NSPCC Respository – June 2018

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

City of London and Hackney LSCB: Child M

Non-accidental injuries to a 13-month-old child of African-Caribbean ethnicity (Child M), including bruising to the face and transverse fractures to both femurs in June 2016. Father found not guilty of grievous bodily harm but both parents were found guilty of child cruelty.

Both parents had criminal records, the father for possession of class A drugs. A half sibling (Sibling 1) to Child M had an excessive weight problem and visits to A&E. Child M was taken to A&E at age 3 weeks and again at age 5 months with what looked like non-accidental injuries and after the second incident both children were made subject to a child protection plan, Sibling 1 for emotional abuse and Child M for physical abuse.

Mother had no recourse to public funds and this may have resulted in avoidant behaviours. Following unsupervised contact with father, Child M was returned home in pain and swelling on both thighs, refusing to walk or sit so the following day mother took him to A&E prompted by a social worker.

Lessons learned: examples of parental avoidant behaviour or disguised compliance which exacerbate risks to children; occasions where more robust professional curiosity or challenge would have been justified; professional responses appeared more positive than the available evidence would suggest particularly concerning the child's injuries.

Recommendations include: to enhance confidence within professional networks in the context of respectful certainty/cognitive dissonance to develop plans and interventions to respond to the possibility of deliberate harm even in the absence of conclusive evidence; support practitioners working with avoidant families, frequently fluctuating circumstance and disguised compliance.

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Croydon LSCB: Joe

Serious injury of a 2-year-11-month-old boy in June 2016 from third-degree burns. Joe had been the subject of a child protection plan for over two years, due to presence of family violence in the home, and continued to receive support through a Child in Need Plan from January 2016. Father had previously been in jail and was known to mental health services. Mother continually refused to disclose information regarding new partner and was misusing drugs. Joe lived in temporary housing with his mother.

On the day of the incident he was found home alone by the buildings manager. Mother was arrested and sectioned under Mental Health Act and taken to a psychiatric hospital; later diagnosed as suffering from an episode of drug induced psychosis.

Lessons identified include: protection of children will be compromised if a child protection plan is not working and there is insufficient insight into safeguarding processes; lack of robust inter- and intra-agency decision making jeopardises children's safety; family and kinship are critical members of the safeguarding network and should be regarded as such.

Methodology based on the Welsh Child Practice Reviews Guidance, taking a multi-agency approach, focussing on systemic strengths and weaknesses.

Recommendations include: to ensure a robust, timely multi-agency process that scrutinises child protection plans for children who are the subject of a child protection plan for 18+ months and evaluate impact; professionals to be supported in gathering evidence and triangulating evidence to improve risk assessments.

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Edinburgh Child Protection Committee: phase 2: the sexual abuse of children in residential care: executive summary.

The sexual abuse of children in two residential care homes over a number of years by staff member Y. All of the victims were looked after by the local authority at the time of the offences and were living in residential care homes. They had all suffered abuse before they came into care and were known to health services, education services, social work and police. Victims were not believed and this led to them mistrusting agencies.

Y was considered to be a good member of staff by colleagues he worked with at both children's homes and Y acted alone. Neither of the homes were abusive but there were aspects of the environment that increased the risk of abuse.

Learning points include: vulnerable victims needs were not acknowledged and they did not trust the adults in authority to protect them; child protection systems contributed to the harm that the victims experienced and agency practice was too dependent on procedures; professionals were insufficiently inquisitive about the source of victims distress and barriers to disclosure and child protection enquires when the victims were in care were not deep or broad enough to get to the truth of abuse.

Makes no recommendations but agencies should consider the distance between the findings of the report, current practice and their own aspirations and take steps to bridge the gap.

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Sunderland LSCB: Baby A

Death of a 20-day-old baby following an assault by the family dog. Baby A was being looked after by father at time of incident who was asleep and had been drinking alcohol. Baby A was the youngest of four children. Father had long term alcohol and drug dependency which was unknown to agencies. Mother usually cared for Baby A. Family was known to children's services for one incident in the past.

Learning includes: many families carry vulnerabilities and pressures not known to professional agencies which may increase risk; professionals need to help families to think about unthinkable risks that may be posed by family pets to children; there is a need to educate both parents about the risks of alcohol to the safe care of their children.

Recommendations include: delivering a public awareness campaign around the risk to babies and children as a result of parental use of alcohol and unsupervised dogs.

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Wolverhampton LSCB: Child G

Death of a 2-year-9-month-old boy of Caribbean and African heritage (Child G) on 22 November 2016 from cardiac arrest. After his death Child G was found to have peritonitis and a complex fracture of the skull along with other injuries. His mother's partner was convicted of murder and sentenced to life imprisonment; his mother was convicted of allowing the death of a child.

Child G's mother came to the UK from the Caribbean in 2003 as a child to live with her maternal grandmother in Croydon. Her status was of an undocumented migrant with no recourse to public funds (NRPF). Child G's half sibling, born about 2009 and mother started living with Child G's father in autumn 2012. She became pregnant in 2013 and, following an alleged assault by the father, mother and sibling were moved to Wolverhampton, returning to London before Child G's birth. Following the birth, mother moved back to Wolverhampton. In autumn 2016 the family returned to London to live with her partner. Prior to child G's death, no particular concern was raised by universal authorities.

Lessons learned include: ways in which professionals assess the risk of domestic violence and the implications that having no right to remain and NRPF have on the lives of the families they work with; professionals need to understand what parents' faith means to them during the assessment process, and find out about other individuals who may be involved with them.

Recommendations include: to consider how the LSCB can draw to national attention the inconsistent application of duties for authorities to safeguard and promote the welfare of children of families with no recourse to public funds

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Manchester LSCB: Child I1

Neglect of three siblings aged 0-1, 5 and 3 years, who were removed from mother and mother's partner in December 2015. The family had been known to children's services since April 2013, after moving to Manchester from the south of England six months earlier. There were 4 children in the family at the time. Home conditions were poor, and the children had complex needs. Father moved out with two of the siblings in March 2014.

In April 2014 the children became subject to child protection plans under the category of neglect. An initial child protection conference was held in September 2014 in respect of the unborn child (Child I1), the child of mother and mother's partner. Mother's partner is described as a transgender person and identifies themselves as female. Mother identifies as male.

In May 2015 the children were removed from the child protection plan but continued to receive support under a Children in need plan. In December 2015 ChildI1 and siblings were removed from the home following an unannounced visit by a social worker.

Methodology: a systems methodology approach focusing on multi-agency professional practice.

Findings include: there was a fixed and overly optimistic view of the case by some of the professionals; at times the parents' needs received more professional attention than those of the children; professionals did not always feel confident in their responses to some of the issues, particularly around gender roles and transgender issues.

Recommendations include: the voice and daily lived experience of the child should be the primary focus of all agency interventions; agencies should work closely together in cases of long term neglect, especially if there is concern about disguised compliance.

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