Heidi – local learning lessons review
SUMMARY

Hull Safeguarding Children's Partnership

The Story

- At 9am on 10th December 2017, Heidi, a girl aged 15 years, was stabbed in the throat by her 17 year old brother when he forced access in to her bedroom, which was locked from the inside. The bedroom had an internal lock fitted as Heidi was frightened by the aggressive behaviours that her brother often demonstrated.
- Mum to both children was also greatly concerned for her daughter's and her own safety and well-being and they were often fearful of her brother and son.
- Between December 2016 and December 2017, Mum made countless contact with both statutory and non-statutory services, both to seek assistance to help her son and also to share her fears for the safety of her daughter and herself. On several occasions contact was also made by Heidi herself.
- Heidi has recovered and does not blame her brother. Heidi recognises that his actions were linked to his mental illness, she's speaks with him regularly. Whilst this review was conducted her brother was in hospital and his psychiatrist judged that he was not well enough to contribute.
- Heidi has emphasised that she would like agencies and practitioners to listen as she feels she was not heard.

Voice of the child

- "….at times we were terrified…I'd tell people, I took videos to show how bad it was, but I didn't get to show them…. I told (her) I didn't feel safe… They didn't take it seriously, they believed us but they didn't do anything."
- "It had to come to that (the stabbing) for them to take any notice"
- My message for professionals – "I just want people to think about all the other people around not just the main target/problem."
- The reviewer noted that there is very little recorded about (the girl) in the records presented to the review.
- Agencies did not sufficiently consider what life was like for (her); she was not heard when she said that she was terrified when he became aggressive and angry, and this was unpredictable.
- When she told someone about what was going on, "she didn't do anything".

What's going well?

- Contacts referred to the Early Help and Safeguarding Hub (EHASH) are reviewed by a Team Manager.
- The Step Down process from Social Care to Early Help has been strengthened.
- The Designated Decision Maker (Police Sergeant) in Humberside Police ensures 125 forms are completed fully and where necessary, request further information from the Officer completing the form.
- A same day crisis response service for vulnerable young people has been established at Kenworthy House.
- A targeted approach to relevant service areas and Division Managers in Humber Teaching NHS Foundation Trust has ensured the development of a robust safeguarding children supervision framework supported by staff who have accessed the required training, this is reported quarterly to strategic managers via Trust governance structures. There is now monthly Named Nurse attendance at CAMHS MDT meetings to provide safeguarding oversight to cases and existing processes. Bespoke training and reflection opportunities have been provided to services involved with this case to remind staff of their safeguarding responsibilities regarding domestic abuse, thresholds, the child's voice and hard to engage young people. Auditing processes now in place ensure assurances of safeguarding children activity is provided in line with Trust policy and processes.

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What are we worried about?

- Lots of agencies recorded that Heidi had been assaulted, and recorded her views about how scared she was, but never fully recognised Heidi as being a child at risk of significant harm. The focus remained on managing (her brother) or service boundaries and did not properly consider the risks to her. Consequently opportunities to refer Heidi to CSC and assess the risk of harm to her where missed.
- There was a lack of 'Think Family' when involved in this case.
- There were no multi-agency meetings. There were no multi-agency discharge plans or risk assessments in place for brothers release from an inpatient unit.
- Correct procedures for making and following up a referral to Children Social Care (CSC) were not followed.
- When contacts were received by CSC there was a lack of clarity as to identified concerns and/or requests for services.

What needs to happen?

- All practitioners and agencies need to remember that safeguarding is the responsibility of everyone and they can liaise with a safeguarding lead to discuss and escalate concerns.
- All agencies need to adapt the 'Think Family' principles when responding to their daily tasks.
- All agencies need to have an understanding of Hull's Threshold of Needs guidance to ensure children, young people and their families receive the right support and where needed a lead practitioner is identified.

Learning for professionals and multi-agency practice

- The voice and lived experiences of all those involved must be listened to. Heidi and her Mum want to ensure that other families receive the help they need.
- Recognise signs, symptoms and indicators of harm abuse and neglect.
- All agencies need to have an understanding of Hull's Threshold of Needs guidance.
- Any agency involved with a family can request and organise a multi-agency meeting if it is felt to be beneficial to support all the family.
- There needs to be co-operative working between agencies to achieve a 'best response' (including, where necessary cross-boundary communication).
- When professionals are making referrals to CSC, they need to provide the right level of information to allow for robust decision making.
- Agencies and practitioners must be aware of how to escalate a concern if they deem that an appropriate response has not been given.
- There is a need for risk assessing, safety planning and a co-ordinated safeguarding response for all children involved. These must be completed and reviewed.

Multi-Agency Resources and Training

- LSCP website: https://www.hullscp.co.uk/
- LSCP multi-agency safeguarding procedures: https://hullscb.proceduresonline.com/index.htm
- Home Office Information Guide: Adolescent to Parent Violence and Abuse https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf

- LSCP safeguarding children training programme https://www.hullscp.co.uk/?s=training
  Specifically:
  - Thresholds Briefing
  - Safeguarding Children Level 1 A Shared Responsibility
  - Safeguarding Children Level 2 Working Together Effectively
  - Domestic Abuse Awareness: The Impact on Adults, Children and the Community
  - Responding Effectively to Disclosures from and about Children and Young People
  - Substance Misuse: Drug and Alcohol Awareness
  - Dealing with Allegations Against People who Work with Children