NSPCC Respository – March 2017

In March 2017 five SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Croydon LSCB: "Claire"

Review of the responses of agencies between 1 January 2012 and 31 January 2014 to a young girl who was found to have contracted two sexually transmitted infections whilst in local authority foster care. "Claire" was known to multi-agency services from the age of five months, and had previously been the subject of a child protection plan.

At six-years-old she was sexually abused by a member of the household and became a looked after child (LAC) in the care of her paternal grandmother. This placement broke down and Claire was placed in foster care. The female foster carer raised concerns about her ability to care for Claire, after which the male foster carer became Claire's main carer. Claire was removed from the placement after 15 months, when she was diagnosed with chlamydia and gonorrhoea.

Issues include: lack of assessment, support and guidance for kinship foster carers; absence of scrutiny and challenge when assessing and approving new foster carers; lack of collaboration between social workers representing different teams within the LAC service; the importance placed on performance indicators compromised the role of the Independent Reviewing Officer.

Uses the Social Care Institute for Excellence (SCIE) methodology to identify findings, including: strengthen the contribution of family members in LAC reviews and child protection conferences; review how agencies are kept informed of planned changes for a child and consider adapting processes to facilitate the involvement of partner agencies; put processes in place to embed challenge as an accepted responsibility in safeguarding children.

Download Report Here

Unnamed LSCB: Child AB

Life threatening assaults of child by mother, followed by mother's suicide attempt, in 2014 and 2015. On two occasions Child AB, a junior school-aged child, was subject to life threatening assaults by attempted suffocation and strangulation by the mother, who then attempted to commit suicide. Mother was charged with attempted murder and placed on bail, and Child AB became subject to child protection investigation and child in need plan, and was placed with father, with contact arrangements managed by children's social care. After a second assault mother was charged and convicted of child neglect. No indication of child abuse prior to the first event.

Maternal history of: mental illness, self-harm, disclosed attempts to harm husband and attempted suicide; disclosure of emotional abuse in marriage.

Key issues identified include: management of screening for maternal mental health and domestic abuse not fully embedded in practice; lack of direct questioning regarding thoughts to harm others and extended suicide in primary care and mental health services; ineffective use of child protection processes; lack of a joined-up process of multi-agency assessment and management of risk by adult and children's services; professional decision-making impacted by affluence and status of family ; management of contact arrangement unclear; ineffective

staff management and supervision processes; limited practitioner awareness of increased risk of filicide, harm to others and the risk of viewing the child as a protective factor.

Makes recommendations to strengthen professionals' understanding of the negative impact of professional biases and beliefs in safeguarding practice, and to review procedures to improve understanding of the child as a protective factor, risk of filicide and harm to others in cases of adult parent or carer mental illness. Please note that this report was written in May 2016 but was published in 2017.

Download report here

Thurrock LSCB: James

Death of a 17-year-old boy of Ghanaian heritage in July 2015 in North London. "James" was found collapsed with a sheet tied around his neck. The Coroner recorded an "Open Verdict" on his death. James was a looked after child in semi-independent accommodation, following a breakdown in relationships with his family. He was known to the police and children's services in a number of local authorities.

James had a history of: running away; violent and criminal behaviour; sporadic school attendance; non-engagement with services; drug misuse; self-reported mental health issues and suspected involvement in gangs.

Issues identified include: looked after child (LAC) placements situated too close to areas where gangs operate; incomplete mental health assessments; insufficient work by professionals on understanding family dynamics and rebuilding family relationships and the absence of a positive action plans in response to concerns raised in LAC reviews.

Examples of good practice include: James was listened to, efforts were made to engage him and he was supported regarding his court appearances. Uses a mixed methodology to identify factors that influenced how agencies and professionals worked together.

Recommendations include: review safeguarding arrangements for children in custody and young people presenting as homeless; widen the remit of looked after children inspections nationally to include semi independent placements; embed a more robust record keeping and follow-up process for health assessments; assess the risk posed by any condition disclosed by a child or young person in custody to a forensic medical examiner and develop a matrix for identifying and escalating concerns about children in care.

Download report here

Surrey LSCB: Child AA

Serious, non-accidental head injuries to a 10-week-old baby, Child AA, whilst in the care of parents. The parents were arrested and bailed pending further investigation and Child AA and an older sibling were taken into care. Sibling was subject to a Child in Need plan which continued following Child AA's birth. Team around the child and professionals meetings were also convened following Child AA's birth.

Concerns about the family included: young age and immaturity of parents; lack of support from family or friends; dependence on professionals for money, food and equipment for the

children; poor living conditions. Mother was a young carer for her mother, was subject to a Child in Need plan and received services from CAMHS.

Issues identified include: the differences of opinion between children's social care and the community health services, which were compounded by a lack of clear and current assessment and co-ordinated planning.

Recommendations include: guidance for social workers on assessment should include joint visiting with other professionals to share perceptions and views; risks to new born babies should be fully understood with the expertise of community health professionals in this area acknowledged; inclusion criteria for the Family Nurse Partnership should be revised to include young parents who have a second or subsequent child.

Download report here

Herefordshire LSCB: Family HJ

Concerns of neglect and possible physical abuse of a period of five years of a minority community sibling group, with mobility, sight and learning difficulties and health challenges. Children known to children's social care and the police.

Concerns around missed or cancelled appointments for weight checks and immunisations, sight and delayed development checks and lack of cooperation by the parents. Child Protection Plans were in place for some of the children as a result of neglect and one was subject to a Child in Need plan. The youngest child was briefly taken into foster care following concerns of possible sexual abuse. Care proceedings started in October 2014 were delayed by legal processes and the children were removed by the court in February 2015.

Themes identified include: identification of neglect and children with disabilities; lack of cooperation by family; clarity of purpose of multi-agency meetings; consideration of each child individually; drift and changes of professionals; internal and external escalation and professional disagreements; specialist social work provision and legal processes.

Sets out key findings using the Significant Incident Learning Process (SILP) methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted in a certain way at the time.

Recommendations include: to provide an effective multi-agency childhood neglect strategy; to request that NHS England reviews its commissioning arrangements for child sexual abuse medicals in the local area; provision of training in culturally competent practice.

Download report here