NSPCC Repository – July 2019

In July 2019 six SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Unnamed LSCB: Child H

Attack by a dog staying within the household of a severely disabled 10-year-old girl in January 2018. Child H has been disabled since birth, unable to walk, talk or feed herself and needs constant care. She was attacked in the early hours of the morning following a move to a new home.

Child H and her siblings had been subject to a Child Protection plan for two years due to long running concerns about poor parenting, poor home conditions and neglect. In October 2017 Children and Family Services recommended changing this to a Child in Need plan. Ethnicity of Child H is not stated.

Lessons to be learned about the way professionals communicate and make decisions to safeguard children: as part of a standard risk assessment, a dog should be considered in the same way as any other safeguarding hazard within a household; although the Child Protection Conference system is managed by Children's Social Care, it is the multi-agency group who are the decision makers; when an abused or neglected child is made subject of a Section 47 Enquiry, the strategy meeting should always consider the need to safeguard any siblings.

Methodology: uses a bespoke 'systems review'.

Recommendations: to consider how the lived experiences of children with severe disabilities and/or limited communication abilities can be represented and heard particularly when significant decisions are made about them; promote good practice whereby practitioners ask parents whether there are pets in the households they visit; review training around assessing parenting capacity to change and working with behaviours of feigned compliance, resistance and deceit.

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Barnsley LSCB: Child R

Accidental death of a 7-year-old boy in July 2015. Child R was found deceased in a pipe on a building site following a police search. He had been at a friend's house in the afternoon and had not returned home. He became subject to a child protection plan in March 2015 under the category of neglect.

During Child R's early life there were instances of domestic abuse and substance misuse which impacted his mother's parenting capacity. In June 2015, Child R's behaviour was becoming more challenging; he was reported missing on several occasions from home; and care proceedings were being considered if required changes as set out in the child protection plan were not achieved. Ethnicity or nationality of Child R is not stated.

Findings: unrealistic expectation by agencies for mother to address her substance misuse in a self-motivated manner; Child R not referred for specialist assessment or counselling as a result of the domestic abuse situation between his mother and father; at age six and a half, Child R was found to have considerable attachment and emotional issues but appears not to have benefited from psychological assessment or professional therapy.

Recommendations: to review, with South Yorkshire Police, the current design of the child protection incident form to ensure it captures essential data to discharge appropriate safeguarding responsibilities to a child; to ensure that children's social care explores the need for specialist input into child protection conference proceedings, where the specialist is not currently engaged with the family and, therefore, not automatically invited.

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London Borough of Barnet: Child E

Death of a 16-year-old boy in the care of the local authority in February 2016. Investigations identified cause of death as drug use. Child E was the eldest of four siblings; the family moved to London from Lithuania when he was 10 years old.

Family history of domestic violence and parental alcohol abuse; siblings became subject of child protection plans in 2012 and were taken into care. Child E had nine residential placements in England and Wales. He had a number of health needs; unmet educational needs, challenging behaviour and self-reported drug misuse.

Findings include: the system for managing the health needs of children in care is not effective where young people in residential care have a complex range of needs; Child E's need for education was not met mainly due to lack of assessment provision at an early stage, frequent placement moves and over tolerance of his illegal work experience; assumptions may have influenced practice which resulted in insufficient challenge where behaviours were unacceptable and putting Child E at risk of harm.

Recommendations include: review commissioning arrangements for residential care to specify where a child/young person attends or is admitted to hospital, staff will accompany them with relevant health information; review policies in relation to children missing education and be clear about what action to take when young people are engaged in illegal work; arrangements for staff supervision to include opportunity to reflect on the emotional impact of work in complex cases and consider how assumptions and cognitive biases may be affecting practice.

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Telford and Wrekin LSCB: Family Q

Neglect of five siblings aged between 6-weeks and 9-years-old from June 2015 to December 2016. In December 2016 teachers noticed a bruise on child Q2's ear who told them his mother had caused it. This precipitated a Section 47 investigation.

Police officer and social worker visited the home and discovered four further siblings living in poor conditions being severely neglected. Parents were arrested and children made subject to Police Protection. Health visitors had previously recorded the house being dirty, smelling and having flies at new birth home visits in June 2015 and October 2016. Family moved local authorities in June 2016.

School records describe child Q1 and child Q2 as smelling unclean. Father had a 13-year-old child from a previous relationship and had been refused contact. Mother reported low mood and told health visitor that Father had a learning disability. The family is White British.

Findings include: limited information sharing about indicators of neglect when children moved within and between local authorities; indicators of neglect were normalised by professionals working in areas of high deprivation; absence of professional curiosity. Uses the Significant Incident Learning Process (SILP) methodology which focuses on why those involved acted in a certain way at the time.

Recommendations include: information sharing processes for children moving between local authorities should be reviewed; barriers to effective use of tools to support the early identification of neglect should be identified; learning, including the recognition of dental health as an indicator of neglect, should be shared across the workforce.

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Western Bay LSCB: Child WB – Child Practice Review

Death of a child in a house fire in July 2016. Child is one of four siblings, all of whom were residing with their mother at the time of the child's death. All the children were on the Child Protection Register under the category of neglect at the time of the incident.

Mother had a history of substance misuse and formed relationships with men who misused drugs; some had been identified as being a risk to children which was the reason for the children being placed on the Child Protection Register. Following the death of the child all surviving children were removed from mother and placed with extended family and are subject to Care Orders. Ethnicity of family not stated.

Findings: important to ensure, particularly during times of disruption and change, that adequate support is in place for professionals; professionals should ensure that clear descriptive language is always used when completing assessments, particularly during cases of neglect; multi-agency, independent supervision would be beneficial with long standing 'stuck' cases; when parental relationships are identified as presenting a risk to children, professionals should consider ways to empower parents to make the right decisions, for example, healthy relationship work; any professional that worked with a child who has died needs to have access to support and debrief session within a short timeframe following the event.

There are no recommendations in the report.

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Wirral LSCB: Child H – CSE: Recommendations, Outcomes and Learning

Sexual exploitation of girls over a number of years by the Rajenthiram brothers. Focuses on the experience of one young person (Child H) as indicative of the abuse suffered by a wider group. Brothers were jailed for 18 and 20 years following police investigation into historical sexual exploitation of children, and their subsequent conviction for sexual offences against a number of girls.

Local Children Safeguarding Board decided not to publish the overview report for many reasons concluding that doing so might lead to the identification of victims of sexual abuse, which in itself would be a crime.

Learning includes: alcohol and domestic violence are frequently evident in families where neglect is a factor and can be common features in the parents of children vulnerable to child sexual exploitation (CSE); children who are experiencing CSE do not always recognise themselves as victims; avoid using phrases such as 'putting themselves at risk' and 'lifestyle choices' as this makes the child responsible for their abuse.

Recommendations include: ensure the thresholds of need are understood so children receive the right service at the right time; ensure robust management oversight of cases is in place and supported by regular reflective supervision of staff; review the response to children who frequently attend A&E.

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