## Serious Case Reviews

### Bolton LSCB
Serious Case Review into death of Child SB, a tragic teenager who was **found hanged** grew up amid a background of violence and drugs.

The review found that focus on his lack of school attendance left agencies addressing just one area of SB's life when in fact his psychological, emotional and mental health needs were of greater concern.

Children's services and police had been involved in Jake's life from a young age, after concerns about neglect and allegations of family violence and parental drug dealing — and later his absences from school.

The Serious Case Review Team stated: “The family's social history and known parental substance misuse should have alerted professional to his vulnerability and the risks to which SB, as a child, was exposed on a daily basis.”

Education bosses have accepted that there “are important lessons to be learned” following the inquiry……

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### An Overview of the Multi-agency response to Child Sexual Exploitation in Peterborough

This **overview report** has been compiled, by taking account of the known child sexual exploitation in **Peterborough**, during the period 2010-2016. The report is focussed on the **learning from Operation Erle** which was the operational name of a multi-agency partnership investigation into child sexual exploitation in the City which spanned 2013 to 2015.

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### Cumbria LSCB
SCR into the death of Child N.
Child N died in December 2012 aged 13 months. The post mortem x-rays carried out 2 days after Child N's death revealed healing fractures to Child N's tibia and fibula. The post mortem also revealed other possible injuries to Child N. During Child N's short life the family were only known to 'universal' services: schools and a range of health services. Child N's mother had a complex childhood and had been a looked after child herself because she was at risk of **Child Sexual Exploitation**.

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### Newcastle LSCB
Serious Case Review into the unexpected death of 15 week old Child J.

Child J and her siblings had been subjects of Child Protection Plans for **neglect** for five months. An initial post-mortem concluded that her death was caused by a head injury. Further tests confirmed that this was likely to have been as a result of shaking. J's mother and her partner were convicted of causing or allowing J's death in December 2015 and given custodial sentences. The exact circumstances of her death still remain unclear..................

The review into the tragedy identified that “cases involving **child neglect** require extra vigilance from agencies, because the warning signs may not be so obvious”.

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### child SB Overview report
BSCB response to learning from child sb serious case review

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### Multiagency response to CSE in Peterborough

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### Child N - SCR Report
Child N - LSCB Response to SCR report
Child N - Lesson Learned

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### Child J - SCR Report
Child J - LSCB Response to SCR Report
Child J - Lesson Learned
The review identified several “procedural issues” that were missed by the agencies involved with the family.

It states that on a number of occasions the history and context of Child J’s family were not fully taken into account. This led, at times, to her being assessed as lower risk than she should have been.

The report also states that some people involved in supporting the family only became aware of their full history as a result of participation in the review.

Colin Morris, chairman of the Newcastle Safeguarding Board, said: “The people responsible for the tragic death of Child J have been convicted by the courts and are now serving long prison sentences.

“It is important that we do look very closely at how the case was handled to see if there are lessons that should be learned that could reduce the risk of similar tragedies happening in the future.

“In this case the review has identified some issues with the way procedures were applied and the way that agencies work together. It is important that lessons are learned from these recommendations and action is taken.”

Improving the quality and use of serious case reviews – new resources from NSPCC joint project with the Social Care Institute for Excellence (SCIE). NSPCC analysed published reviews and gathered the knowledge and practice experience of frontline staff, managers and leaders across multiple agencies as part of the Learning into Practice Project funded by the Department of Education (DfE).

A serious case review has criticised the role of the family courts for their role in returning six-year-old Ellie Butler to her parents 11 months before she was beaten to death by her father.

Ellie suffered fatal head injuries while being looked after by her father Ben Butler, 36, at their home in Sutton, south-west London, in October 2013. A serious case review (SCR) into the circumstances around the death criticised family court judge Mrs Justice Hogg and private social workers at Services For Children (S4C), who were appointed in place of social workers from the London borough of Sutton.

Ellie had been removed from her parents’ care at seven weeks old after Butler was arrested and later charged and convicted of assaulting her. He was convicted in March 2009 of causing his daughter grievous bodily harm and was sentenced to 18 months in prison. However, his conviction was later overturned in the court of appeal on a legal technicality and he launched a campaign to regain custody of her and her younger sibling.

Social workers at Sutton Council opposed the return of Ellie and her sibling to their parents, but Justice Hogg, in addition to ordering their return, took the step of "exonerating" Ben Butler of causing injuries to Ellie in the past......

Lincolnshire LSCB SCR C

Serious Case Review C relates to a white British family with three children, the youngest of whom, Baby G, died in January 2014, aged 5 months. The eldest child had been the subject of a Child Protection Plan in 2011 and all three children were the subject of Child Protection Plans, in the category of neglect, at the time of Baby G’s death.

Chairman of the board Chris Cook said: "This is a tragic case involving a young baby with complex health needs and an undiagnosed medical condition.

"Throughout his short life a full range of medical investigations were in progress for a fuller understanding of his medical condition. Sadly, events overtook this...
and he died due to his complex health needs.

"A number of agencies were involved with this young child and his family with extensive efforts made to engage and support the young family.

"The report states that medical and child protection processes could have been better joined up which would have led to a greater sharing of information and a more effective approach in dealing with the family.

"This was made more complicated by the family’s frequent moves between Lincolnshire and Telford & Wrekin. However, despite this, the death of this young baby couldn’t have been prevented given his complex health needs…..

### Other / Safeguarding issues

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<th>Failure to report signs of child abuse could become criminal offence</th>
<th>Guardian Article in full</th>
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<td>The government will shortly announce a 12-week consultation on the mandatory reporting of child abuse – which could result in teachers and doctors facing criminal sanctions if they fail to report concerns. The consultation is the result of lobbying from Mandate Now, the largest coalition of survivor charities in the UK, which has been pushing for a law requiring staff who work in regulated activities to report concerns about the welfare of children and vulnerable adults to their local authority. But the UK's Lucy Faithfull Foundation, which works with sex offenders and abuse victims, said it was not convinced that mandatory reporting would prove effective. &quot;Those who argue for mandatory reporting seem to assume that most known or suspected abuse is not reported. I don't believe that is the case,&quot; director of research Donald Findlater said, adding that there are already sanctions that could be invoked against those who failed to take action.</td>
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<th>The children's commissioner for England to call for a radical rethink of the way children are interviewed in abuse cases</th>
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<th>Parents who are frequently distracted by their mobile phones are putting their children in danger, a new study has revealed.</th>
<th>Huffington Post article in full</th>
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<td>One in four parents admitted their child has had an accident or “near miss” while they were engrossed by their phones, according to a survey of 2,000 parents by the Child Accident Prevention Trust (CAPT) for Child Safety Week</td>
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The CAPT warn that a baby can drown or be seriously burnt in the same amount of time it takes to check a text.

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<th>A mother from Hereford is warning parents about a so-called 'choking game' after her 10-year-old son died.</th>
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<td>Louise Hembrow found her son, Alfie Hyett, slumped by his bedroom door three months ago.</td>
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She believes he was copying a 'game' that encourages participants to restrict their airways.

At the opening of an inquest, it was said Alfie died of vagal inhibition, which causes the heart to stop through the stimulation of the vagus nerve in the neck.

No evidence was given to the hearing that he died as a result of an accident.

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<th>A blanket ban on legal highs has come into effect in the UK, with anyone found producing or supplying the psychoactive substances now facing up to seven years in prison.</th>
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<td>The new legislation gives police the power to seize and destroy the drugs and carry out searches of people, premises and vehicles. Possession by individuals, however, will not be a criminal offence.</td>
<td>BBC News Report</td>
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Over the last 3 years the [NSPCC in Hull](#) have been delivering our [FEDUP group programme](#) (Family Environment: Drug using parents) to children between the ages of 5-12 years who live with parents who are dependent upon drugs and/or alcohol. We have also delivered parallel parenting work to help parents understand the impact of their substance misuse on their parenting and ability to meet their children’s needs. Our interim evaluation findings provide promising evidence that FEDUP can help reduce the negative impact of parental drug and alcohol misuse on children. (We are currently awaiting the final report.)

We are currently supporting ReNew to take over the delivery of FEDUP and are pleased that it will still be an available service in Hull. ReNew will run their first FEDUP group in September and this is now full. The next group will now run after Christmas and referrals can be made from September onwards. The contact number to make a referral is 0800 161 5700.

Hull NSPCC will no longer be taking referrals for FEDUP.

Please do not hesitate to contact our duty officer at the NSPCC on the number below if you have any further queries.

Analysis by the [NSPCC](#) has found a third of [clinical commissioning groups (CCGs)](#) have failed to acknowledge that childhood abuse and neglect leads to a high risk of going on to develop mental health problems,

Of the 117 plans the NSPCC reviewed, 39 did not mention the links between childhood abuse and mental health, while many of the remaining 78 plans failed to give a detailed analysis of local need or available support.

**Dating app Tinder is banning under 18s - previous limit was 13 - but age verification must be robust says NSPCC.**

**NSPCC report – How safe are our children?** which again provides the most comprehensive overview of child protection in the United Kingdom.

The report draws on official data and authoritative research. We have compiled 20 different indicators to help us understand the extent of abuse and neglect in the UK today. We have aimed to provide the most robust and comprehensive picture possible. We hope that the report will help improve professional practice in both statutory and voluntary agencies and inform planning and policy at all levels.

With children spending more time online and using social media, the report explores the issue of online sexual abuse.

**Dedicated web portals to allow people to report images and videos of child sexual abuse are being launched in 12 British overseas territories, the Internet Watch Foundation says.**

The online reporting system is to help people who "stumble across" abuse to report it anonymously, the IWF said. Reporting portals have already been set up in Mauritius and Uganda. Any reports generated in the territories will be assessed and passed on to police. Funded by the UK Foreign and Commonwealth Office, the 12 new portals are being rolled out in: Akrotiri and Dhekelia, Anguilla, Ascension Island, Bermuda, the British Virgin Islands, the Cayman Islands, Gibraltar, Montserrat, the Pitcairn Islands, Tristan da Cunha, Turks and Caicos and St Helena. A team of IWF analysts will work directly with the internet industry and law enforcement to have the abusive imagery removed.

**Children’s commissioner urges councils to support more young asylum seekers**

The children’s commissioner for England has written to all local authorities saying they have a “moral duty” to support more unaccompanied asylum-
Children's commissioner Anne Longfield says 300 asylum-seeking children being looked after by Kent council should be placed in the care of other authorities.

The letter, sent to council leaders, chief executives and directors of children's services by children's commissioner Anne Longfield, calls on them to "immediately pledge" their backing for national schemes to support refugee children.

**Commissioner to monitor placement moves of children in care**

An index designed to measure stability for **children in care** is to be launched by the **Office of the Children's Commissioner for England**.

Changes to looked-after children's foster placement, school and social worker are to be monitored. Picture: Shutterstock

Speaking at an All-Party Parliamentary Group (APPG) for Children meeting this week, **children's commissioner Anne Longfield said data collection has already begun for a “stability index”, which will monitor the number of placement moves experienced by children in care and changes in social worker.**

**The index will be published annually and highlight variations in practice across the country.**

**New report examining advocacy services in England 'Helping children get the care experience they need'.**

Experts told the women and equalities select committee that a culture of **sexual harassment** is widely prevalent in **schools** and that better sexual education is needed to change pupils' attitudes.

The panel of experts called for new school guidance on tackling sexual harassment, better teacher training on how to handle the problem and for Ofsted to inspect schools on how they address the issue.

**Inspection**

**Concerns** have been raised by inspectors over the lack of suitable **secure accommodation for children** who have been charged by police and refused bail in one area of England.

**Lack of secure accommodation in Swindon has been criticised by inspectors**

Following an unannounced visit last December to 60 custody suites in Swindon and Melksham in Wiltshire, the joint HM Inspectorate of Constabulary and HM Inspectorate of Prisons team found a chronic shortage of suitable council accommodation for young people who had been turned down for bail.

Their inspection report said the shortage “resulted in children being detained in police custody unnecessarily” sometimes for days at a time.

**A growing number of councils with children’s services departments that have been rated as “good” by Ofsted are considering alternative delivery models.** ....... A report published by Birmingham Council, which is planning to establish an independent trust to deliver children’s services, reveals that a number of councils with "good" ratings are now considering fundamental changes to delivery structures.

**Under proposals set out in February the inspectorate had said it wanted to change regulations so that reinspections focus solely on service areas causing concern rather than all elements of children's services. However, following a**

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consultation on the plans, Ofsted now says a decision on which elements of children’s services should be re-inspected will be taken based on the findings of quarterly monitoring visits. The visits will involve two Ofsted inspectors spending two days at the council in question. Monitoring activity will relate to the key weaknesses and recommendations in the inspection report, but the inspectors will also check that performance in other areas has not declined.

A narrative report will be published, in letter format, following the second monitoring visit, and each subsequent visit after that, with the information gathered informing the timing of the re-inspection.

**Newsletters**

Childrens Commissioner – In Brief Newsletter June 2016

In Brief Newsletter