NSPCC Repository – November 2019

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

Croydon LSCB: Child Y

Death of an adolescent boy due to a fatal stabbing. Child Y's murder believed to be linked to a feud between local gangs.

Emotional and learning needs highlighted when Child Y began secondary school. He was excluded twice and had several managed school moves, including one to a Pupil Referral Unit.

Moved in with aunt after physical punishment by father; Children's Services involved, and Interim Supervision Order made. Victim of a stabbing and admitted to hospital. Allocated support worker from Safer London Gang Exit Service (SLGE). Family is Black Caribbean.

Learning includes: early help and prevention is critical; schools should be at the heart of multi-agency intervention; disproportionality, linked to ethnicity, gender and deprivation, requires attention and action; an integrated, whole systems approach is needed across agencies, communities and families.

Recommendations include: review evidence-based practice to revise and publish Croydon's model of intervention to effectively respond to vulnerable, risky, and gang-linked young people; review service arrangements and introduce support for mental health patients to support a child's relationship with their parent and provide support to the care giving parent; ensure adequate sustainable resources are in place to support the multi-agency response to address gangs and serious youth violence.

Download the full report here

East Sussex LSCB: Child T

Death of an 18-year-6-month-old male in May 2017. Child T had been in hospital for three months prior to his sudden and unexpected death. At admission, he was in an extremely poor physical and emotional state; he had type 1 diabetes which he had developed at age 13 and diabetic control was inadequate.

Agencies had been involved prior to January 2014 due to concerns that he was morbidly obese at primary school and attendance was low in secondary school. Ethnicity or nationality of Child T is not stated.

Findings: prior to admission to hospital there was limited consideration of the child's lived experience; trust was placed on what the mother was saying without considering the impact on Child T; mother's avoidant behaviour was not effectively identified or challenged; professionals need to remember a person is a child until they are 18 years old; despite processes being in place to identify neglect when a child is Did Not Attend/Was Not Brought, they were not used in this case and a lack of professional curiosity and ownership of the case led to on-going neglect.

Recommendations: to share the learning from this review with both adult and child safeguarding boards; to ensure that any child with a serious health condition has a written down multi-agency plan to coordinate and review the child's health care and support needs; to ensure that education providers take responsibility and the initiative to make available appropriate diabetes education and practical information in schools and colleges.

Download the full report here

Isle of Man LSCB: Serious Case Management Review

Review of the practice and care of several children between 2002 and 2011 in the Isle of Man.

Report focuses on learning and does not include details of facts or a chronology of events. Ethnicity or nationality not stated.

Good practice identified includes: eventual conviction of the father/foster carers due to the dedication of the police officers involved; prompt safeguarding action when children first disclosed physical abuse which led to their removal from foster care.

Learning includes: need for staff to fully understand the behaviours and presentation that is indicative of sexual abuse; need for staff to understand the factors that have an impact on disclosure; importance of multi-agency engagement in all aspects of the child protection process; need for staff to feel confident in working with challenging families; need for professionals and sectors to enhance their confidence and build opportunities to hear the voice of children and young people; importance of professional curiosity and for professionals to respectfully challenge each other.

Recommendations to the Safeguarding Board include: review single agency training on child sexual abuse to ensure sufficient focus on the key indicators and disclosure process; provide clarity on the use of professional meetings as a tool in dealing with difficult and complex cases, highlighting the opportunity they provide for multi-agency reflection.

Download the full review here

Lewisham SCP and Harrow LSCB: Child LH – Joint Review

Physical abuse of a 4-year-3-month-old boy by his maternal aunt in 2017. Child LH was hit in the face and a child protection medical assessment showed 43 injuries, consistent with being non-accidental. Aunt charged with assault and received a suspended 20-month sentence.

Child LH's mother diagnosed as having a learning difficulty and siblings subject of Child Protection Plan for neglect since January 2015. Child LH placed with his aunt in June 2016 via Special Guardianship Order (SGO). Aunt had historical contact with police for accusations of grievous bodily harm and racial abuse.

In June and July 2017 Child LH was not taken to pre-school for a number of days. Aunt took Child LH to GP in September 2017 after abuse incident. Family is Black African/Caribbean.

Learning includes: important to ensure that SGO placements are supported by a robust plan that is tailored to the individual needs of the children (including any children who are existing members of the household) and their potential carers; practitioners should be aware that information from a DBS check may not contain significant pieces of information that should be included in any assessment prior to placing a vulnerable child.

Recommendations include: ensure that for prospective SGO assessments, the needs of children already living in the household, and their wishes and feelings are fully considered; oversee a multi-agency review of current arrangements for Children in Need that are also subject to SGOs. This is to ensure that the needs of children in SGO placements are met wherever they are placed.

Download the full report here

London Borough of Greenwich LSCB: Child U

Death of an 8-week-old boy in September 2016 due to non-accidental injuries. Child U was taken to hospital in respiratory arrest and transferred to intensive care but died three days later.

Initial explanation was that father was bathing Child U who slipped and hit his head. Mother was an 'over-stayer' but father had achieved permanent residence status in 2012. Mother indicated during ante-natal care that she would need an interpreter for future health appointments but this was not arranged and father acted as interpreter on occasions.

Both parents arrested and father faced trial for murder in 2018 and found not guilty. Parents originated from the Ivory Coast.

Finds that there were no significant deficits of policy, procedure or practice, but opportunities for learning across the network include: scope for greater professional curiosity; greater precision in record keeping; more consideration of the significance of birth fathers/relevant men; enhanced recognition of the need for interpreters.

Recommendations include: LSCB to identify and support opportunities for 'evidence-based' programmes directed toward reducing the risk of head injuries in very young children; Lewisham & Greenwich NHS Trust (LGT) to: develop an information sharing pathway when a pregnant woman attends their services and is booked at another hospital; remind staff of the need for compliance with Trust guidelines on the use of interpreters; to consider including 'safeguarding concerns' tick box to GP discharge letters.

Download the full report here

Unnamed LSCB: Child F

Death of a 14-year-old young person from an aggressive malignant tumour.

Child F suffered chronic neglect and abuse before entering foster care at age 7. At age 8, Child F was diagnosed with a Growth Hormone Deficiency and was started on therapy. From age 13 and 9 months, Child F presented at the GP twice and at A&E on five occasions, once for a leg injury and four for feeling unwell. Foster carers thought the illness was fabricated and a result of previous trauma.

At age 14, Child F was moved to a respite foster carer. Attendance at the GP led to transfer to a specialist children's hospital and Child F subsequently received palliative care in a hospice. Child F was White British.

Learning: Child F's voice was heard but was not understood and acted on; evidence of poor interagency communication and information sharing; the need to manage conflict and work with challenging carers whilst not losing focus on the child; quality of care issues raised by Child F received an inadequate response by Children's Social Care.

Uses a systems approach with the practitioners' event based on the Child Practice Review Model.

Recommendations include: children cared for by the Local Authority should be provided with advice either from an independent legal advisor or advocate when they are in disagreement with professionals or carers; raise awareness regarding prevalence and symptoms of brain tumours in children and young adolescents; foster carer recruitment, training and supervision should encompass lessons from this review.

Download the full report here

Unnamed LSCB: SCR

Sexual abuse of three girls by their male foster carer. The victims, Grace, Lisa and Carey provided evidence to convict the perpetrator, who was sentenced to 9 years imprisonment.

Perpetrator and his wife were approved foster carers from 1998 until their deregistration in December 2014. They had 38 children placed with them; 28 were placed prior to 2011. Grace made several disclosures from 2011 but no action was taken. She was contacted by police investigating disclosures by Lisa and Carey in 2014.

Learning includes: mishandled or ineffective investigation of child sexual abuse is especially damaging for the victims and leaves them in greater jeopardy; presentation of perpetrators as pillars of the community and hiding in plain sight; foster carers who have well-established and long relationships with people such as social workers and teaching staff will undermine a child's confidence in talking with anybody about sexual abuse or other maltreatment by that those foster carers; role of local authority designated officer (LADO) has a significant role in regard to any criminal investigation, enquiries and assessment as to whether a child or children are at risk or in need of services.

Recommendations to LSCB include: ensure that an apology and an appropriate account of the lessons learnt is provided to the three 'children'; ensure that all practicable steps have been taken to identify and contact any other children who were placed with the perpetrator. Recommendations relating to national policy include: professional bodies and regulatory authorities have a role in promoting improved awareness of child sexual abuse and exploitation and the responsibilities of professionals in regard to the protection of victims and prevention of crime.

Download the full report here