NSPCC Respository – February 2018

In February 2018 eight SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Unnamed LSCB: Charlie and Sam

Sexual abuse and sexual exploitation of a 12-year-old girl and her 11-year-old sister. Sam, aged 12 years, and Charlie, aged 11 years are of Roma heritage and moved from Slovakia to the UK in 2012. Charlie has significant learning difficulties. In January 2015-July 2016 there were concerns around episodes of missing from home, missing school, risk of sexual abuse and child sexual exploitation (CSE), physical assault and two allegations of rape.

In February 2016 both children became subject to child protection under the category of CSE concerns. Sam had also been assaulted by an older male following a refusal to engage in a sexual activity with an adult male. Charlie was the victim of two rape incidents by different perpetrators and both children became subject to police protection orders and interim care orders.

Learning includes: the importance of assessment to ensure that the needs of minority ethnic children are considered; there was a delay in moving the initial joint investigations forward which resulted in a delay to direct work; the importance of accurate assessment; and the use of professional interpreters within safeguarding practice. Makes a number of recommendations around management of CSE concerns, assessment and information sharing.

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Unnamed LSCB: Child H1

Sexual abuse of a 15-year-old adolescent by her older brother in 2015. Child H1 had made a previous disclosure at age 12. Child H1 lived with her parents and Sibling 1 and Sibling 2. She had a history of temporary school exclusions, and reported being bullied at school; episodes of missing from home; self harm and suicidal ideation; non-attendance at CAMHS; and reports to the police about her behaviour in the community.

In 2015, mother informed children's services that H1 had disclosed sexual abuse by Sibling 1 18 months earlier. Section 47 enquiries were made, and Sibling 1 was accommodated, but later moved back home.

Learning identified includes: when Early Help is delivered without holistic access to information and there is no plan with agreed outcomes, it is a challenge to monitor the impact of the intervention; it is important that efforts are made to understand why young people are engaged in behaviour described as "risk taking" and "challenging"; it is essential that practitioners recognise cultural influences on children and families from diverse communities. Identifies good practice around use of multi-agency resources and information sharing between the nurse practitioner and the school nurse. Recommendations include: to audit and monitor how the voices of children and young people inform assessments and interventions.

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Kent LSCB: Child C: Overview Report

Death of a girl aged two years-and-four-months in June 2015 caused by accidental ingestion of her mother's methadone. Child C's parents were long term drug users and were known to multiple drug dependency agencies in Kent. Child C's mother had a history of booking in her pregnancies late and unplanned home births. Child C was admitted to the Neonatal Intensive Care Unit for two months for treatment for neonatal abstinence syndrome. There had been 16 referrals to children's services, seven initial assessments and one core assessment before Child C was born. The family had contact with 21 health services and there was consistent non-attendance of all appointments including ones pertaining to Child C's health. Concerns were expressed by neighbours and health visitors when the children were left alone on occasions. Concerns led to several “Team around the Family” meetings. Learning includes: no documentary evidence about the views of the children or the ability of the mother to prioritise her children; potential neglect not identified; not every agency had a full picture of the children's needs and their reactive working was not conducive to identifying long term neglect; there was lack of clarity about the safeguarding risk assessment process. Recommendations include: update training on resistant and hostile parents; all agencies should use chronologies when carrying out risk assessments; KSCB to review and update the training programme for working with substance misusing parents.

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Somerset LSCB: Child L and Child J

Non-accidental injuries to 6-week-old Child J, sustained on at least two separate occasions. Child L, aged 5-months, half-sister to Child J, had sustained a mouth injury and bruising 10 months earlier and had been subject to a Child Protection enquiry but after a Child and Family assessment the case was closed.

Both parents of Child J had traumatic backgrounds. They were offered extra support with enhanced health visiting, teenage pregnancy programme, housing, benefit and educational issues but the couple were unable to take advantage of this help. Seven health visitors were involved with the family as well as others offering other services.

Child J was found to have bruising by the GP; further examination at the hospital found multiple rib and a leg fractures. As result of injuries to younger child, both were removed from the home and Care proceedings began.

Issues identified include: the need for practitioners to be aware of the significance of early life experiences, drug use and mental health problems in parents and their impact on the children; the need to understand normal child development which would have improved the quality of decision making; inter-agency cooperation; the need for effective supervision and managerial oversight. Examples of good practice were noted by the GP, the housing support worker and the health visiting service.

Recommendations include strengthening interagency procedures for the police, children's social care, housing providers and the NHS Foundation Trust. Please note that this report was written in June 2016 but was published in February 2017.

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Enfield LSCB: YT

Death of 17-year-old boy after his arrest for illegal entry into the UK and subsequent placement in foster care a day earlier. YT was found in the back of a cargo lorry in Enfield on 8th July and was taken into police custody. Once it was established YT was a child a foster placement was sought and he was taken to a foster family the same day.

The foster family struggled to communicate with YT but were planning to introduce him to another Eritrean the next day. Late the next evening YT was found dead in his room hanging from the curtain rail. None of YTs family are in the UK and it is unclear how he was travelling to the UK. As YT had only been in the country for one day, and there was a language barrier there is very little known about him and his situation.

Recommendations include reviewing out of hours emergency child protection to record all aspects of vulnerability, ensure the voice of the child is heard and facilitate effective communication.

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Nottinghamshire LSCB: Baby ON16

Non accidental injuries of 16-week-old baby which resulted in admission to accident and emergency. Baby ON16 lived with the birth parents who were in their mid-twenties, an older sibling Child A and Child B who is a younger sibling of the father of Baby ON16.

The family was known to Children's Services, health services and the police. Baby ON16s father and Child B had experienced disruptive childhoods and had witnessed serious domestic violence and physical and emotional abuse and had all been subjects of Child Protection Plans. The Family Court Care proceedings that followed determined that on balance of probability Child B had caused the injuries but as they were 10 years old at the time a criminal prosecution was not considered to be in the public interest.

Issues identified include following up referrals from CAMHS, more detail in record keeping, assessment information being shared across agencies and information sharing.

Recommends reviewing procedures for children cared for by extended family members and undertaking a learning exercise to improve responses to injuries and bruises in young babies.

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Nottinghamshire LSCB: Perry

15-year-old child, Perry, who suffered a serious injury in April 2015 as a result of poor physical care and hygiene. Perry's father was convicted on four counts of neglect and sentenced to four years imprisonment in February 2017. Perry and three siblings went to live with their mother and received support as children in need.

Perry's parents separated in 2008 and the children lived with father who refused to allow them any contact with mother. Siblings were subject to a child protection plan for neglect between December 2010 and July 2012. Referrals in 2014 resulted in further involvement by social workers and other professionals through a child in need plan. There were allegations of sexual assault of one of the siblings by a young adult male living in the household and concerns around poor living conditions and the physical care of the children.

Key findings include: the need to recognise the potential for harm from neglect; the need to have high expectations; collating evidence about risk, vulnerability and resilience more systematically; having strategies to respond to parental resistance; identifying who is living in households; avoiding the use of euphemistic language which obscures professional communication and understanding; and listening to the views of children and assessing their level of understanding.

Makes recommendations for the LSCB to consider including: do they have sufficient information about the use and effectiveness of local assessment resources, including guidance on identifying and responding to children at risk of significant harm from neglect?

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Trafford LSCB: Child N

Circumstances around Child N becoming a looked after child at the age of 7. Child N was the fourth child within a sibling group of six children born to the mother (MN) and father (FN). Aged 3 Child N was removed from nursery in an intimidating and threatening manner by FN when he felt that the Early Years Lead was interfering with his family. Health visitors felt that FN was aggressive on a visit to the family home and left under threat.

Three years later MN contacted the police when FN physically assaulted an older sibling of Child N. Following this all children were placed in foster care and disclosed physical, sexual, emotional and psychological abuse. FN and MN are both under public law investigations for the abuse against the children. The family was known to Trafford Council, Pennine Care and Greater Manchester Police.

Identifies learning lessons in relation to multi agency working maintaining the child as the focus.

Recommendations included: focused outcomes and plans for children, the value of multi-agency working, undertaking a thematic audit on working with violence and aggression and developing a strategy to hear the voice of a child for children subject to multi agency procedures.

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