SERIOUS CASE REVIEWS

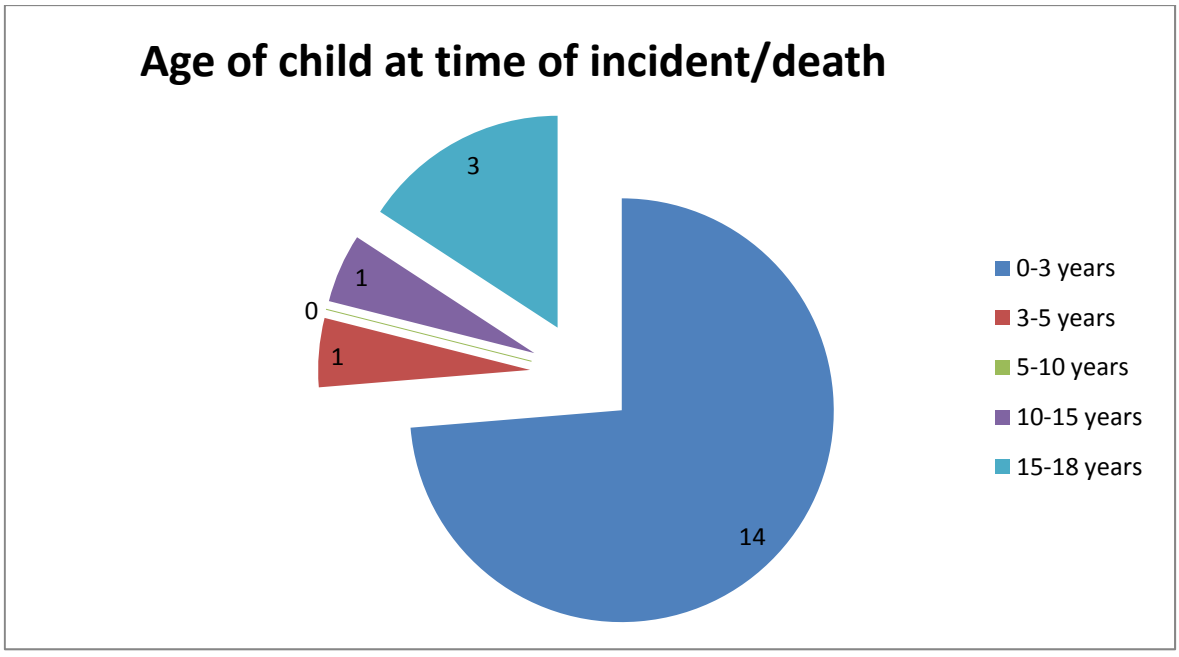
BLACKBURN WITH DARWEN, BLACKPOOL AND LANCASHIRE SAFEGUARDING CHILDREN BOARDS

REMEMBER – THE PROFESSIONAL LEARNING DETAILED HERE IS MULTI-AGENCY LEARNING. THERE WILL BE SPECIFIC LEARNING AND RECOMMENDATIONS FOR YOUR AGENCY AND YOUR PROFESSIONAL ROLE. ASK YOUR MANAGER OR CONTACT YOUR LOCAL SAFEGUARDING CHILDREN BOARD FOR MORE DETAILS.

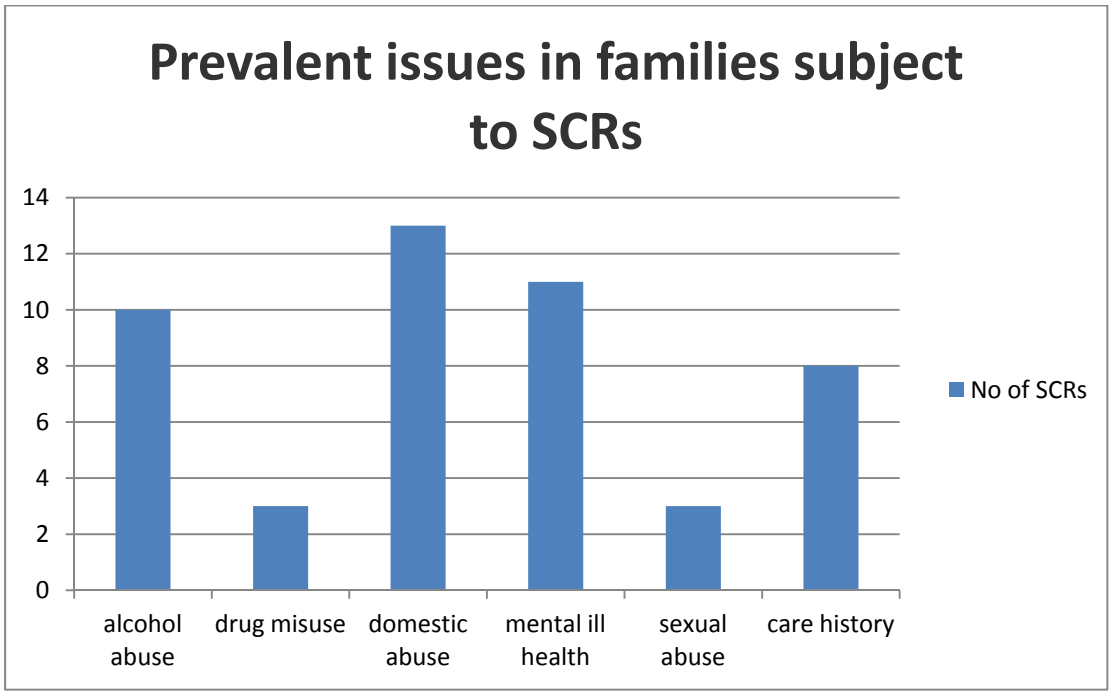
Since January 2007, the three Safeguarding Children Boards across Lancashire have completed 19 Serious Case Reviews. Blackburn with Darwen has completed 6 serious case reviews (SCRs), Blackpool 3 and Lancashire 10.

15 out of the 19 concerned a child aged less than 5 years, and 11 of those related to a child less than 1 year of age. This reflects national trends, as children of this age are more vulnerable because of their size, immobility (physical and social) and limited communication skills, amongst other reasons.

There are few cases in the age group 5 – 15 years, but 15 – 18 year olds are more vulnerable again, sometimes as a result of self harm or risky behaviour.



Out of the 19 SCRs, 14 involved the death of a child, whilst 5 related to a serious incident where there had been concerns about inter and intra agency working.



The issues that were prevalent in families that were the subject of SCRs again reflect national findings. The most prevalent issues in pan-Lancashire cases are mental ill health, alcohol abuse and domestic abuse. In most of the SCRs, there was more than one issue present, and alcohol abuse, domestic abuse and mental illness were often found together. Some of the parents involved in SCRs had a care history of their own, and associated issues resulting from this. Drug misuse did not feature as frequently as alcohol abuse, which is slightly different to the national picture where drug and alcohol abuse feature equally.

Neglect is an issue in many of the families that are the subject of SCRs, identified either before the incident/death or during the SCR itself. Many of the families live chaotic and complicated lives, which makes it difficult for professionals to obtain an accurate and full picture of what is happening.

Brief Details of Blackburn with Darwen Serious Case Reviews

SCR 1 (Executive Summary published on BwD LSCB website as NP)

The child was two months old at the time of receiving excessive paracetamol based medicine and died aged 3 as a result. The case review was initiated after the child's death. The child was in foster care at the time of the death. Mother had suffered post natal depression at the time of the poisoning and had administered too much paracetamol based medicine to the child.

Professional Learning

Lessons in this case were mainly for health agencies with a lesson for the Police and one multi-agency lesson. The multi-agency lesson focused upon post incident events and how confidential information came to the attention of the media. This resulted in the development of a multi-agency serious case review media protocol.

SCR 2 (Executive Summary published on BwD LSCB website as Baby Z)

The child was six months old when it sustained non life threatening injuries whilst in foster care. The case review was initiated due to concerns about multi-agency working in the case. Mother was in a violent and volatile relationship with the father of Child Z and had suffered significant domestic abuse in a previous relationship. The mother had a child from her previous partner and paternal grandparents had legal custody of the half-sibling. As a result of the domestic abuse suffered at the hands of Child Z's father, the mother was unable to care for Child Z and requested that the child be placed in foster care.

Professional Learning

Within Children's Services there were lessons for the social care and early years teams. There were also single agency lessons for health agencies, council legal team and CAFCASS.

Multi-agency lessons included ensuring the quality of analysis in statutory assessments. Related to assessments was a lesson about professionals being alert to the indicators of domestic abuse and understanding issues of emotional coercion and implications for the physical and emotional care of children whose parents are in a violate or violent relationship. A further lesson on assessments highlighted the need for them to be multi-agency in nature rather than only collate and assess single agency information.

SCR 3 (Executive Summary published on BwD LSCB website as Baby M)

The five month old child died and the serious case review was initiated as initial information suggested possible abuse and neglect. The coroner's inquest ruled that the child died of pneumonia. The child and half sibling were known to social care from their births and the mother had been known to social care in two local authority areas as a child. There had been long standing concerns about the appropriateness of care provided by the mother and father of Child M, with alcohol abuse, domestic abuse and post natal depression as factors in the life of the family.

Professional Learning

Single agency lessons were identified for Children's Services, Lancashire Constabulary, health agencies including an independent sexual health service provider and housing providers.

Multi-agency lessons included ensuring that the CAF, Child in Need (CIN) and Child Protection Plan (CPP) planning processes have robust procedures to monitor the effectiveness of services that are provided to families. The multi-agency recommendations concluded that the LSCB produces and implements a disagreement protocol to resolve disagreements between agencies about thresholds

and service provision. The case also highlighted that referral pathways to alcohol and drug misuse services were not clear across the LSCB agencies and recommended clear policies on this.

SCR 4 (Executive Summary published on BwD LSCB website as Child A)

The seventeen year old teenager died as a result of suicide and had threatened and made one attempt in the weeks before the death. The child's early family life was traumatic with domestic abuse and separation of the parents a feature. As a teenager Child A was homeless, accommodated by a neighbouring local authority and eventually moved to supported accommodation in Blackburn. Substance and alcohol misuse and emotional wellbeing were factors in this child's life.

Professional Learning

There were sixteen agencies involved in this case review covering three local authority areas. The key themes identified in this case review were:

· Lack of leadership and direction by all the statutory agencies;

· Failure to provide a full assessment of the child by a number of agencies;

· Failure by agencies to fulfil statutory responsibilities;

· Fragmented communication between agencies and between local authority areas;

· Lack of transition planning and care planning for the child, including a lack of engagement with the child.

SCR 5 (Executive Summary published on BwD LSCB website as Child J)

Child J was five weeks old when during a domestic violence incident the child sustained serious head injuries. Throughout the parent's relationship, J's mother had suffered domestic abuse with some violence, but had not disclosed this to professionals. There had been several call outs when the Police attended the home; J's mother was sign posted to services and generally declined any additional help. J's father had sought help with his anger but the referrals were not progressed. J's grandmother had also raised concerns about the relationship but the information was not clarified by professionals with the grandmother and the case closed.

Professional Learning

Lessons were identified for Children's Services, police and health agencies. Multi-agency lessons included the need to improve multi-agency domestic abuse risk assessments across all agencies and for all agencies to include historical information into the assessment of risk. To include current and historical information into assessments, agencies need to ensure all available information is shared. Assessments of adult victims of domestic abuse need to be separated from child risk assessments. Practice and knowledge in relation to specific aspects of domestic abuse (working with perpetrators; victims who deny abuse and where the denial poses a risk to the child) requires improvement and incorporated into policies and procedures.

SCR 6 (Executive Summary not yet published)

Brief Details of Blackpool Serious Case Reviews:

SCR 1 (Executive summary published on BSCB website as child B)

This young person was convicted of sexual assault and sentenced to 5 years in youth custody and five years extended licence. The offence was against a young child and committed whilst the subject was looked after and living in a care home.

Professional learning

It should be a matter of routine for any agency that comes into contact with a family who have moved into their area to seek and use historical information to inform their assessments.

Lack of clarity about alleged sexually harmful behaviour by children and young people should always be subject to rigorous attempts by all relevant agencies to gain as much clarity as possible so that intervention can be accurately targeted. Children who are alleged to have sexually harmed another child should receive a thorough assessment of their behaviour and needs so that this behaviour can be appropriately addressed. Safeguarding procedures have been revised to make it clear which parts of the multi-agency professional network are responsible for ensuring that this happens.

Risk assessments undertaken by all agencies must ensure that the assessments include both the risk posed by a young person and the risk to them.

From this review, a joint protocol was developed between Children's Social Care and Adult Mental Health Services for work with children and young people when parents are deemed not to have capacity under mental health legislation.

SCR 2 (Executive Summary published on BSCB website as Child F)

This case concerns a baby who died whilst in the care of a family member; the cause of the death was established as 'overlay'.

Professional learning

The Review concluded that although there were some examples of good single agency working practices, there were also a number of missed opportunities for agencies to work together and share information.

Professionals must ensure that they share information about the strengths and vulnerabilities of children and their families with partner agencies.

It is important for professionals whose primary client is the adult to be aware of, and pay attention to, the wider safeguarding issues for any child in the household.

It is essential that when police officers respond to calls for assistance regarding domestic abuse and antisocial behaviour, they not only ensure the immediate safety of family members but also identify and act upon any safeguarding concerns for the children present.

All agencies must ensure that assessments, monitoring and support include fathers as routine.

Key professionals should advise parents about safer sleeping arrangements for babies, emphasising that this applies not only when their baby is in their care but also when the infant is cared for by someone else.

SCR 3 (Executive summary NOT yet published)

This review is in relation to a baby who was the youngest of 3 children in the family; the cause of death was unascertained although co-sleeping may have been a factor in his death. The post mortem examination revealed that baby had some healing injuries to his ribs which pre-dated his death and were thought to be non-accidental; there had been historical child protection concerns about an older sibling before the family moved to Blackpool.

Professional Learning

8 key areas of learning emerged from this SCR. This included the importance of undertaking holistic assessments that reflect historical information about the family and previous child protection concerns. Assessments will be incomplete if professionals do not take steps to actively both share information with other agencies but also seek out information from organisations that it is known have had contact with the family in the past. Although it is important to offer support to young parents, it is important that this doesn't inhibit professionals from considering potential risks to the children in the family. There were concerns about the response to alleged domestic violence – when assessing allegations of domestic abuse, workers must ensure that they speak to the alleged victim in private. The importance of proactively engaging fathers in services is also reinforced from this review.

Finally, the experiences, characteristic, feelings and needs of the children in this family were hard to identify. It is therefore important that practitioners record *when* they see children through contact with the family and reflect the *quality* of such contact. A starting point is to develop a sound understanding of the child's day to day experience of life at home. Being interested in what happens in the child's day and what life is like at home helps practitioners to understand the child (or infant) as a real person along with their wishes, feelings and experiences.

Brief Details of Lancashire Serious Case Reviews:

SCR 1 (Executive Summary published on LSCB website as Child Z)

This two year old child fell out of their pushchair and into a canal, but was fortunately rescued in time. Mother had chronic alcohol abuse issues and the child had symptoms of foetal alcohol syndrome. Mother had shown a lack of engagement with agencies involved with her and her child. There was a history of domestic abuse and mother's parenting was variable. There had been significant involvement by a number of agencies with this family over a period of time.

Professional Learning

The focus of many professional interventions was on mother not the children. The assessments that were completed could have been more analytical – looking at the impact of the family's circumstances rather than just describing what was happening.

The assessments were not multi-agency and therefore did not reflect everything that was known about the family.

Communication between professionals was not as good as it should have been and the impact of the family's issues on the children was not fully recognised. Mother was given many opportunities to try again despite chronic alcoholism.

There were a number of professionals however that were commended for their ongoing efforts to support the family.

SCR 2 (Executive Summary published on LSCB website as Child C)

The mother of this one month old child tried to suffocate them, and she pleaded guilty to attempted infanticide. Mother had a history of significant alcohol abuse and there was also a history of domestic abuse and attempted suicide by mother. Mother had been in local authority care. Both parents had a long history of agency involvement due to their alcohol issues, depression and self-harming.

Professional Learning

Actions of agencies during the pregnancy focused on mother and her issues, especially her alcohol abuse and domestic abuse issues. The impact on the unborn child was considered but no referral was made to Children's Social Care regarding the concerning behaviour of mother.

Mother was intimidating and threatening at times and this made it difficult to challenge her behaviour.

Agencies worked in 'silos' during the pregnancy, unaware of the concerns and work of other agencies that were involved with mother. The GP was not asked for information despite significant involvement. Meetings and assessments, including strategy meetings, need to be multi-agency to ensure full consideration of the known facts.

SCR 3 (Executive summary published on LSCB website as Child A)

Child A was found dead in his room at a residential children's home in November 2006. He was found hanging by staff working at the residential unit. The coroner concluded at the inquest held into his death that he had intended to take his own life.

This child had been know to services for the majority of his life and as a teenager had spent a considerable amount of time being looked after by the Local Authority.

This SCR highlighted the importance of the looked after children (LAC) review when working with children who are looked after. If the review is to be effective and assist in the production of a meaningful care plan it is vital that all relevant agencies attend and contribute. Plans should not be allowed to drift, they must be child focused and be based on all relevant information being shared between agencies. Those agencies working with looked after children must also realise the importance of using the child protection procedures if they feel they are at risk of significant harm.

SCR 4 (Executive Summary published on LSCB website as Child D)

This two month old child was found dead in bed with mother in an apparent overlay incident. Grandmother to the baby had significant mental illness, and there were alcohol issues with mother and other family members. There were issues of violence within the family.

Professional Learning

There were issues that alcohol abuse by parent and family members was not assessed in terms of potential impact on the child. Family could be hostile and aggressive when challenged, which made it difficult to progress discussions with them.

Services working with adult family members did not fully assess the impact of adult issues e.g. mental illness on the children they lived with. They were adult focused rather than child focused.

SCR 5 (Executive Summary published on LSCB website as child F)

This 17 year old died as a result of a significant illness, but there were thoughts that the death may have been premature. Within the family there were issues of physical and sexual abuse, alcohol and drug issues and also criminal involvement.

Professional Learning

This case raised issues about how professionals assess risk to children with complex health or disability issues. Professionals need to be confident that they can identify and fully analyse risks to a child regardless of his or her health and disability issues. They also need to confident that they know how thresholds apply to a young person with disabilities or health issues who may be making their own decisions about their treatment and care.

There is a need to make sure that families can read and understand written information they are given – make sure you ask if they can read.

SCR 6 (Executive Summary Published on LSCB website as Child S)

This two month old died whilst on the sofa with mother as a result of an apparent overlay. Mother had a Care history, and issues with not attending appointments. There was a lack of stable housing and issues around isolation, anxiety, mental health problems and financial difficulties.

Professional Learning

This family moved within Lancashire on several occasions and there were issues with the information known to professionals not moving thoroughly or quickly enough. There were also incidents where information known was not shared between agencies, particularly between different parts of the health economy.

This case pre-dated the Common Assessment Framework. This family would have benefited hugely from a CAF assessment and a lead professional, by ensuring all information was shared and support was targeted as needed.

SCR 7 (Executive Summary Published on LSCB website as Child B)

This four year old child sustained a fracture following several incidents of bruising and injuries over a period of time. The Court felt that either mother or her partner could have caused the injuries.

Professional Learning

Where there are safeguarding concerns about a child, there must be a discharge planning meeting prior to the child leaving hospital. Children should be spoken to alone when they are old enough to communicate, to allow them to talk without fear or interference from other adults.

Whilst medical evidence of physical abuse is important, so too is the assessment of all the other family factors, and medical evidence should be viewed as an addition to other evidence. Non-resident fathers should be included and involved in assessments when it is possible to do so.

SCR 8 (Executive Summary published on LSCB website as Baby M)

This 7 week old child was in hospital having treatment for a Urinary Tract Infection when she arrested and subsequently died. Her young father was found guilty of her manslaughter, and it was discovered that she had a number of fractures of varying ages at the time of her death.

Professional Learning

Referrals to other agencies should always be done in writing, or followed up in writing if the need is for an urgent verbal referral. That way, the referral is not misinterpreted or lost. The Common Assessment Framework should be initiated in families where there are thought to be additional needs, to ensure support is coordinated. Some agencies worked in 'silos' – in isolation from one another, and they did not share what they knew.

Once your assessment is completed, don't make it static. It should change as new information comes to light, and re-assessment will be needed. Don't forget to consider and include fathers, and young parents could be children in need in their own right. However, the focus of any assessment needs to be the safety and well being of the child.

SCR 9 (Executive Summary published on LSCB website as Child AB)

This fifteen month old child died after fitting at his home whilst in the care of his mother's partner, and he was subsequently found guilty of murder. Mother had a troubled history and her two older children lived elsewhere, but mother's partner had no concerning history whatsoever.

Professional Learning

Assessments need to be analytical, not simply describe what is happening. The analysis has to focus on the impact of the family's circumstances on the child.

If families move between Local Authorities, information needs to be transferred, or sought. In the same way that you would search your own agency's historical records, you should contact agencies in other areas to do the same.

A family's history must be taken into account when analysing risks to a child.

When involved with families, make sure you ask who is living in or visiting the household, and strive to find out about their suitability; particularly when families have already been identified as vulnerable.

SCR 10 (Recently completed but not yet published)

This serious case review cannot be shared in detail yet as there are ongoing issues that prevent this from happening.

FINDING OUT MORE ABOUT SERIOUS CASE REVIEWS

If you would like to read more about why we undertake Serious Case Reviews and how, please visit the Department for Education website (previously the Department for Children, Schools and Families) and view Working Together 2010, chapter 8.

Department for Education website - www.education.gov.uk

Look out for updates on your Local Safeguarding Children Board Website:

Lancashire Safeguarding Children Board Website - www.lancashire.gov.uk/corporate/web/view.asp?siteid=3829&pageid=20739&e=e

Blackburn with Darwen LSCB website - www.lscb.org.uk/serious-case-reviews

Blackpool Council website - www.blackpool.gov.uk/Services/S-Z/SafeguardingChildrenBoard

Serious Case Review Briefing

Blackburn with Darwen, Blackpool and Lancashire Safeguarding Children Boards

Time	What
9.00	Arrival, registration and coffee
9.30	Introduction to the briefing
9.40	What is a SCR?
10.00	Regional and local picture
10.15	The main themes
10.45	**Coffee**
11.00	The main themes continued
11.30	Practice Lessons
12.15	Action Planning
12.30	**Finish, Action Planning & Certificates**

Questions for Hypothesising and Reviewing Hypotheses

The intention is that these questions are used as triggers to help practitioners reflect on whether they have explored all possible hypotheses during an assessment and have explained this thoroughly in their assessment report.

1. **Hypothesising at the Early Stage of Involvement**

- Can you develop some hypotheses - at least four? (More if you can - keep them broad, not just single-incident based ones.)
- What knowledge and information are the hypotheses based on (for example, theory, research, observation, assumptions, information given, hearsay)?
- What actions could you take to test out your hypotheses?
- Can you construct an action plan for testing them, with timescales identifying the methods you will use?
- Who will be involved in gathering information to test out your hypotheses?
- How will you seek evidence to disprove (disconfirm) your hypotheses?
- What will you use to help you decide how to weight the value of different hypotheses?

2. **Reviewing hypotheses Mid-Way through on Assessment**

- Have you been able to test out all of the original hypotheses
- Are you satisfied that you have tested the hypotheses rigorously and you haven't simply sought out information to confirm your original hypotheses?
- Of the original hypotheses, which have you discarded and why?
- Have any new hypotheses emerged?
- What methods are you going to use to test out the new hypotheses?

3. **Evaluating hypotheses Towards the End of the Assessment**

- Are you satisfied that you have tested all the available hypotheses sufficiently rigorously?
- Are you able to demonstrate, in your assessment report, the methods you have used to test out the hypotheses and why you have discarded or retained each one?
- Are there some hypotheses that you have not been able to test out because of the unavailability of sufficient information or lack of time or access to key people?
- If so, are further enquiries indicated beyond the point of this assessment?
- If so, what form do you recommend these should take?

Hypothesising exemplar

Hypotheses	Methods for Testing Hypotheses
Domestic violence	Ask each parent. Alone. Physical evidence? Talk to older children. Check with Police and CIS / ISSIS, check other agencies, investigate previous relationships, talk to extended family
Overlay is a possibility	Check the sleeping arrangements, temperature of the room, parent's understanding. Parent's capacity for rational actions at all times
The parents' histories are affecting their parenting	Take a full history from parents, grandparents and check out facts with agencies where possible
Some other possible hypotheses:	
There is likely drug/alcohol abuse	Ask parents. Ask others. Check for involvement with substance misuse services. Check with police. Check with grandparents/ neighbours. Use the SCODA assessment framework.
There might be attachment issues for this baby	Careful assessment of parents' understanding of baby's needs. Do they understand the baby as having separate needs? Do they respond consistently to expressions of need? Use Fahlberg checklists.
Neglect might be happening	Check baby's physical presentation. Check food and hygiene in the home. Check stimulation for baby. Use graded care profile.
Mum is depressed (post-natal depression?)	Use Edinburgh scale (HV), use DOH adult wellbeing scale or other similar. Ask mum. Liaise with other agencies
Financial difficulties. impact of poverty	Talk to parents. Look at financial information, check benefits take-up / entitlement etc
On the run from CP registration / Plan in another authority	Check with agencies and authorities

Professional Dangerousness

Key examples of professional dangerousness

1. Rule of optimism: Professionals tend to want to believe that all is well for the child. Even when the indicators of abuse are visible there is a tendency to explain them away and be convinced that the child is safe. This is a form of denial and probably the most common form of dangerous practice. In one case the social worker saw the child looking sick but afterwards saw her with the family on an outing. He allowed himself to believe the latter to be proof of the child's safety and thought his original concerns to be unfounded.

2. The Stockholm syndrome: This theory is based on hostage situations where the people taken hostage begin to identify with the cause of the terrorists. It is a survival mechanism common in child abuse cases. Sometimes a parent or abuser is powerful ' and intimidating, perhaps critical of professionals and the worker will begin to see the adult's point of view rather than the child's. It is one way that the worker feels safe at the expense of the vulnerable child.

3. Professional accommodation syndrome: The worker may mirror the child's retraction of abuse, deny the reality of the abuse and be keen to be persuaded that any allegation by the child must be suppressed. Any other possible reason for the abuse will tend to become accepted in preference to considering the possibility that abuse has occurred.

4. Exaggeration of hierarchy: Adults of low status who report abuse may not be heard or taken seriously even though they may be close to the child e.g. neighbours, friends or a nursery worker. A psychiatrist, lawyer or paediatrician will probably get their important opinions heard more readily by other professionals. In one child abuse scandal the cook in the children's home had a wealth of information about the child abuse taking place but was not interviewed by the inquiry.

5. Concrete solutions: Professionals respond swiftly to abuse situations with practical solutions such as housing, washing machines, or money rather than by investigating and attempting to verify the alleged abuse.

6. Assessment paralysis: Sometimes professionals feel helpless and incapacitated. It might be thought that change is hard to achieve because the family have always lived in an abusive way and it

is just their way of life. Chronic neglect and inter-generational sexual abuse are often ignored because of this attitude.

7. Stereotyping: Professionals may make assumptions about how families bring up their children. These may include cultural stereotypes. In one case the stereotype of the black grandmother being able to cope with every situation falsely portrayed her as a protector of the child against a powerful and abusive adult within the family.

8. False compliance: Parents may be able to convince professionals that they are cooperating to protect the child but in fact a skilled practitioner who can analyse parental behaviour will be open to considering the possibility of them being abusive. Professionals may become enmeshed with the family and be so collusive with the carers that they do not see the needs of the child.

9. Omnipotence: Professionals believe that they know the best interests of the child and will not revisit their perceptions in the light of new evidence.

10.Closure: Families may shut out professionals. Calls go unanswered, appointments are missed, curtains are closed and doors locked. Child deaths from abuse are often preceded by closure. This dynamic may be mirrored by professionals avoiding contact with the family.

11.Role confusion: Professionals may be unclear about tasks and assume that someone else is responsible for protecting the child. In child protection everyone has prime responsibility for the safety of the child. Clarity of decisions is essential. In one case a health visitor said she would see the baby and the social worker assumed that the health visitor was visiting the home. Instead, she was seeing the baby at the clinic and no-one saw the appalling conditions in the home.

12. Children unheard or parent and carers unheard: Every child abuse inquiry highlights the central importance of listening to the child. Although children do find it hard to speak of abuse it has been shown that prior to a child's tragic death they have often forewarned someone in authority about the risk. Similarly prior to fatally harming a child, carers often raise the alarm by telling a professional that they are afraid of hurting the child or they cannot cope.

13. Information which is emotional, recent and vivid takes precedence over the old: Inquiries inevitably demonstrate that there was, among agencies, a great deal of knowledge and understanding about actual or potential harm to the child. New information must be examined

in the context of prior facts, The importance of chronologies to allow analysis cannot be over emphasised. This information must be transferred as a family moves between authorities. This is sometimes referred to as **The Start Again Syndrome** which prevents practitioners from having a clear understanding of a case based on past information (Brandon et al., 2008: 11).

14. Non-compliance with statutory procedures: Inquiries commonly report that legislation, policy and practice are sound but that professionals did not comply with their implementation. When child protection procedures are in place such as conferences and strategy meetings, children generally become safe. Formal procedures allow for collation and analysis of all available information.

15. Unsafe Practices: Professional is unclear about Safe Working Practices. Examples could be using their own home as a venue to meet the child, giving children gifts based on favouritism, using personal 'e' / 'online' spaces or mobile phones to contact children, discussing their own sexual relationships, having inappropriate physical contact (eg 'Horseplay') or visiting a child's house unannounced to see the child alone, not recording contacts, not letting managers know when another member of staff does not follow procedures.

Handout: Dealing with Angry and Aggressive People

The first and most important point is to keep yourself safe, and remove yourself from any situation that feels unsafe. Check out your agency guidelines about personal safety. But if you find yourself in a situation with an angry person, the following tips may help to calm the situation if it is safe to try.

1. Hear the person out

Don't interrupt or try to make your point. Instead, listen attentively, using head nods or short verbal statements like "Uh-huh" or "I see" to encourage the person to continue to talk.

2. Keep asking for elaboration and clarification

Keep a cool head. Realize that when you show that you are open to hearing and understanding what the person is saying, this will eventually encourage the individual to calm down. You may ask questions like, "Then what happened?"

3. Consider taking notes

In some cases this can be helpful, if you say something like, "I want to be sure that I understand your main points, so would you mind if I take a few notes while you tell me about it?" This sometimes has a way of slowing what the person is saying, and it may tend to cause him or her to be less raging.

However, the note-taking strategy must be used with caution, because at times it could make the person even angrier, especially if they're tending toward suspiciousness and paranoia about your motives.

4. Show concern on your face

Your facial expressions should be attentive and concerned. Indicate your interest in what the person is saying by maintaining a pleasant, relaxed facial expression and a steady (not staring) gaze.

5. Keep your voice tone soft

Never raise your voice volume so that you can be heard over a person who is yelling. This will only make the other person yell more loudly! Instead, lower your voice tone even below your normal range. The natural effect of this is that the other person will also speak more softly.

6. Paraphrase and summarize what the person has said

In an attempt to show to the person that you are listening and trying to understand, you might say something like, "Let me see if I have the main points that are important to you"…(then proceed to summarize those in your own words)

7. Do not argue

An argument occurs when you listen to what the person is saying with the intent of finding the weakness in it. You then begin to rebut their statements, often interrupting to do so.

8. Empathize with the person's feelings

You might say something like, "I can see how you would be really frustrated. In situations before where I felt that I was cut off and my opinions didn't matter, I felt frustrated, too."

9. Ask if the person would be willing to hear some additional information

This is where you begin to share your side of the story. You are saying something like, "Would be it all right if I shared with you some other facts that may give us a part of the total picture?"

10. Ask what he or she thinks would make the situation better

Very often the person is so consumed with the expression of anger; he or she has not really paused to think about what can be done now to improve the situation. Openly asking the individual for suggestions for improvement can begin to move the situation toward a problem-solving mode.

11. Add your suggestions

If the person has not offered constructive suggestions, but insists on continuing the attack, you may want to suggest something that could make the situation better.

12. Make an action plan; restate it for clarity

If you have been able to agree on some action steps, be sure that you both restate those steps to ensure that you understand your agreement the same way.

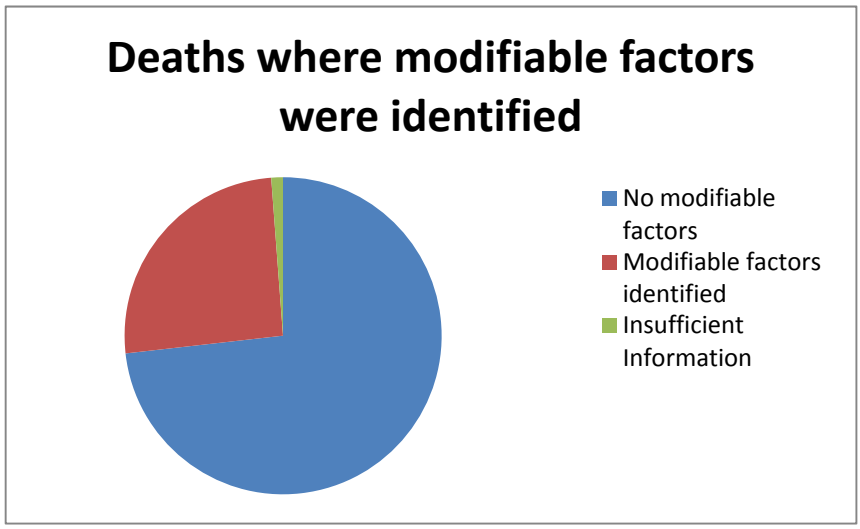
Child Death Overview Panel Newsletter

What is the Child Death Overview Panel (CDOP)?

The Child Death Overview Panel (CDOP) is a multi agency group responsible for reviewing all child deaths. The Panel is a sub group of the Local Safeguarding Children Boards. The deaths of all live-born children 0-18 (excluding infants live-born following planned, legal terminations of pregnancy), are reviewed by the Child Death Overview Panel in line with Working Together to Safeguard Children (2010).

What have the CDOP found out?

Since establishment of the CDOP in April 2008, the Panel have reviewed the deaths of 339 children. From these reviews the Panel have identified that in 86 deaths there were one or more factors which could have been modified to potentially prevent the death. In 10 or more cases domestic abuse, co-sleeping



(on a bed or sofa), substance misuse (of child or carer), alcohol use / misuse (of child or carer), child or adult mental health problems and road traffic collisions were identified as modifiable factors. Other factors present in 6 or less deaths, include chaotic home environments, overheating, life-limiting conditions (or children with complex needs), smoking in the household and bullying. A

further 40 modifiable factors were identified that fall into three broad groupings:

- Access to medical advice – either carer's delay in seeking medical advice, advice not available or inappropriate at that time.
- Environmental Factors – such as security issues around water or child dying abroad where medical advice was not available
- Communication & information sharing between professionals – inter or intra-agency communication

Expected or Unexpected?

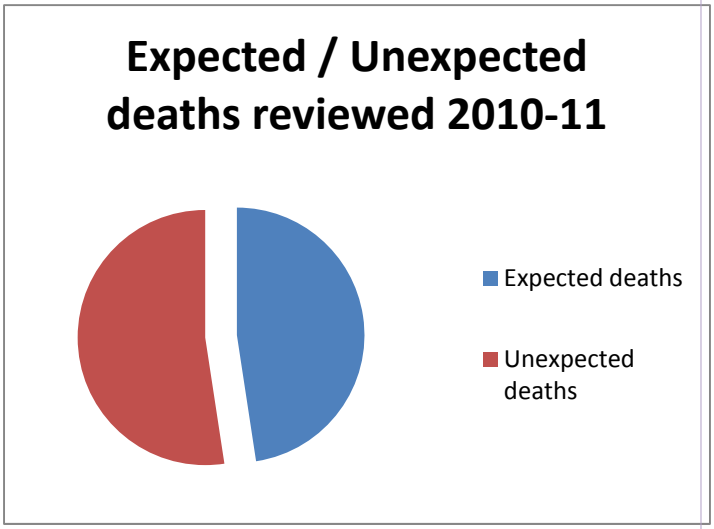
During the reviews of child deaths which took place in 2010-11 76 were thought to be 'unexpected deaths'. These deaths receive a multi-agency Rapid Response. But, in order for this to happen all deaths which are unexpected must be notified to the Rapid Response team (in line with the SUDC protocol, http://panlancashirescb.proceduresonline.com/chapters/p_child_death_rev.html).

Remember

An unexpected death:

- was not anticipated as a significant possibility for example, 24 hours before the death; or
- where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

A death can fit this definition but isn't necessarily investigated by the coroner.



An area where identifying whether a death was expected or unexpected has been difficult is for **neonatal deaths:**

If a baby dies within 24 hours of birth or shortly thereafter due to an event related to the birth whilst under medical supervision, and there is a clear medical explanation for the death, this should not be treated as an unexpected death.

If a baby dies within 24 hours of birth in the same circumstances (i.e. whilst under medical supervision), with no immediate medical explanation apparent for the child's death, the situation should be discussed with the on call SUDC Nurse. The SUDC Nurse will make a decision (informed by the circumstances surrounding the death and information available to them within Health) as to whether the case should be regarded as an unexpected death and so fall within these procedures.