NSPCC Respository – April 2017

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

Unnamed LSCB: Considering child sexual exploitation

Child sexual exploitation of three girls by a young adult female who was involved in sexual activity with them and additionally recruited them in abusive sexual behaviours by a number of older adult males between January 2013 and August 2015. All girls had complex needs and missing from home episodes.

Hannah had a history of self-harm, alcohol and substance misuse and may have been involved in grooming other young people herself. She was on the Child Sexual Exploitation (CSE) list and was a Child in Need.

Samantha was added to CSE list following her mother's concern about her relationship with a 26 year old man, which resulted in a police referral to children's social care.

Lauren was looked after by her grandparents from 2011 who struggled to manage her behaviour. The police were involved following a violent incident by her grandfather and a Section 47 enquiry began. She was in foster care for short periods and a Care Order was discussed. The alleged perpetrator was relatively young and had been a vulnerable child; in tandem with Hannah on occasions, she was part of a wider network of predominantly male operatives.

Issues identified include: the difficulty in identifying the alleged perpetrator as a risk to children; the need for services to work with parents to strengthen parental confidence as perpetrators set out to deliberately drive a wedge between child and family; importance of early intervention in responding to sexual exploitation; the need to understand children as victims without choice or informed consent.

Uses narrative stories for each of the children as the basis for identifying emergent themes and the Review Panel worked collaboratively to identify critical pathways, points of learning and to focus on thematic issues.

Makes recommendations to introduce a process for responding to vulnerable children/young people which incorporates child sexual exploitation, in particular identifying and minimising risk from a non-familial source, build on factors that increase resilience, facilitate a multi-agency team around the child and facilitate partnership with key people in the life of the young person. Also recommends the LSCB is regularly kept abreast of information relating to sexual exploitation and missing from home incidents. Please note that this report was written in September 2016 but was published in April 2017.

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Unnamed LSCB: Child F and Family

Harmful sexual behaviour and death of 17-year-old in 2015 as the result of stab wounds. Child F lived with his mother, and experienced uncertainty related to the family not having their residence in the UK regularised, poverty and poor housing which affected his health.

Maternal history of abuse, domestic violence and mental health problems. Father deported in 2006 following imprisonment for serious drug offence. Assessed as child in need in 2011. Behaviour and attendance at school erratic, and several incidences of involvement with others in minor and serious offences, including rape of a 12-year-old and 14-year old.

Decision made that prosecution relating to first rape was not in public interest. Learning points identified include: when cases are not pursued in the public interest it is still necessary for the young perpetrator to be given a full understanding of the implications of his actions face to face; lack of support for mental health needs due to referrals to and fro between agencies; good chronologies of key events would help spot risks; impact of long bail periods should be recognised and support should be provided to young person; agencies should take great care when describing sex as consensual when in law it cannot be; young teenagers are often unclear about consent.

Recommendations include: review safeguarding approach to child perpetrators of sexual abuse and harmful sexual behaviour; encourage education providers to ensure law around consent is explained clearly; ensure that a young person's stated concern about violent risks to them is taken seriously by agencies.

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Blackpool LSCB: BW

Death of 3-month old child in 2015 due to medical causes. A child protection plan had been in place one year before the death for child BW and siblings, who lived with their mother, due to concerns of neglect. In 2013 there had been concerns about neglect when family lived in a different area, which resulted in a common assessment framework process being started to support the family. A 'Getting it Right Assessment' was completed in 2014 due to increasing concerns about the family.

Issues identified include: views on a good enough home environment can be subjective and is complicated by working in a deprived area; safe sleep advice had been provided but was not followed; mother's disguised compliance may have added to the optimistic view of her intentions and capacity to change.

Good practice identified: robust information sharing processes and good local professional relationships.

Recommendations include: wider promotion and clarification for staff of the Graded Care Profile 2, and any other agreed neglect assessment tool for the multi-agency partnership; audit on how expected outcomes are recorded on Children's Services' documentation particularly Child Protection Plans, to clearly highlight what difference is expected to be made, and the consequences should positive change not occur; audit of pre-birth child protection processes to ensure that when siblings are on a child protection plan the needs of an unborn baby in the family are considered separately; review the Multi-Agency Pre-birth protocol; review of position of progress of the recommendation regarding safe sleep assessment from an earlier serious case review ; develop training on non- engagement and disguised compliance.

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Merton LSCB: Child B

Serious physical assault in September 2015 of a 16-year-old girl, Child B, whilst she slept. B's mother pleaded guilty to grievous bodily harm and was sentenced to a Hospital Treatment Order under the Mental Health Act, 1983. B became a looked after child.

Long history of mother's poor mental health, reports of excessive alcohol consumption and tensions in the parental relationship resulting in disputes which sometimes escalated to possible domestic abuse. B was subject to a child protection plan for emotional abuse, later becoming a child in need and finally a vulnerable child, supported by universal services. She was also a young carer for her mother.

Lessons learned include: a holistic 'Think family' approach had not been embedded across multi-agency children's and adults' services; young carers were not always recognised as such and their needs were not always understood or attended to by the whole multi-agency system; recognition of trends or patterns of risk, or changes in risk and when to 'step up' or 'step down' a case were not robust with a lack of confidence in escalating concern.

Uses the Multi-Agency Child Practice Review methodology and recommendations include: review how the principles of the holistic 'Think Child, Think Parents, Think Family' approach are operating and how they are embedded in commissioning and leadership of frontline practice and its management, with joint working and understanding of mental ill-health and parenting.

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Birmingham LSCB: Shi-Anne Downer

Death of Shi-Anne Downer, an 18 month-old-girl from a white British and black African background in September 2015. The post mortem revealed over 150 internal and external injuries that had been caused over a number of months; Shi-Anne's guardian was subsequently convicted of murder. Shi-Anne's mother had a history of drug abuse, mental health issues, reluctance to engage with services and time in prison; her father was in prison at the time of her birth; and her five older siblings had previously been taken into care. Shi-Anne was made the subject of a child protection plan before her birth and was placed in foster care after birth. In January 2015, Shi-Anne became the subject of a special guardianship order (SGO). Her guardian was not related to Shi-Anne but had previously been married to Shi-Anne's father's cousin, and her name was put forward by a family friend.

Issues identified include: the pre-birth decisions made about Shi-Anne's care followed the same approach as decisions made for her older sibling, without considering whether this was also appropriate for Shi-Anne five years later; the assessments for the SGO were flawed and incomplete; professionals had little or no contact with Shi-Anne after the SGO; risk factors for the guardian's reduced parental capacity, such as becoming pregnant and the breakdown of her relationship, were not recognised and acted upon.

Uses a blended methodology to establish lessons that can be learned, including: ensure all relevant checks are carried out and consider the need for a period of monitoring before a SGO is finalised.

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