NSPCC Respository – October / November 2016

In October/November 2016 three Serious Case Reviews were published to the NSPCC Repository. A summary of each of these cases can be found below:

Brighton and Hove – Child E

Death of E, a 17-year-old boy, from injuries sustained by hanging in December 2014. Coroner returned an open conclusion on whether E's death had been an accident or suicide. The local authority looked after E from when he was 3-years-old in a 'Family and Friends' placement with his maternal aunt and her partner. He spent time in respite foster care and before his death, moved to the same area as his birth father. Family history includes: mother's mental health and substance misuse difficulties; mother's death from an overdose when E was 8-years old and the absence of E's birth father for much of his childhood. E faced difficulties including: emotional distress; challenging behaviour at home; being known to the police and alcohol and substance misuse.

Findings include: there is a tension between the roles of the local authority as corporate parent and 'Family and Friends' carers who can be seen as 'parents', this can result in blurred boundaries and difficulties asserting the local authority's statutory responsibility for a child when this is needed; due to inconsistent standards in transfer summaries and chronologies, new social workers do not always receive enough background information to gain an holistic understanding of the needs and risks facing young people and their carers. Uses the Social Care Institute for Excellence (SCIE) learning together systems model and poses questions for the local safeguarding children board based on the findings.

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Wiltshire – Baby J

Suspected non-accidental injuries to a 6-week-old baby boy whilst in the care of his parents in September 2014. Baby J recovered and was placed with foster carers. No one was charged with any criminal offence. During the mother's pregnancy, at age 17, the family were subject to the Common Assessment Framework (CAF) pathway because of the mother's young age and a Team around the Child (TAC) meeting. There were two referrals to children's social care. Concerns included: homelessness, reliance on a food bank and J's faltering weight gain. The second referral, shortly after Baby J's birth, met thresholds for a single assessment.

Services working with the family included: midwives, health visitors, children's centre outreach and substance misuse support. Mother's history included: her parents' separation; parental substance misuse problems; suspected neglect and being placed on the child protection register. Baby J's father had a history of substance misuse and had witnessed domestic abuse as a child.

Learning points include: assessment is a dynamic process and new information or changes to family circumstances may affect the nature and degree of risk; the Multi-Agency Pre-Birth Protocol to Safeguard Unborn Babies is a valuable tool for all practitioners assessing risk and protective factors and making or deciding the outcome of referrals. Uses the Partnership Learning Review model and makes recommendations for the LSCB including: investigate ways of embedding, improving and sustaining the CAF process without resorting to further guidance and more onerous expectations.

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South East Wales – Executive Summary of Chelsey and Mary who dies in a house fire in 2012

Death of a 6-month-old baby girl, her 17-year-old mother and her maternal grandmother on 18 September 2012 in a house fire. The baby's father, who started the fire, was convicted of murder and given a life sentence. The mother “Chelsey” met him after being groomed on a social network site when she was 15-years-old and he was 26-years-old. “Chelsey's” mother “Sharon” sought to involve child protection services; referrals were made to social services by the police and Chelsey's school due to concerns about his violent behaviour towards “Chelsey” and her family. The baby “Mary” was born prematurely and spent time in a Special Care Baby Unit, and had serious on-going health concerns. A Safety Plan was put in place for “Mary” when she was discharged from the hospital due to concerns about her father's violent and controlling behaviour and influence over “Chelsey” and future arrangements for “Mary's” care.

Findings include: agencies did not recognise that “Chelsey” was being groomed and controlled and did not treat her as a child at risk; a child protection conference was not held despite referrals, meetings and enquiries; agencies did not seek legal action to restrain the father; police records were not accessed from other forces and information held by the police was not fully shared with other agencies. Agencies did not recognise “Mary” being at risk due to domestic violence.

Recommendations include: a review of the responsibilities of partners in interagency processes should be undertaken by South East Wales Safeguarding Children's Board; authorising staff to supervise child protection enquiries; all agencies should retain copies of working documents; South East Wales Safeguarding Children's Board to consider how to raise awareness of child sexual exploitation with frontline staff including interagency training on the correct language to use in recording child sexual exploitation, how to apply All Wales Child Protection Procedures to all children up to the age of 18; review police multi-agency information-sharing processes; improve training on domestic abuse within Housing associations.

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