# NSPCC Respository – July 2017

In July 2017 eight SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

## Bradford LSCB: Jack

A teenage boy, Jack, was sexually abused over several years from the age of 13, by multiple adult males. He had come out as gay to friends at school. The school had responded appropriately and his parents had sought help from the family GP. He was visiting adult chat rooms, being groomed and meeting individuals who posed a severe risk to him. There was significant multi-agency support for Jack, but services were not effective in keeping him safe from abuse. Good practice identified by the school and GPs.

Key learning: a lack of understanding of technology assisted abuse and its effects; restricting a young person's access to technology will not keep them safe; we must educate children, young people, carers and parents in how to keep safe whilst online; child protection procedures were inconsistently applied; a lack of coordinated support for families and young people; absence of leadership and planning. Review was conducted using a Partnership Learning Review model.

Recommendations include: the need to investigate technology assisted abuse and consider local responses to protect children and young people; to seek assurance from Police and Children's Social Care that child protection processes are fit for purpose; and that issues relating to practice identified by this case are being dealt with.

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**Nottingham City LSCB: Child J**

Death of a 7-year-old girl in July 2014. Her aunt, who she lived with under Special Guardianship Order (SGO), and paternal grandmother were both sentenced to imprisonment for child cruelty. Child J was born with mild learning disabilities and a kidney condition. Her mother was a single parent and had poor mental wellbeing; her father had several other children and spent time in prison.

Mother disclosed having thoughts of harming Child J and made allegations of abuse against the paternal grandmother, father and father's new partner. Child J became a Child in Need. She was placed with a foster family at 4-years-old and received support from child and adolescent mental health services (CAMHS) after showing signs of having experienced significant early trauma. She was placed permanently with her aunt (her father's sister) under an SGO, with support under a Family Assistance Order (FAO). During this time the aunt stated Child J was self-harming and deliberately misbehaving. Several concerns were raised about the aunt's punitive parenting style, including a referral to the NSPCC helpline.

Uses a hybrid systems methodology to identify findings including: there was a lack of understanding about the impact of early emotional abuse and neglect on young children and the likely manifestation of this in their behaviour; a full assessment which brought together all the available information on Child J in the context of possible physical abuse was needed; the importance placed on engagement with parents/carers can mistakenly leave children at risk.

Recommendations include: professionals should not accept the term self-harm in children under 10 without a consideration of potential wellbeing or safeguarding concerns.

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**Swindon LSCB – Child D**

Death of a 2 week old baby boy, Child D who was found dead on the sofa after his mother fell asleep whilst breast feeding. Child D was born prematurely and had been at home for four days at the time of his death. His mother was visited by midwives, his health visitor and his social worker in the days when he was bought home. Child D had a sibling Child C living in the same home who was designated as a child in need. The mother also has 2 other children removed from her care. Child D's mother spent much of her childhood in care and was known to misuse alcohol, took several overdoses and moved frequently to escape from domestic abuse.

Key issues include: communication between agencies; professional standards; mother's impact on staff; safe sleeping; the impact of parental ill health; and hospitalisation. Methodology used is in keeping with the underlying principles of the Statutory Guidance set out in Working Together 2015.

Recommendations include: training for staff about working with men; use of chronologies; identifying sexual exploitation; and assessing parental capacity to change.

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## Camden LSCB – Child B and her family

Serious injury of a nine-week-old girl resulting in permanent disability in November 2014. The injuries to Child B were caused by a single episode of shaking and impact to the head perpetrated by one of Child B's parents.

Both parents were in their early twenties and had been known to a number of services in Camden, including mental health services and a young parents' support service following a domestic abuse incident. Child B's mother had briefly been looked after by a London local authority as a child.

Findings include: Child B's parents received a number of services for short periods of time leading to a lack of continuity and fragmented service provision.

Recommendations include: Camden LSCB should seek evidence as to how information on the dangers of shaking small babies is delivered in antenatal settings; Camden LSCB should seek evidence that providers of antenatal services in Camden are asking women about domestic violence; LSCBs and training providers should take account of the 'halo effect' of seemingly cooperative parents; the LSCB should work with commissioners to ensure perinatal services are consistent and accept post-natal as well as antenatal referrals; the LSCB should consider what steps can be taken to improve effectiveness of risk assessments for children affected by domestic violence.

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## Haringey LSCB – Child R

Death of a 6-month-old child due to traumatic head injury in January 2015. Father was found guilty of murder in December 2015. On 23 January 2015 Child R was taken to hospital by ambulance following cardiac arrest at home whilst in the care of the father. Bruises and injuries were seen to be consistent with physical abuse and traumatic brain injury. Child R died on 26 January. Child R was living with his parents, who were both East European, and older sibling. In 2002, the mother was convicted of murder in her country of origin, and after a serving 9 years in prison she broke her parole in 2012 to come to England. In January 2014 whilst pregnant with Child R she was served with a European Arrest Warrant and bailed whilst awaiting extradition. Father had a history of drugs, shoplifting, and alcohol-related aggressive behaviour. The family had had limited contact with agencies.

Key issues identified: agencies failed to undertake a risk assessment once the criminal background of the mother was known. Identifies learning for the police, the courts and the probation service. Good practice identified include: the actions of the safeguarding midwifery team in attempting to find out whether the mother presented any risk.

Recommendations include: when police are asked to undertake a welfare check on a family by health agencies or children's services there is an understanding of what this means; ensure that the judiciary is made aware of the importance of considering any safeguarding risks to the children of foreign nationals convicted of serious and violent offences.

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**Norfolk LSCB – Child P**

Sexual abuse of a 15-year-old girl by her step-father. Child P disclosed two incidents of sexual abuse in 2014. Step-father received custodial sentence and mother imprisoned for her knowledge of and failure to prevent the offences. Step-father was a known sex offender and was involved with the family for 10 years. Convicted of indecent assault on his 14-year-old sister in 2001 and placed on the sex offenders' register. In 2006 he was arrested on suspicion of indecent assault on the 14-year-old half-sister of Child P's mother. History of domestic abuse.

Child P's mother had a blood disorder (which Child P believed to be life threatening) and was taking medication for depression; learning difficulties noted. Children's Social Care drew up four written agreements with Child P's mother in the period 2006-2014 where she promised not to allow her partner unsupervised contact with Child P. Child P was known to children's services and had frequent visits to A&E and GP during her childhood with conditions including ear infection, stomach upset; accidental scalding, a low weight was consistently recorded. Low mood reported and referral made to CAMHS. History of poor attendance at school and evidence she was being bullied. Evidence of physical abuse by mother.

Key findings include: insufficient knowledge on the part of children's social care about how sex offenders operate; and fragmentation of available intelligence within / across agencies. Recommendations include: the development of guidance in managing absences from school reported by parents to be for health-related reasons; mandatory training for social workers about working with adults known to pose a risk to children; training on the impact of domestic abuse for school nurses; and GP safeguarding policies should include processes for responding to safeguarding enquiries.

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**Calderdale LSCB – Overview report in respect of Jeanette**

Sexual exploitation of a girl when she was aged between 13 and 15 by a large number of British Asian men of Pakistani heritage. Jeanette had to care for her mother from a young age; she was neglected and physically abused by her father; her mother died when she was 13 and she subsequently lived without parental supervision. She spent time outside the family home in the company of older men who gave her cigarettes, alcohol and drugs. Following disclosure to the police, 54 suspects were arrested, and 25 were charged.

Issues identified include: failure to allocate a consistent children's social care worker; lack of suitable forums to discuss children at risk; lack of action to 'disrupt' the activities of men who abuse children; a lack of systems, practices and procedures in services to children in need and children at risk of sexual exploitation.

Recommendations include: that police and the LSCB ensure that regional statistics relating to perpetrators of child sexual abuse are accurate; that professionals working with children and young people are able to identify and act upon drug and/or alcohol use; to ensure that perseverance is still a key component of any training on child exploitation; to ensure that escalation procedures are fit for purpose and that all professionals are aware of their existence and are confident in using them; a version of this report to be commissioned by the LSCB to use with young teenagers to make them more aware of the dangers of child sexual exploitation.

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**Hertfordshire LSCB – Child A**

Discovery of multiple injuries resulting from the severe physical abuse of Child A, aged eight, in March 2013. Mother and stepfather were arrested and bailed. A member of the extended family was convicted of offences arising from Child A's physical abuse in 2016. Child A was born prematurely when his mother was in her teens. He suffers from cerebral palsy and is profoundly deaf. Due to his disability, he had been a child in need since birth, receiving services from children's social care, occupational therapy, speech and language services and he attended a specialist school.

Stepfather had a history of domestic abuse, drug and alcohol problems and criminality; mother had physical health problems and was arrested for assault. The police, stepfather's probation officer and his drug and alcohol service made referrals to children's social care. Following child protection enquiries, concerns were substantiated but Child A and his siblings were not judged to be at continued risk.

Findings include: there is multi-agency confusion about the child in need processes for disabled children leaving them without effective outcome-focussed plans and multiagency reviews; there's an unwillingness to label the early signs of poor quality care provided to disabled children as neglect leaving those children's needs unaddressed. Uses the Social Care Institute for Excellence (SCIE) learning together systems model and poses questions for the local safeguarding children board (LSCB) based on the findings.

Recommendations include: the LSCB should explore how embedded the "think family" agenda is and take remedial action as appropriate.

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