NSPCC Repository – December 2018

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

Blackpool LSCB: Child CA

Child CA lived with both parents who had moved to Blackpool from Bolton. Both parents had a history of mental health problems, alcohol misuse and domestic violence.

Mother and father had 15 children between them with no parental care for any of them before the birth of Child CA. 11 of the children had been subject to child protection procedures for neglect and emotional abuse.

In April 2017, Child CA was found unresponsive in the home, and later died at hospital. The review followed the 'Welsh Model'.

Learning points centred on information sharing; the application of pre-birth protocols; stronger leadership; and multi-agency arrangements to identify and support individuals and families with complex needs arriving to a new area with high levels of transience.

Recommendations include: child protection assessment should be proportionate and plans should be specific, measurable, relevant and timely; frontline practitioners should receive regular and meaningful supervision; leaders should be able to demonstrate that they have a grip on cases assigned to their staff.

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Bristol LSCB: Child D

Death of a 17-year-old British/Caribbean mixed heritage boy in February 2016. Child D and Brother D had consumed significant amounts of alcohol and illegal drugs before returning home in early hours of the morning, where after an argument Child D was fatally stabbed by Brother D. Brother D charged with murder and sentenced to life imprisonment with a minimum tariff of 11 years and three months. Family was previously known to children's services as well as police.

Learning includes: the crucial importance of building relationships when working with families where there are both needs and challenges; the need to develop a constructive practice model with young men and boys who may not engage with services; the need for improved responses to domestic abuse in families in situations when it is not intimate partner abuse.

This is a joint Domestic Homicide Review (DHR) and Serious Case Review (SCR).

Recommendations include: Children's Social Care and Youth Offending Team to draw on the learning from this review to improve joint working; Bristol Safeguarding Children Board to consider working with adolescent boys as a thematic priority in its strategy. Please note that this report was written in November 2017 but was published in 2018.

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Kent LSCB: Child D "Jamie"

Non-accidental injuries to a five-month-old infant in April 2016, including a head injury and 28 fractures; toxicology findings suggest exposure to controlled drugs during his life. Child D, Jamie, was the youngest of seven siblings who lived in an overcrowded home with their mother and father.

Shortly before Jamie's birth, his parents separated and mother started a new relationship. Previously, in January 2015, siblings were made subjects of child protection plans for neglect. There were questions about the mother's ability to sustain change and the youngest child, Jude, had an increasing number of bruises.

In February 2016 all the children except Jude were stepped down to children in need. In April, following the fatal injury to Jamie, his siblings were taken into interim care. The mother and partner were found guilty of causing or allowing Jamie's death and were sentenced to 8 and 13 years respectively.

Key lessons: the need to keep an open mind in neglectful families that injuries may not be as a result of neglect but may result from physical abuse or mishandling; the importance of engaging parents and other adults, especially new adults who join households; importance of focusing on the child's experience and life including their emotional experience; understanding implications for children missing health appointments as the term Did Not Attend puts the focus on the child.

Recommendations include: to review multi-agency and single agency guidance and training on understanding and working with drug and alcohol use; to strengthen the voice of the child in safeguarding assessments.

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Norfolk LSCB: Child Z

Sexual assault of a 14-year-old male, by a 20-year-old male care leaver (YPA) in June 2016.

The assault took place whilst the two males were being housed in temporary accommodation by the local District Council who were unaware of YPA's harmful sexual behaviour. Child Z had been placed in temporary accommodation with his mother and sister in January 2016 after eviction from previous rented accommodation in November 2015.

YPA had been taken into care after a difficult and unsettling early childhood. He developed inappropriate sexualised behaviour in early adolescence and in 2011, aged 14, was placed in residential care.

In December 2015 he was arrested for assault of an 11-year-old boy and bailed with conditions that he should not be alone with a person under 16.

Lessons learned include: Children's Services should ensure its leaving care service is fit for purpose; the need to put in place effective early intervention services for young people, including care leavers, who exhibit HSB; unaccompanied children under 16 years of age must not be placed in temporary accommodation; Police child sexual exploitation perpetrators' risk assessments must result in effective and timely multi-agency planning of suspected individuals.

Recommendations: that HSB procedures are fit for purpose and up to date; to disseminate and embed HSB policies and procedures; to widely disseminate and implement findings and learning from this SCR; for the Sexual Abuse Referral Centre (SARC) to report to the LSCB on the feasibility of expanding the service remit to include children and young people who have suffered non-penetrative sexual abuse

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Norfolk LSCB: Family U

Sexual abuse of 4 children under the age of 13 by their father over a number of years.

Family U composed of mother, father, and the four siblings. The siblings were part of a larger sibling group who were living independently. In October 2015 Sibling 2, aged 11 years, who had very recently been placed in foster care by the local authority, made disclosures that she and three of her siblings had been seriously sexually abused by her father over several years. All four children were made subject to Care Orders.

The father subsequently received a life sentence with a minimum tariff of 16 years for a number of sexual offences. The mother pleaded guilty to an offence of child maltreatment and was sentenced to 2 years imprisonment. An older sibling also pleaded guilty to a sexual offence with a child.

Learning includes: understanding and mapping family history; difficulty in recognising or naming sexual abuse prior to 'disclosure'; implications of limited focus on relationship building, especially with adolescents; impact and causes of drift.

Recommendations for the Local Safeguarding Children Board include: to continue developing a multi-agency approach to child sexual abuse so as to ensure it is not reliant on disclosure by victims, but on proactive and supported practitioners; review the support provided to front line staff regarding the impact of the emotional content of child safeguarding on frontline; to develop a shared approach by which partners report on, or seek information about, any significant changes to an agency's function, resources or practice which could impact on multi-agency safeguarding.

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