LSCB
Learning from Reviews

September 2015

East Sussex Reviews 2013-14

- 5 Serious Case Review (SCR)
  - 1 SCR in progress
  - 4 Completed
- 5 Multi-Agency Reviews (MAR)
  - Not SCRs so will not be published
  - All completed

SCR Child G

- 15 year old girl abducted by a teacher from her school. They had been in a relationship for several months prior to the abduction

- The teacher was subsequently convicted of child abduction and sexual activity with a child

SCR Child G

- In the months leading up to the abduction information came to light within the school on a number of occasions that was suggestive of a relationship between Child G and the teacher.

- These were interpreted as evidence of a “crush” by the pupil on the teacher rather than an abusive relationship

SCR Child G
Key Learning

- Recognising Abuse- the ability of staff to see the teacher as a potential abuser

- Listening to Children- no one spoke to Child G in a meaningful way. A number of children provided information indicating a relationship between Child G and the teacher

SCR Child G
Key Learning

- Working with parents- lack of contact with Child G's mother
- Record Keeping-lack of coordinated and centrally located recordings
- E-safety- Lack of understanding by staff of these issues and access to advice

SCR Child G
Summary of Recommendations

- Ensure that the school can demonstrate –
- - an appropriate understanding, at all levels of seniority, of safeguarding issues and how to respond to them, including appropriate parental involvement
- - arrangements for the support and supervision of staff with specialist child protection responsibilities
- - compliance with arrangements for the recording of safeguarding concerns and actions taken in response to such concerns

SCR Child G
Summary of Recommendations

- Developing initiatives which promote the ability of young people to raise safeguarding concerns, and the capacity of schools and other agencies to hear and respond to such concerns.
- Use the report and the outcomes of this review in training and development opportunities, particularly for school staff with safeguarding responsibilities: "What would stop this happening in our school?"

SCR Child G
Summary of Recommendations

- Development of robust “e-Safety” arrangements in schools.

- Review the arrangements for the LADO service, with reference to the key issues arising for that service from this SCR.

SCR Child H

- 5 year old child who was found by police standing in a bucket with a bin liner taped to the body following a call from a neighbour. Child H had significant bruising to the face, body and genital area.

- At the time Child H and a sibling were being looked after by Mother's partner in his flat. Child H later referred to being hit by this man, and being punished for urinating on the floor

SCR Child H

- Both children were accommodated by CSC. The Mother and her partner were later convicted of GBH and Neglect and received custodial sentences.

- Had the neighbours not called the police to intervene the outcome in this case could have been fatal

SCR Child H

- Prior to arriving in Sussex the family had lived in Bristol and then Grimsby. There had been GP and HV involvement in Bristol but no concerns

- Whilst in Grimsby there were concerns over parental supervision of the children, and when the sibling was at school on-going issues of neglect and attendance

SCR Child H

- Later the family left Grimsby and both children were considered as missing from school.

- Around this time the police were called to assist the RSPCA in the recovery of an abandoned dog from the families flat, which was described by the landlord as being in an appalling condition with faeces on the walls.

SCR Child H

Although it was clear children had been living in the flat, no consideration was given by the police to the potential child protection issue for a family living in these circumstances when the dog was recovered

Child H
Key Learning

- Difficulties in working with mobile families who do not inform agencies of their plans
- Impact for professionals working in areas of poverty and deprivation
- Avoiding Tunnel Vision-most intervention was at a low level and relied on information provided exclusively by mother- the need for management challenge and critical review

Child H
Key Learning

- Invisible men and risks to children - need for all agencies to collect information on current partners and for them to be considered in assessment process

- The role of the community in protecting children- both the grandparent and the manager of the hotel where the family lived in Sussex saw bruising

Child H
Key Learning

- The importance of early intervention processes being owned and understood by all agencies

Child H

Summary of Recommendations

- CSC to report on the effectiveness of Thrive in enabling professionals like teachers and health visitors to provide early help for vulnerable families

- Agencies to report on effectiveness of supervision and management processes

- Review of MARAC processes

Child H
Summary of Recommendations

- Need for research about the impact on professional judgement when working in areas of poverty and deprivation where the boundary between signs of material deprivation and those of poor parenting or neglect may be blurred

- How to increase public awareness around safeguarding

Child H

Summary of Recommendations

- Develop mechanisms for managers reporting shortfalls of resources to the LSCB
- Safeguarding training for providers of accommodation used by district and borough councils
- Assessment processes to ensure effective consideration of fathers and partners

SCR Child K

- 5 week old baby who died as the result of a catastrophic brain injury
- Baby also had older injuries
- Child was in the sole care of the father who reported a history of uncontrolled epilepsy

SCR Child K

- No previous involvement with any other agencies except health
- Father had troubled and disturbed childhood. Effectively raised by grandparents
- Referred for psychological assistance from the age of 8 years

SCR Child K

- Father had complex health history of self-harm and self reported seizures with non-compliance with treatment

- Father pleaded guilty to manslaughter and received a custodial sentence

Child K
Key Learning

- Communication between practitioners was identified as a recurring theme
- Tools designed to facilitate communication were either not used or not fit for purpose
- Changes to frontline services not communicated

Child K
Key Learning

- Presence of reported poorly controlled epilepsy should have prompted further enquiries regarding Father's health and the potential impact on his parenting capacity especially in light of the Mother's intention to leave Father in sole care when she returned to her studies

Child K
Key Learning

- Impact of high caseloads, erosion of early support services and expectation of providing early help services

- Need for effective and challenging supervision

- Need for management support working in this climate

Child K- Recommendations

- All families where one or both parents suffer from epilepsy/non- epileptic seizures should be signposted to the British Epilepsy Association guidelines on safety of infants in their care. Where seizures are uncontrolled and the parent has sole care of the child, a risk assessment should be undertaken by health
- LSCB to ensure that agencies communicate changes in services and monitor the impact

Child K Recommendations

- Quality of supervision to midwives and health visitors should be audited by East Sussex Healthcare Trust and provide evidenced assurance to the LSCB

- LSCB should monitor the individual agency recommendations

SCR Child M

- 17 year old Looked After Child who died of a drugs overdose whilst in the company of her “boyfriend” who was 7 years older

- The boyfriend was subsequently convicted of supplying a class one drug in connection with the death of Child M

SCR Child M

- At 13 years of age Child M found unconscious in the street having consumed a litre of vodka
- By age of 15 years using Ketamine with alcohol and injecting drugs including Heroin by 16
- Subsequent history of continuing substance misuse, drugs overdose, mental health issues, continued relationship with older drug abusing male and concerns of under age sexual activity

SCR Child M

- Child M embraced drug misuse and believed it added to the quality of her life. She engaged with professionals on her terms and to her own advantage

- Although Child M spent her childhood is Surrey she later moved several times to be in the company of her boyfriend. At the time of her death she was residing in Surrey, was an East Sussex LAC but died in the Thames Valley area

SCR Child M
Key Learning

- The difficulties of professionals working within the legal frameworks applying to 16 and 17 year olds who are in effect regarded as adults

- The conflict that existed between professionals wanting to protect Child M from the risks posed by her behaviour and Child M's own wish to live with the male who exposed her to risk

SCR Child M
Key Learning

- Following her first overdose, the underestimation by CSC of the serious risk posed to Child M which in turn led to CSC not taking action to bring agencies together to manage the risks posed to Child M

- The difficulties for professionals working across areas when Child M moved between local authorities

- The ineffective use of Child Abduction Warning Notices to prevent contact between Child M and her boyfriend and lack of national policy

SCR Child M

Summary of Recommendations

- Reminder that child protection arrangements should apply equally to all children under 18, and that 16 & 17 years olds may need to be subject of a CPP

- Need for drugs services to tailor their provision to the needs of young people

- Adult mental health and substance misuse services to ascertain details of children who may be effected by the behaviour of adult service users

SCR Child M
Summary of Recommendations

- LSCBs to consider how to improve continuity of health care for LACs who move placement especially to a different LA area

- All LSCB professionals to consider the vulnerability of children who go missing or who present in different LA areas

- LSCB to raise the issues from this review relating to Child Abduction Warning Notices with CEOP and DFE

SCR 2013-14 Recommendations

- Improve links between adult and children's services
- Communication between CAMHS and CMHT
- View of the child at the forefront of any assessment
- Need for composite chronologies by agencies referring to CSC
- Need for robust family support arrangements when CPP ends

SCR 2013-14 Recommendations

- Impact of drug abusing parents on their children
- Working with avoidant and resistant families
- Need for improved procedures for unexplained injuries to infants and young children
- Police to speak to alleged perpetrators of domestic abuse in person

Emerging Themes

- Promoting Professional Curiosity
- Effectiveness of Strategy Discussions; inter-agency communication and understanding of roles and responsibilities
- Understanding of ‘unexplained injury’ within investigations
- Role of men within the child protection process
- Elective Home Education

Emerging Themes

- The need for practitioners to have critical challenge and reflective supervision
- Use of chronologies to assist assessment
- Importance of seeing the child in all assessments and ensuring the views, wishes and feelings of the child are represented
- Professional challenge and escalation
- The need to consider verifying information in cases where domestic abuse is totally self reported

Current SCRs

- Death of a 7 year old child who was shot by the Father. He subsequently shot himself and died of at the scene. Previous extensive history of domestic abuse resulting in Mother being placed in a refuge.