NSPCC Respository – September 2016

In September 2016 four Serious Case Reviews were published to the NSPCC Repository. A summary of each of these cases can be found below:

Peterbough LSCB – Overview of the MA response to CSE in Peterborough

The sexual exploitation of young people in Peterborough over the period 2010-2016. Focuses on learning from Operation Erle, a multi-agency investigation which resulted in ten male defendants being found guilty of 59 offences against 15 girls. Issues identified include: lack of robust response to disclosures of sexual activity at a young age; lack of robust response to the assessment and safety planning of missing episodes; difficulties in transitions between children's and adult's services and a tendency to see young people as adults capable of choosing to be in abusive relationships.

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Suffolk LSCB: Baby D

Death of a 12-week-old baby boy whilst co-sleeping with his mother. Police arrested the parents, following anonymous allegations of heavy drinking and drug taking in the family home, but there was insufficient evidence and no further action was taken. No concerns were identified about the care of Baby D before or after his death. A range of agencies had been working with the family due to the increasingly challenging behaviour of Baby D's half-sibling Child P. Mother had reported feeling overwhelmed by Child P's behaviour, and a social work assessment had taken place the day before Baby D's death. Issues identified include: need for some improvement in agencies' delivery, recording and coordination of advice about safe sleeping and need for improved public and professional awareness of the issue of safe sleep.

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Gloucestershire LSCB – "Lucy"

Death of a 16-year-old girl, "Lucy", and her unborn child in 2014. Lucy died as a result of an assault by her partner, "Daniel", who was found guilty of her murder and given a life sentence. Lucy was made subject to a Child in Need plan but social care decided to close her case when her unborn child was made subject to a child protection plan under the category of physical and emotional abuse. Lucy became homeless at 15 after relationships with her family deteriorated. After a brief period staying with her partner Daniel, the couple separated and Lucy returned to live with her mother. Lucy presented with multiple risks including: emotional difficulties; self-harming; challenging and risky behaviour; school refusal; estrangement from family members; homelessness; pregnancy and being in an abusive and violent relationship. Services supporting Lucy and her family included: child and adolescent mental health services (CAMHs), family support services and a voluntary sector organisation specialising in young people's mental health. Findings include: when safeguarding teenagers, there is a tension between respecting their autonomy and keeping them safe; the Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) form does not capture all critical information for under-18s; there is a lack of understanding of how to recognise key features of domestic abuse between young people leaving child victims and child perpetrators without the necessary support and protection.

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Gloucestershire LSCB – "Ben"

Death of a 9-month-old baby boy of brain damage assessed to be a non-accidental head injury. At the time of review inquiries were ongoing. Ben's half-sister was living permanently with her grandmother due to concerns around the mother's neglectful parenting. Ben was born prematurely and remained in hospital for the first six weeks of his life. Following his discharge home, the family received regular home visits. Mother had a history of: emotional abuse in childhood, substance misuse, parental neglect and homelessness. Little was known about the father. Issues identified include: lack of professional knowledge of or focus on the father, lack of a pre-birth risk assessment and lack of consideration of the potential impact of the past on present or future parental care. Findings include: the need for evidence-based multi-agency pre-birth or at-birth assessments; the importance of involving fathers in the antenatal and postnatal period; the need for a Lead Professional to support parents whilst their baby is in neonatal care; the need to take into account the additional vulnerabilities of premature babies; and the importance of all agencies, not just children's social care, seeing themselves as having a responsibility for safeguarding children.

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