NSPCC Repository – September 2019

In September 2019 six SCRs were published to the NSPCC Repository. A summary of each of these cases can be found below:

Croydon LSCB: Child Q: "where were you when I was six?"

Death of a 16-year-old boy following a road accident in 2017. Child Q was one of the 60 vulnerable children included in the Vulnerable Adolescents Thematic Review, an analysis of multi-agency involvement by Croydon SCB.

He had unaddressed behavioural and emotional challenges; he was a looked after child with Croydon Children's Services; he was believed to be a gang member and was known to Youth Offending Services. He had frequent moves to various locations within a short space of time often for short periods. The family are Black British Caribbean.

Learning includes: provide support to parents as early as possible in a child's life paying particular attention to attachment in early years and experiences of separation and loss; equip children's workforce to provide a trauma informed response to adults and children; Child Q's behaviours were not adequately addressed in school, which led to exclusion; ensure that transfer or transition arrangements are as robust as possible; Child Q required intervention and treatment for various emotional and mental health issues, but treatment was unacceptably delayed.

Recommendations: the need to strengthen working protocols between Adult Mental Health and Children's Services to facilitate development of integrated whole family health care pathway; to influence the Department for Education to review alternative education and agree a consistent methodology of working with high-risk pupils in a multi-agency context; join up multi-agency risk and safety planning forums to improve services for children at high risk in the community, such as gangs, serious youth violence, missing and all forms of exploitation.

Download the review here

Nottingham LSCB: Child KN15

Death of a 13-year-old girl, KN15, in June 2015. KN15 was found by the police two days after she had been reported missing from home following a family argument. She died of unconfirmed causes.

KN15 had witnessed domestic abuse between her mother and father during her early childhood. Her parents separated in 2011, and at the time of her death KN15 was living with her mother, her mother's partner (who had self-reported mental health problems), and two siblings. The family was known to social services and frequently moved between Nottinghamshire and Derbyshire local authority areas involving multiple changes of schools and GPs. The police had investigated potential emotional abuse within the household.

KN15 went missing from home on several occasions and she presented with challenging behaviour at school. KN15 and family are White British.

Key findings include: the importance of using assessments to support early intervention; the needs of children who live with adults who have reported mental health problems should be systematically assessed by all partner agencies to ensure that children and families receive the support they require; and assessments should explore the wishes and feelings of the child to understand the cause of a child's behaviour and underlying distress.

Uses the Significant Incident Learning Process methodology, a learning model which engages frontline staff and their managers in reviewing cases.

Recommendations include: LSCBs should review policy and information sharing processes when a child moves school within and between local authorities; ensure that practice is consistent and child centred when potential safeguarding concerns are to be discussed with parents/carers.

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Reading LSCB: SCR I17

Serious incident involving a 4-year-old child who was admitted to hospital in June 2016 after ingesting a potentially lethal dose of a sibling's epilepsy medication. Child I taken to hospital by ambulance having been found unresponsive by Father. Blood tests showed high levels of epilepsy medication. Incident treated as non-accidental. Police unable to prosecute due to insufficient evidence. A strategy meeting was held and Child I's siblings were placed in foster care.

Family were well known to services. Mother and Father had presented as homeless prior to becoming parents. There had been multiple reports of domestic abuse and possible physical abuse of Child I's siblings. This led to Section 47 enquiries but concerns were not substantiated. Ethnicity and nationality unknown.

Learning points include: thorough risk assessments should be undertaken when a partner has left a domestically abusive relationship but children are with the perpetrator; it is important to be aware of the pressures and difficulties faced by young parents; and all professionals who can offer insights into a family should be invited to meetings examining levels of need and risk for children and families. Uses the SILP methodology.

Recommendations include: promote awareness of the Escalation Policy; GPs should consider social issues in a child's life that may affect the ability of the parent/carer to maintain a medication regime when prescribing children medication; and the LSCB to seek assurance from Children's Social Care that issues highlighted are being addresses in a timely manner, particularly the application of Child in Need procedures.

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Swindon LSCB

Death of a 1-year-old boy in November 2017 from unascertained causes. Neglect concerns had been shared by those involved at the time. Family are White British. A criminal investigation was undertaken with a decision of no further action in respect of Child U as the cause of death was Sudden Unexplained Death in Childhood.

Intensive and targeted support was provided to the family by the Family Nurse Partnership, the Family Service, supported temporary housing provision and Children's Social Care. Father had a difficult childhood with concerns around neglect, sexual and emotional abuse. Mother had anxiety issues and slight learning difficulties. Child U and Sibling were the subject of both Child in Need and Early Help plans.

Learning: the child's experience must run through all work undertaken with families and thresholds should be focused on the impact of parenting on the child; professionals need to use the neglect framework and practice guidance to help them identify neglect; if a parent voices concern about being a parent due to their childhood experiences of sexual abuse, specialist support should be made available; when assessing if an injury is consistent with the story provided by the parent, consideration should be given to the child's developmental stage.

Recommendations to the Safeguarding Board: to question how professionals in partner agencies make referrals that provide the evidence and information required when they have safeguarding concerns; to request assurance from partner agencies that professionals understand the risks of interfamilial sex abuse and a parent's adverse childhood experiences (ACEs).

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Middleborough LSCB: SCR Billy

Serious injuries to a 6-year-old boy following a road traffic collision in April 2017. Police had recorded incidents of Billy and other children playing unsupervised on a busy dual carriageway in 2015 and referrals were made to Children's Social Care. At the time of the accident, Billy and three siblings were subjects of Child Protection Plans due to neglect, including lack of adequate care and supervision of the children and mother's substance misuse.

Mother, father and mother's partner have historic incidents of domestic abuse; mother had mental health problems. Family is White British.

Findings: all children within a family need to be considered in assessments and plans; professionals need to identify when parental cooperation with a plan is superficial; the need to be curious about information held by other agencies and be proactive in sharing information that may improve the understanding of the child's lived experience; consider the daily life of all the family through the child's eyes when working with parents who misuse substances; view with respectful caution a parent's self-report of their drug taking; good quality plans and reflective supervision is key to effectively recognising and challenging neglect.

Uses the Significant Incident Learning Process (SILP) methodology.

Recommendations: to consistently capture the voice of the child and lived experience with meaningful analysis; to request assurance from partner agencies providing early help about arrangements for reflective supervision for their practitioners; and how can the LSCB ensure that the impact on children of parental substance misuse is appropriately considered in multi-agency assessments and plans.

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Sefton LSCB: Martha, Mary and Ben

Neglect of three siblings, a 2-year-old and 5-year-old twins, in August 2017. Police investigated a burglary which they suspected had been committed by the children's mother and maternal great uncle. Drugs paraphernalia were found in the home and family appeared 'drowsy and incoherent'.

Great Uncle had a history of drug misuse, violence and criminality. Mother had learning difficulties and had been a victim of rape in 2009. Questions regarding Mother and Great Uncle's relationship, including parentage of children. Martha and Mary were placed with foster carers, Ben remained in relative's care. Children were made subjects of interim care orders, with drug tests confirming their exposure to significant levels of drugs over the past six months. Ethnicity and nationality of family not stated.

Learning includes: child protection enquiries should not be ended without considering the actions agreed at strategy meetings; there were shortcomings in the early recognition and identification of neglect and a subsequent delay in providing the family with the right help at the right time; where neglect is an issue, Child in Need assessments and plans can be enhanced by the use of the Graded Care Profile.

Recommendations include: require an audit of decisions to end child in need plans with an accompanying action plan, if necessary, to secure improvement; practitioners and managers must use the Graded Care Profile where there are issues of neglect in early intervention or working with children who may be in need; ensure that there are specific actions in respect of the identification and assessment of dental neglect as a safeguarding issue.

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