Knowsley Safeguarding Children Board

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NEWSLETTER

Knowsley Serious Case Reviews 2016

This is the most important newsletter Knowsley Safeguarding Children Board (KSCB) has produced for all staff, organisations and agencies working with vulnerable children in Knowsley. I would ask you to read this and the Serious Case Reviews (SCR) it highlights on our website. I would also ask you to discuss the findings in your team meetings, development sessions and supervision and decide how it will change and improve practice in the future.

Audrey Williamson
Independent Chair KSCB

KSCB has commissioned the following SCRs, undertaken in accordance with Regulation 5 of the Local Safeguarding Children Board (LSCB) Regulations 2006.

A SCR takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved.

The purpose of the review is to establish what lessons can be learned from the case, which will enable the LSCB to improve safeguarding in the future, to improve inter-agency working and to better safeguard and promote the welfare of children in the local area.

The interests of children are an important aspect of the review process. Children are provided with pseudonyms to protect their and their family's identity.

The learning from these SCRs have been accepted by the Board and will be incorporated into an action plan. Actions will be driven and monitored by the Serious Incident Review Group.

This newsletter has been prepared to reflect the Board's commitment to ensure we all learn from the lessons that have been highlighted in these reports.

Child O

In 2015, Child O was found deceased in a public place. At an inquest held in June 2015 the Coroner ruled a verdict of suicide.

Child O lived in the family home with both parents and a large sibling group. The review established there had been significant contact between agencies and the family concerning a range of issues, including school attendance, home living conditions, domestic violence and substance misuse.

The review concluded that based on the information received, neither professionals, agencies or indeed Child O's family could have predicted or prevented Child O's tragic death.

The following lessons were identified by the Reviewing Officer:

1. Responses to neglect and emotional abuse lacked shared understanding, consistency and multi-agency action.
2. Reponses to domestic abuse need to be strengthened to ensure that the needs of children who live with domestic abuse and the impact that this has on their emotional wellbeing is understood and responded to by all professionals.
3. Parental substance misuse impacted the lives of Child O and their siblings however some agencies were unaware of the concerns in relation to drug use, there was a lack of follow up to referrals and plans to escalate the case to child protection were not followed through.
4. Housing and anti-social behaviour services did not give sufficient consideration to safeguarding in their involvement with the family.
5. Many agencies were involved with the family over the timeline of the review however there was a lack of case leadership and no clear 'lead professional' co-ordinating activity and responses.
6. None of the agencies involved in the review used the local escalation policy to address concerns when the case did not meet thresholds for statutory intervention.
7. Listening to and acting on the voice of the child.
8. There was a lack of engagement by Child O's family with Children in Need.

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We hope you find this newsletter useful and if any of you have ideas you would like to see in future issues, please contact **sarah.herron@knowsley.gov.uk**

Child R

Emergency services responded to a 999 call in November 2015. It was reported that an infant below the age of 12 months had suffered a suspected cardiac arrest. Child R was pronounced deceased at the home address. Child R had been co-sleeping with a parent.

Police conducted an investigation into the death of Child R. A report was submitted to Her Majesty's Coroner, who recorded the cause of death as 'Unascertained'.

Child R was the youngest child in a large sibling group. The family had a history of involvement with services dating back a number of years. The primary agencies involved with the family were Mental Health Services; Maternity and Midwifery Services; Health Visiting Services; Probation Service; Children's Social Care and Family First/Early Help Services. Police were also involved in relation to domestic abuse call-outs and the father's offending.

Concerns for the wellbeing of the children, adult mental health, substance misuse and domestic abuse were the key concerns identified during this review.

The following lessons were identified by the Reviewing Officer:

1. The daily lived experience of the children did not influence professional practice in the case.
2. The impact of the father's mental health on the family was not fully assessed or acted upon. Mother's mental health was not fully explored. Systems need to be strengthened to support joint-working with adult mental health services.
3. Domestic abuse was an ongoing factor in the relationship between the parents. One incident resulted in a Multi Agency Risk Assessment Conference (MARAC) referral, however this did not appear to influence decisions in relation to safeguarding the children e.g. there was no Section 47 resulting from MARAC.
4. Parental drug use and its impact on the children was not fully explored or addressed.
5. Multi-agency working was inconsistent and uncoordinated.

Child N

The Child N SCR concerns a serious sexual offence committed by a teenager in 2014. KSCB took the decision not to publish this review due to it not being in the best interest of any of those concerned.

The review identified a number of findings:

1. A commonly understood policy and procedure to support practitioners to identify and respond to sexually inappropriate and harmful behaviour is necessary to maximise the welfare and protection of children who are affected as both victims and perpetrators.
2. The investigation and response to sexually abusive behaviour is best delivered through multi-agency partnerships that involve core and specialist agencies relevant to the individual child.
3. For children with additional needs, school transport arrangements should be subject to a risk assessment that considers the welfare of the individual and group of children.
4. In order to achieve best evidence who are victims of crime, the arrangements for joint working between Police and Children's Social Care need to be integral and embedded into general practice. For children with additional needs, the use of skilled intermediaries should always be given consideration.
5. The use of written agreements as a single agency approach and without a multi-agency process for review cannot be considered as a tool that will keep children safe. Conversely, they may give the impression of a protective action being taken without any foundation in fact.

You can find published reports, executive summaries and the KSCB response at the following link on our website: www.knowsleyscb.org.uk/professionals/learning-from-practice-scrs-mrs/

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