NSPCC Respository – September 2018

In September 2018 six SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

East Sussex LSCB: Family 'S'

Significant neglect of a 7-year-old child and 22-month-old sibling in 2015 because of parental substance misuse and alleged domestic abuse. The children were living with their mother in a privately rented flat where the home conditions were so poor that when professionals gained access to the accommodation it was deemed unfit for human habitation. The older child was found to have a significant disability which had not been addressed, and which means that there will be a need for lifelong medical treatment.

Learning includes: failure to register a child with a GP is a risk factor for neglect; babies discharged home after birth with no professional oversight of home conditions is a risk for children born to vulnerable mothers; lack of system for 'late starters' in schools means that children who start later in the term may not see the school nurse; perception that health visitors should not make unplanned visits.

Recommendations include: consider the feasibility of a system for raising alerts on children not registered with a GP for longer than three months; guidance to midwifery staff requiring that all women receive a postnatal visit at their normal address; all agencies to provide assurance that their assessment processes enable the effective involvement of fathers, partners and other men within the household.

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Hampshire LSCB: Child U

Death of a 7-week-old infant from non-accidental head injuries in 2015. Child U's father was caring for the child at the time of their death and has subsequently been found guilty of manslaughter.

From early pregnancy there were several agencies involved with the family including midwifery services, emergency departments, ambulance service, GP, adult mental health team and perinatal mental health services. Child U was Child in Need at the time of their death.

Mother had reported to her GP thoughts of self-harm and suicide ideation during the pregnancy and the perinatal mental health team continued to work with her. Father of Child U was seen on several occasions during the pregnancy and first two weeks of Child U's life and was considered to be supportive and a protective factor. Appointments after two weeks of age were attended only by mother and Child U.

Learning points include: promoting participation of parents in multi-agency meetings; information management and sharing; the need for assessments to be a continuous process including at times of increased vulnerability and awareness; understanding and implementation of key policies and procedures.

Recommendations include: review key policies, procedures and protocols and update as needed; educate parents regarding the prevention of head injuries to babies; and promote positive and safe parenting.

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Hull LSCB: Baby D

Death of a baby boy in December 2014 aged six-weeks. Cause of death was given as sudden death in infancy; the birth of a second child led to reinvestigation of the case. The pathologist felt the two fractures to the baby's knee were more likely to be non-accidental injuries and not linked to vitamin D deficiency.

Both parents were known to statutory services during their childhoods in response to concerns about parental care. The mother was a vulnerable adult and was diagnosed with a mild learning disability. Shared Lives carers described her as needing constant prompting with basic daily living tasks. Mother left the scheme before her pregnancy. Parents received enhanced health visiting services and were in regular contact with a children's centre. Children's social care were not involved with the family at the time.

Key findings include: the importance of professional curiosity to ensure roles and remits are well understood; when a learning disabled woman becomes pregnant, the impact on her ability to care for her children should be considered; adult services practitioners require a deeper understanding of their safeguarding responsibilities and should work collaboratively with other agencies; importance of professionals communicating with each other to verify information given to them by family members; the need to communicate key information to the couple should have been informed by a formal assessment.

Recommendations to the LSCB: to develop a local partnership-wide "think family" strategy; to secure a better shared understanding of roles and responsibilities to enhance effective joint working; to cascade key learning from this SCR to front-line staff by means of bespoke briefings.

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Medway LSCB: Dawn

Death of a 16-year-old girl due to Diabetic Ketoacidosis in 2015. Review focuses on the concerns around the management of her illnesses both in the home and by professionals and services.

Dawn was born in 1999 and had a twin sister and younger brother. The family are Black (Caribbean) British, and had been known to Children's Social Care. Dawn's sister was taken into care after living with her father. Dawn had four significant health problems which needed careful management to avoid her becoming ill. In December 2015 Dawn was found collapsed at home following a short period of illness.

Key findings and learning include: safeguarding needs were not assessed by any of the agencies involved; there was a lack of professional curiosity around siblings and parental neglect; child's voice not sought or heard; lack of understanding of how the family's cultural beliefs impacted on their attitudes; comprehensiveness of assessments, including risk; information sharing between health agencies.

Recommendations include: health providers should provide assurance about how they manage and co-ordinate the care of children and adolescents with complex health needs to ensure that safeguarding issues are not missed; develop flagging systems across agencies which identify children and adolescents where other children or young people in the family are looked after; develop a system for regular liaison between children's services in different areas, where children in families of concern live between parents and across areas.

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Mid and West Wales LSCB: Child A

Death of a 17-year-9-month-old young person by suicide. He had been placed in care at the age of two years as a result of severe physical and emotional abuse and neglect; his foster carers subsequently adopted him. His behaviour was aggressive and challenging and he had an attachment disorder.

At the age of 10 years, he was again taken into care by the local authority but with parental authority remaining. He had therapy around the age of 13 and was cared for by very supportive foster carers. He had significant worries about his future once he turned 18.

Learning: effective communication and planning between professionals is an essential component of good multi-agency working; a professional resolution process would avoid drift and delay in care planning; professionals need to feel confident when working with parents who are perceived as challenging and be more empathetic in working with families; pathway planning for young people in care to consider their holistic needs, emotional resilience and learning ability; enabling young people to communicate what is important to them is not the same as repeating what they say.

Recommendations include: local authority training for practitioners on the legal framework for children in care, particularly where disruption is evident or does not share parental responsibility; produce good practice guidance to ensure focused supervision of practitioners based on high challenge and high support; all agencies to assure the LSCB on how the child's voice influences their ability to ensure good outcomes for children in care taking into account the child's lived experience.

Unnamed LSCB: Sibling A and B

Significant abuse, neglect and cruel parenting of two siblings aged 12- and 14-years by their relative carer over a period of ten years. The siblings had been removed from their parents' care in their early years because of abuse and neglect. Both siblings had a diagnosis of mild learning disabilities; Sibling A was assessed as having global developmental delay at age 6 and attended a specialist school; Sibling B attended a mainstream school.

The siblings had long term involvement with specialist services from birth. The relative carer reported difficulties with both siblings' behaviour to the GP and CAMHS. There were concerns about the carer's negative and hostile approach to Sibling B; whilst in foster care Sibling B made a number of allegations of previous physical and emotional abuse. Sibling A was subsequently also placed in foster care.

Findings: all children and young people deserve to be effectively safeguarded from harm; the additional vulnerability of disabled children to abuse needs to be recognised and addressed; insufficient professional recognition or challenge of the blame of children by parents/parent figures as their defence against harsh, abusive and inconsistent parenting; poor assessments and ineffective Child in Need processes leave children and young people's needs unaddressed and at risk of potential abuse and harm; fixed professional thinking which is not picked up through supervision and reflection has the capacity to undermine the ability of the safeguarding system to keep children and young people safe. Sets out key findings using a hybrid version of a systems process. There were no recommendations.

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