NSPCC Respository – November 2017

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

Surrey LSCB: Child GG

Concerns about child sexual exploitation (CSE) of a 16-year-old girl. Child GG was known to a number of services and several assessments of her psychological and physical needs were undertaken. She was excluded from school on a number of occasions. Concerns around Child GG being sexually exploited were formally discussed at six multi-agency meetings in the six months preceding Child GG being taken into police protection in December 2015.

Learning issues identified include: lack of recognition among professionals of the risk of CSE as well as 'drift'; lack of coordination of services, especially around referrals and thresholds; the importance of relationship-based practice with children who have been involved in CSE, including the recognition that some children involved in CSE find it difficult to accept that they are being exploited and consequently do not engage fully with agencies; the need to avoid blaming or holding children responsible for the abuse and CSE; the importance of information sharing and of professionals proactively seeking information when there are concerns.

Recommendations include: increase knowledge about CSE and the features and manifestations of adolescent behaviour, ADHD and ASD so that professionals can distinguish between these; review the skills of professionals in building positive relationship with children; audit the extent to which children involved in or at risk of CSE are no longer blamed or held responsible and that records are respectful about the child and their family; raise awareness of CSE with taxi drivers, hotels, after school clubs, youth groups, park wardens and sports clubs.

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Liverpool LSCB: Chris: period under review May 2013 to September 2015

Subdural haematoma suffered by Chris, a baby under six months old, in September 2015. Further examination revealed recent and old injuries including rib and leg fractures. Chris's injuries will have a life-long impact. Police are currently investigating the incident. Chris's mother is a migrant to the UK. Her husband, MH, is also a migrant. MF is the birth father of Chris and sibling, CS. Both MH and MF had access to the children. Family had contact with services including the GP, health visitors, midwifery and maternity services and the police.

Police attended incidents involving the family on five separate occasions and notified children's services each time. Referrals were also made by maternity services and the health visitor following Chris's birth.

Concerns included: domestic abuse; the family being victims of anti-social behaviour; mother's rough handling of CS during a medical appointment. Uses the systems methodology developed by the Social Care Institute for Excellence.

Findings include: safeguarding children in migrant families could be improved by addressing cultural competence in understanding family dynamics and more effective use of interpreters; services are too reliant on self-report information from migrants due to a lack of robust historical health, social care and criminal records.

Recommendations include: the LSCB should ensure that professional interpreter services are always used by agencies - the use of family members or others is not acceptable; LSCB should contact the relevant government department to highlight poor availability of historic health and social care records for migrants to the UK.

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Hull LSCB: Baby J

Death of Baby J aged 4 weeks in summer 2014 owing to head injuries associated with being shaken. Baby J's father, FJ, was later convicted of manslaughter. Baby J's parents had both received support from mental health services prior to and after Baby J's birth. FJ had a history of domestic abuse with a previous partner and increasingly with Baby J's mother. He was the subject of a Non-Molestation Order in relation to his previous partner and their child. Both parents were homeless and living in separate hostels throughout the pregnancy although Baby J's mother moved to her parents after the birth. An initial assessment was carried out November 2012 and although recommended, a pre-birth risk assessment was not carried out.

Findings include: no one agency had a full picture of the parents' history of mental health issues and drug and alcohol misuse; risk assessments did not provide the full picture; the risks posed by domestic abuse and coercive control by perpetrators were not understood; written agreements with families need to be monitored.

Recommendations for all agencies included improving information sharing, communication and record keeping in relation to domestic abuse and mental health issues, and involving fathers in risk assessments.

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Derbyshire LSCB: ADS14: Polly

Death of a 21 month old girl, Polly, in May 2014 after attempts of resuscitation in hospital failed. Polly's mother was convicted of murder and child cruelty, and her boyfriend of allowing the death of a child.

Polly was subject to child protection plan (CPP) at birth due pre-birth concerns about possible neglect. Polly was in foster care for a period in 2013 following a reported incident of domestic violence at home, but returned to her mother's care in October 2013 with a supervision order which included regular contact with her birth father.

In October 2013 Polly's mother started a new relationship. Between January and April 2014 Polly was involved in a number of medical incidents including being taken to hospital following a sudden collapse at home, there were reports of domestic abuse which were referred to agencies, and the family moved from supported living arrangements to rented accommodation in a neighbouring county.

Issues identified and recommendations made include: the child protection plan did not assess the implications of the mother's mental health needs on her capacity to parent; lack of authoritative professional practice that saw Polly as the primary client; lack of understanding by some professionals about their role and responsibility when Polly was subject to a supervision order which may have deflected their focus from original safeguarding concerns; little recognition of the role of the boyfriend and father were playing in Polly's life; and medical staff did not consider the possibility of child abuse or neglect when Polly presented with medical issues.

Additional learning points cover: parental drug use; the housing of young vulnerable adults; cross border moves and notifications and the use of written agreements.

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Birmingham LSCB: BSCB2015-16/01: born in 2014: died on 1st April 2015 aged 5 months

Death of a 5-month-old child of Lithuanian parentage from a brain injury in March 2015. Father was found guilty of murder of Child D in February 2016 and also found guilty of injuries caused to siblings DD and LD. Child D was a twin who was born prematurely and spent 2 months in hospital after their birth; Child D's sibling had further health complications that required hospital appointments. Child D's parents came over from Lithuania in 2010 and started a family 3 years later. They were not known to children's social services until the death of Child D. The family were under financial pressures and away from the main support system of their extended families. There was contact with health visitors, GPs and hospitals before the birth of the twins.

Findings included: considering all children in a family; fathers must be included in assessments and plans for children; highlights the importance of interpreters. Good practice was noted at the neonatal unit the twins attended and the health visitor was pro-active in seeking help for the family. FInds that improved arrangements would not have prevented the death of Child D, but there are opportunities for services to make some changes to develop their services.

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Trafford LSCB: the placements of Child PB

Alleged sexual abuse of an adolescent boy by foster carers in two separate placements between 2013 and 2015; a criminal investigation was initiated but neither foster carer was charged with criminal offences. Child PB became looked after aged 12 due to behavioural problems.

His first long-term foster carer (FC1) requested that the placement be ended, citing ill health. PB was placed in a residential educational setting, living with a second foster carer (FC2) during weekends and holidays. His behaviour deteriorated and he was moved to a permanent residential placement. PB went missing several times, returning to FC2 although this was not always reported. On one occasion FC2 told police he hadn't seen PB, but PB was found hiding undressed at FC2's home. Despite FC2 being suspended as a foster carer, PB was persistently found at FC2's home. Weeks later, following therapeutic support, PB disclosed sexual abuse by both FC1 and FC2.

Key findings include: although the disclosures have not led to prosecutions, the actions and behaviours of both foster carers should have led professionals to consider at a much earlier stage whether they could keep children in their care safe and whether they posed a risk to children placed with them.

Recommendations include: ensure foster carer assessments and reviews are robust, thorough and appropriately challenging; ensure supervision files have carefully maintained chronologies to support supervision and review so that any emerging concerns or issues can be addressed; ensure all practitioners have a sound understanding of the range of characteristics, motivations and behaviours of people who seek to sexually abuse children.

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Warwickshire LSCB: regarding a child to be known as Child J

Non-accidental leg fracture of a 7-month-old baby who had been on a child protection plan since birth and had been living in a mother and baby foster placement with her mother until aged 5-and-a-half-months. The family were well known to agencies for about six years before the pregnancy with Child J, due to concerns about the care of the two older children in a household of family violence, substance misuse and a number of probable non-accidental injuries.

These children were subsequently taken into care and adopted. After the placement in foster care ended, the mother was housed in her home town some distance from the foster carer.

Learning: importance of assessing the accuracy of current or historical concerns reported by others; a thorough knowledge of the case history; the need to respond flexibly to requests to house families in other local authority areas; to consider what formalised support is required following a move out of a baby and mother foster placement.

Recommendations include: clear records kept of issues identified during proceedings that are not used, need to be made available to those involved when a later referral is received; to make arrangements for appropriate medical/health advice to be available at strategy meetings; to consider how new professionals working with a family are made aware of the case history and reasons for decision making.

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