NSPCC Respository – September 2017

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

Waltham Forest LSCB: Child S and Family

Death of 3-year-old Child S, cause unknown, in summer 2014, six months after moving to a London Borough. Child S had lived for most of his/her life in another Local Authority. Child S's mother had a history of long term substance misuse. Child S, a sibling Child Y, and the mother were known to Children's Social Care (CSC), universal and specialist health and disability services, pre-school support services and drug support services in both local authorities. Child S had been the subject of a Child Protection Plan in 2013 but removed from the plan in the same year.

Child S had serious health concerns from birth, eventually identified as cerebral palsy. Contact with all agencies was sporadic and featured many missed appointments. When the family moved to the London Borough there were concerns about the lack of support for Child S's health in the transition.

Learning points focus on: coordination and leadership; escalation of concerns; core and follow up assessments; continuity in social work practice; healthy scepticism about long term drug use; reporting and sharing information in drug services; experience of the child; transferring information between areas; hidden men; safeguarding children with disabilities; police sharing information.

Recommendations for the two LSCBs include: pre-birth planning and assessment appropriate with drug using parents; Children in Need meetings properly recorded and CSC assessments up to date; compliance with 2009 guidance on safeguarding children with disabilities; review compliance on transferring cases; embedding healthy scepticism about long term drug using parents

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Warwickshire LSCB: Child T

Death of a 23-month-old infant due to non-accidental injuries whilst in foster care in June 2013. Child T was a looked after child who was placed with foster carers in March 2013 as a result of injuries sustained whilst in his mother's care. In June 2013 Child T died following admission to hospital with non-accidental injuries. The foster mother pleaded guilty to manslaughter and was sentenced to a term of imprisonment.

Key learning include: the role of fostering social workers includes considering the needs and wellbeing of the children in foster care from a safeguarding perspective; regular and consistent supervision of foster placements is crucial for safeguarding children; unrealistic expectations and views of foster carers due to lack of knowledge of child development must be challenged and addressed through training; information sharing between teams within a local authority is important.

Recommendations include: ensure that partner agencies give sufficient scrutiny and importance to the safeguarding of looked after children; social workers should be made aware of the need to formally register any concerns about the care offered by foster carers as complaints to be investigated; the role of the Family Nurse Practitioner needs to be clarified where children are in foster care.

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Rochdale Borough LSCB: Child K

Death of a baby girl who drowned in a bath in the presence of her older brother and sister. The three young children had been left alone in the bath whilst in the care of their mother. Child K's family had professional involvement from specialist services and there was a history of domestic violence. One sibling had been subject to a child protection plan. Following a move to Rochdale the family lived in separate households with Child K's sister living with her mother and her brother living with her father. There was extensive contact and shared care.

Child K was born in Rochdale. Child K's mother reported to her GP that she was feeling depressed following the birth but an offer of family support services were declined as Child K's mother was suspicious of social workers. Issues identified include: poor decision-making by the police reflecting poor communication between the police and children's services and poor judgement on the part of the officers involved; the need to find ways of engaging with families who do not reach the threshold for extra help or reject it.

Sets out findings using the RBSCB Systems Model which is not a full scale systems review and is used for reviews which are less complex and/or where there has been limited professional involvement.

Recommendations include: the LSCB to conduct a multi-agency practice and service review on how agencies meet the needs of families who are reluctant to engage with services.

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Brighton and Hove LSCB: Siblings W and X

Reported deaths of two brothers in Syria in 2014; it is understood they went with a friend to join their elder brother fighting for the Al-Nusra Front. Child W died soon after his 18th birthday (but travelled when he was under 18), and Child X died aged 17. The children had several siblings and grew up in Brighton but spent considerable periods in their parents' North African/Middle Eastern country of origin. It is understood that the family came to the UK because they opposed the regime in their country and at least one family member was killed for his political beliefs. The family left the UK for several years, and were victims of racism when they returned.

The children disclosed physical and domestic abuse by their father and became subject to child protection plans; the mother separated from the father who spent long periods overseas. Child W and his sibling Q began behaving antisocially and became involved with Youth Offending Services. Siblings W and X left the UK in January 2014. Professionals believed the boys were in the parents' country of origin.

Uses the SCIE (Social Care Institute for Excellence) Learning Together methodology to identify findings, including: professionals do not have effective ways to intervene in families who have suffered long standing trauma: this can increase the risk of young people being vulnerable to exploitation; efforts to support children so they are less likely to become vulnerable to radicalisation do not seem to address all the core issues.

Recommendations include: practitioners need to have a greater understanding of, and curiosity about, the role and potential impact of culture, identity, gender, religion and beliefs on children.

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Waltham Forest LSCB: Child M

6-year-old child, "M", who witnessed the murder of her mother, "B", in September 2014. M had been looked after and subject to a child protection plan. This was stepped down to a Child in Need plan before the case closed. During the period under review, there were concerns M was experiencing neglect. The police made five reports to children's social care. M's school made a referral to the education welfare service and a multi-agency referral to children's social care. A decision that the case did not meet the threshold for a child protection investigation was challenged.

A planned social worker visit did not take place because B and M moved to another authority. A referral was made to the new authority but B and M had no further contact with agencies prior to B's death. B had been looked after as a child and experienced physical and sexual abuse, she had substance misuse problems and experienced domestic abuse.

Findings include: inconsistent information sharing processes resulted in no one agency having an overview of the child's history and needs; universal services were not consistently applying assessment frameworks to help aggregate repeat low-level presentations of neglect; families with known child protection concerns were not being "tracked" across local authority boundaries.

Recommends the LSCB consider questions including: how confident they are that agreed thresholds in use across all services are embedded in practice, being applied consistently, and are sufficiently sensitive to identify indicators of cumulative neglect.

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Thurrock LSCB: Harry

Death of a 16-year-old Black British boy of West African parentage in a young offender institution (YOI). He had a history of epilepsy and a post-mortem examination confirmed death from natural causes. Harry's parents separated when he was aged 5 after which he lived with his father and step-mother.

A formal diagnosis of epilepsy was made at age 7. Neither primary nor secondary school records recorded this diagnosis and prescribed medication may not have always been ingested. His aggressive behaviour caused concern from age 13; he was excluded from school on several occasions and two separate assaults of railway ticket inspectors led to his detention in the YOI.

Identifies findings: possible side effects of medication (aggression, impulsivity, violence) may not have been explored; no annual reviews by the GP practice of medication in 2009, 2010, 2012 or 2014 in accordance with practice policy; delay on the day of death by YOI staff to provide an immediate response including failure to use a 'pouch key' and to call emergency services; weaknesses in internal information sharing within the YOI.

Makes recommendations to the YOI to strengthen its procedures around medical risk factors of under-18-year-olds; the health service provider at the YOI should undertake an audit of the ordering of medical tests to ensure procedural compliance; school nurses should alert teaching staff if a pupil has a diagnosis of epilepsy; NHS England should ensure that GP practices have policies in place with respect to regular medication reviews for children with epilepsy.

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