services into adult services particularly difficult appearing to trigger an escalation of stresses and self-harm behaviours. Efforts to contain her stresses with various therapies and medications did not appear to alleviate her self-harm with overdoses and self-	**Learning:** • Young people benefit from clarity and flexibility in the transition process that is person centred but that work underway in the NHS 10-year plan could provide local solutions to improve practice. • Early recognition and diagnosis of Autism Spectrum disorders is vital to ensure right approaches and treatment. • There can be confusion regarding the status of a person subject to detention under the Mental Health Act as well as appropriate application of the Mental Capacity Act where a person is presenting with severe self-harm and suicide behaviour and is refusing treatment. • Professionals may benefit from guidance to support them with understanding advanced decisions and high risk and complex cases that they do not face very often.

	laceration. It cannot be underestimated how Sasha's extensive and very controlling OCD rituals and behaviours impacted on all efforts by professionals and her parents to find treatments and therapies that would be successful. Sasha SAR Executive Summary	
2020 – East Sussex – Ms C The coroner's inquest ruled that Ms. C's cause of death was a result of 'mixed drug toxicity'.	Adult C was found dead by a friend on 31st December 2017. Whilst the cause of Adult C's death was mixed drug toxicity, Adult C had experienced domestic violence and abuse on many occasions and at times she reported to feel suicidal. There was a complex interplay of many other factors in Adult C's life, and her presenting issues and vulnerability included: • Significant levels of domestic violence and coercive control • Poor mental health, including a history of depression and patterns of self-harm • Drug and alcohol dependency • Involvement in criminal behaviour leading to a short-term prison sentence in August 2017 • Periods of street homelessness and barriers in accessing housing provision Adult C Safeguarding Adults Review	**Learning:** Read Learning Briefing