NSPCC Respository – August 2017

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

Staffordshire LSCB: Child B

Death of a 14-month old girl in July 2014. Cause of death was not ascertained but there were concerns that Child B had died while co-sleeping with her mother and maternal grandmother, who were both believed to have been under the influence of alcohol. Child B and her siblings were on a child protection plan under the category of neglect due to concerns about their mother's alcohol misuse. Mother was involved with a number of agencies, and practitioners described her as being pleasant, intelligent, and having insight into her difficulties. In total there were five critical incidents related to the children's mother's alcohol misuse.

Key findings include: there was evidence of poor practice and a number of missed opportunities to safeguard Child B and her siblings; there was a tendency to parent-centred practice; Child B's mother was involved with a number of agencies yet was not challenged or confronted about her behaviour; there were no records of any inter-agency communication before the initial child protection conference; professionals did not listen to Child B's siblings who said they were left to care for Child B and did not want to live with their mother; there was failure to involve birth fathers in assessment and planning.

Uses the Social Care Institute for Excellence (SCIE) Learning Together systems methodology. Makes recommendations around involving fathers and other significant men connected to a child in child protection cases; listening to the voice of the child; and interagency communication.

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Buckinghamshire LSCB: Child Sexual Exploitation 1998 – 2016

Discusses all the cases of child sexual exploitation (CSE) in Buckinghamshire from 1998-2016. Since 1998 there have been more than 10 Thames Valley Police operations across the county involving up to 100 children and young people. In 2013 a serious case review was undertaken to examine the response to one young person (J), but the impact of CSE on the other young people has not been reviewed. Looks at the chronology of events starting in 1998 and the operations and reviews since then that have shed light on the experiences of young people and how professionals responded to them.

Outlines reviews carried out by Thames Valley Police, Children's Social Care and Buckinghamshire Safeguarding Children Board and the Misunderstood audit of peer-on-peer sexual exploitation. Explores the voice of those affected including interviews with 16 survivors and victims and two parents. Points out that some had rebuilt their lives and moved on, while others lives had been irrevocably changed and appeared damaged, lost and alone.

Identifies what needs to change in order to improve agencies' response to children, young people and adults facing CSE. Discusses evidence of improvement in tackling CSE, including the strategy and action plan developed by Buckinghamshire Safeguarding Children Board as well as Barnardo's RUSafe service, and the Swan Unit a multi agency team working on CSE.

The review makes 14 recommendations including: Buckinghamshire Safeguarding Children Board and Children's Social Care should facilitate discussions with organisations such as Young Carers, Youth Clubs and the Youth Service to ascertain how they can better engage with statutory agencies to safeguard young people at risk of CSE; Buckinghamshire Safeguarding Adults Board should bring agencies together to ensure there is an appropriate, effective and coordinated response available to victims of CSE as they become adults; the development of a strategy to engage with all communities within Buckinghamshire on CSE; the government should consider introducing a national central database of all licensed taxi drivers.

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Unnamed LSCB: Martin

Death of a 14-year-old boy in February 2016, initially thought to be due to suicide but, before the review was completed, an inquest determined the cause to be misadventure. Martin was an adolescent with mental health needs. His parents separated following domestic abuse by the father; the mother moved to London from a rural location to live with a new partner and two teenage daughters who had experienced a troubled childhood.

Martin received special education provision, first from a home tutor and then in a special school outside the borough. Although there were worrying concerns about his emotional wellbeing at home and school in December 2015, a referral to children's social care was not made.

Issues identified include: the challenge for professionals working with families where members have a range of complex needs; lack of coordination in provision of services across local authority boundaries; specific practice issues were found which highlight the dilemmas faced by front-line practitioners when exercising professional judgement in their safeguarding practice.

Recommendations include: to strengthen the sharing of information to ensure a whole family approach when working with children in complex, blended families; to re-launch the CAMHS pathways within the borough; to review the effectiveness in which Education Health and Care plans are shared with health professionals; for the London Safeguarding Children Board to work with organisations across London to mitigate the risk to children where there is a lack of clarity associated with localised commissioning arrangements; and partner agencies should be asked that contracts with service providers include an expectation that they should fully participate in any serious case review process.

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Central Bedfordshire LSCB: Bethany

Death of a girl, Bethany, aged 19 months on 11 April 2015. Cause of death was inconclusive after an open verdict at the inquest. Both parents had learning difficulties and troubled childhoods. Concerns were expressed by professionals from pre-birth onwards as to the parenting capacity of both parents. Bethany had been the subject of a Child Protection Plan for Neglect from October 2013. The parents received Early Support in parenting Bethany, and later a Care Order was put in place for Bethany to remain in her mother's care with the support of professionals and extended family when the father moved out.

After key family members withdrew their support, the Care plan was in breach and the process to take Bethany into care was started. Bethany died before steps towards removal could be completed.

Findings include: the assessment of parental capacity is essential; vulnerability of the parents should not override the needs of the child; over-reliance on extended family support in planning; there were issues of professional bias.

Recommendations include: the LSCB should examine parental assessment processes; be able to identify and respond to neglect; ensure multi-agency challenge processes are in place for child protection plans lasting longer than 9 months.

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Gloucestershire LSCB: Philip (and his siblings John and Darren)

Serious, non-accidental injuries to "Philip", aged three. Mother's partner pleaded guilty to grievous bodily harm and was sentenced to three years imprisonment. Mother pleaded guilty and received a sentence of 12 months, suspended for 12 months. Philip and his brothers, aged 10 and five, were placed with a relative. In nine months, the police, GP and nursery staff made six referrals about the family to children's social care.

Concerns included: poor home environment, mother's parenting difficulties and extensive bruising on Philip's body. After the fifth referral, Child in Need (CIN) processes were initiated. Family received support from the children's centre, health visitor, community nursery nurse and family support worker.

Family history included: mother and father's substance misuse; father's threatening behaviour; mother and her new partner's offending behaviour.

Findings include: the importance of formal early help in keeping children safe; the need for more child-focussed practice, less reliance on parental self-report and greater recognition of the role of fathers / father figures; the importance of effective decision-making and assessment in the management of physical abuse.

Recommendations include: Gloucestershire Safeguarding Children Board should review the guidance for all professionals on the assessment of potential non-accidental injury and ensure it is compliant with NICE Guidelines, including information provided to paediatricians prior to child protection medical.

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