Introduction

One of the roles of the LSCB multi-agency Case Review Group is to identify key learning points which should inform our practice when working with vulnerable children and their families. The group has recently reviewed a number of reports involving children with connections to either Hammersmith & Fulham, Kensington and Chelsea or Westminster. In this edition of the Learning Review, you can find out more about these cases and how learning might inform your practice:

1. CD, a care leaver who had a long history in care with multiple placements. Despite high levels of input from professionals throughout her life, they were not able to make sustained changes to her lifestyle and the risks this included. CD died aged 21 as a result of drug misuse.

2. Sofia, a one year old who died from asphyxiation and was significantly underweight. Prior to her death she had experienced a number of historic injuries that did not appear to have been medically treated. She had been seen by medical staff as well as being supported by social workers, housing professionals and the police. 7 local authority areas had some involvement with her family.

3. JJ, a 3 year old boy who died in the care of his father while having overnight contact. JJ’s father reported his son had been jumping up and down on the stairs and had fallen backwards hitting his head on the floor.

4. A Serious Case Review following investigations into multiple and systematic sexual abuse of boys by a teacher at Southbank International School in Westminster. The teacher responsible for the abuse is now known to have had a prior conviction for offences against children in America before moving to the UK.

5. A Serious Case Review of events leading up to the closure of an independent residential school in Hampshire which had been attended by children with special educational need from the three boroughs.
“JJ” Serious Case Review

This review took place following the death of a 3 year old boy who died in the care of his father while having overnight contact. JJ’s father reported he had been jumping up and down on the stairs and had fallen backwards hitting his head on the floor. JJ was taken to hospital by ambulance where he was later pronounced dead. There was no sign of head injury or bruising. The review concentrated on JJ’s history leading up to the tragic incident. The review of the case made no criticisms of the care provided by his mother. JJ was taken by her to Accident & Emergency on 12 occasions due to coughing, shortness of breath and vomiting. There were some concerns about JJ’s speech, and behaviour and his mother had commented on the different styles of parenting he received from her and his father. Learning that emerged from the review was as follows:

- Health agencies need to ensure that they have safe and robust approach to managing families who frequently use Accident and Emergency Departments and General Practice to address their children’s needs. For individual workers, this should include “professional curiosity” about the wider circumstances and needs of children who present in this way.
- This case involved a father who did not live with the child but had contact including overnight stays. There is a need to ensure that we routinely ask about and clarify the role and involvement of fathers have with their children. This should inform ongoing assessments and interventions.
- When circumstances change for families and children, universal services need to ensure that appropriate and proportionate assessments have taken place including the identification of any risks. For this case, this might have been prompted by the mother appearing to be “anxious” and how this was responded to.

CD

A Single Agency Review was carried out of the case of “CD”, a 21 year old care leaver who died as a result of substance misuse including class A and prescription drugs. As a teenager, there were concerns about her behaviour including drug overdoses, self harm and low mood. However she was resistant to offers of therapy or counselling. After leaving care she had over 20 different addresses and spent time sleeping on the streets. There were concerns about domestic violence and possible sexual exploitation. Key learning that emerged from this review included:

- A need for Leaving Care teams to have access to specialist substance misuse knowledge. For this case, this was specifically in relation to the pathology of young people returning to drug use after periods of abstinence.
- A need to consider how best to meet the needs of young people who cannot keep to regular appointments, including the possibility of drop-ins and peer mentoring.
- That Pathway Plans for some care leavers need to have input from a wider range of agencies.
- To consider the need for some young people to have input from more experienced personal advisors and continued involvement from Independent Reviewing Officers.
"Sofia" Serious Case Review

Sofia was a one year old who died after aspirating food and choking. The preliminary autopsy findings suggested that she was significantly underweight and that prior to her death had experienced a number of historic injuries that did not appear to have been medically treated. She had not been seen by any professionals for over 9 months as her mother had moved without notice when Sofia was three months old. No professionals had any contact with Sofia’s father who was described by her mother as living abroad. However it is now known that he had overstayed his student visa and was illegally residing in the UK, a fact which mother tried to conceal from authorities. The family accommodation was unsuitable for a child with no toys or baby equipment. The only concerns raised by professionals from 7 local authority areas were in relation to mother’s accommodation and financial difficulties with no concerns expressed that Sofia may have been at continuing risk of significant harm.

Learning from this case included:

- The need for increased training and consultation to be made available to frontline teams working with families who are affected by complex housing and benefits legislation to better ensure that families have access to all available options.
- The need to start children’s social care assessments when mothers are known to be pregnant rather than waiting for unborn babies to be seen as “viable”.
- Ensuring there is a formalised and standardised system in place for information to be transferred between GPs and Health Visitors to promote reliable oversight of babies’ health.
- Child protection strategy meetings should be strengthened where required to make sure there are fully inclusive contributions from all the key agencies involved.
- Practitioners need to be aware of the complex, less visible signs of neglect rather than over-focusing on physical manifestations such as weight loss.
- Professionals also need to be aware of concerns about ‘avoidant’ families and to review whether some families might better be described as being ‘in need of protection’ rather than ‘in need’, therefore enabling work at a higher threshold.

Serious Case Reviews: Learning into Practice Project (LiPP)

The LSCB has agreed to take part in this project which is being led through a partnership between the NSPCC and Social Care Institute of Excellence (SCIE). The aim of the project is to improve the quality of Serious Case Reviews (SCRs) and how learning is used to improve practice. There will be a focus on identifying common themes that emerge from SCRs in relation to professional practice, rather than the usual approach which is to identify common characteristics of families who are subjects of SCRs. If you would like to know more about the project and how the LSCB is becoming involved, please contact Debbie Raymond.
Southbank International School

A Serious Case Review has recently been completed (published 20 January 2016) following investigations into multiple and systematic sexual abuse of boys by a teacher, William Vahey, at a Southbank International school in Westminster. The teacher responsible for the abuse committed suicide and is now known to have been a prolific offender over his 40 year career history. He had been convicted in the USA in 1969 following offences against children. Whilst the SCR involved an international school, key findings and learning have wider relevance for the whole children’s workforce:

- A clear lesson from this case is the need to make appropriate checks on the employment history of potential employees from abroad although the challenges of doing this effectively are acknowledged. Being clear that such checks will be and are being pursued helps give a strong message to offenders who may be seeking roles in organisations where they will have access to children.
- There will be other learning from this review concerning the importance of the content of training, including information about the “modus operandi” of perpetrators which all staff in multi-agency services need to be aware of.
- It is equally important that a safeguarding culture of ongoing vigilance is promoted in all settings working with children and young people, where any concerns about adults’ conduct towards children are taken seriously and followed up effectively and in a proportionate way, through consultation and/or referral to the LADO (Local Authority Designated Officer).

Towards Safer Organisations
The NSPCC has published two version of this study in 2009 and 2012

These studies are very relevant to the Southbank International School Serious Case Review. The 2012 study included interviews with adults convicted of sexual offences against children whilst in positions of trust. It aimed to identify organisational risk factors, how such adults became involved with organisations that work with children. It also recommends good practice in recruitment and within work settings to better safeguard children against abuse and exploitation. The 2012 study concluded that robust vetting and screening is not enough to protect children from sexual abuse. This has to be in “an organisational culture where: the welfare of the child is paramount, there is an awareness of what is inappropriate and abusive behaviour and there are clear and accessible routes for colleagues to express concerns”
Serious Case Reviews – Learning for Schools and agencies that work with schools

A Serious Case Review has concluded on Stanbridge Earls, a special educational needs residential school in Hampshire which children from the three boroughs had attended. The SCR was prompted by the Special Needs Tribunal judging that the school had failed in their responsibility to keep a female pupil safe. There were significant recommendations and learning from the review for Ofsted, residential schools and how GPs can work effectively with such schools. However, more generally there were also aspects of the review where:

- Professionals had acted in ways which blamed the victim, minimising and not taking allegations seriously.
- There had been poor reporting and record keeping.

Many of the findings from the report chime with themes and questions in another report regarding Child O, published by Haringey LSCB in October 2015. These include:

- How good is the interface with independent schools, Children’s Services and the LSCB and do staff in independent schools have access to or attend training?
- To what degree do we take account of the degree to which children with special needs and/or disabilities are inherently more vulnerable.
- How effective are we at gaining the confidence of and listening to children, especially those who are seen as “challenging”?
- Do we understand the respective protocols and responsibilities for children's “home” local authorities as opposed to those of the local authority where residential schools are located?
- Is the Local Authority Designated Officer (LADO) role understood by all and effectively engaged
- How effective is joint commissioning between health and social care in planning for such children? Is there sufficient access to health services in independent schools as well as education when a child in hospital?
- How well do we manage the impact of organisational change in children’s services and overall risk assessment strategies.

The LSCB has published three Serious Case Reviews which can be accessed here: