NEWSLETTER
February 2015

Message from Deborah Lightfoot, LSCB Chair

Welcome to the February issue of our joint Board newsletter which will be considering the LSCB Learning and Improvement Framework. Working Together 2013 outlines that each LSCB should maintain a structure to ensure local learning of good practice and practice where multi agencies could work better together is fed back into the training and development of the local workforce. We seek to do this through briefings, reports and our learning and development offer (www.kingstonandrichmondlscb.org.uk). The decision for a Serious Case Review (SCR) to be undertaken lies with the LSCB Chair. Any agency can recommend that there is learning required from a local serious incident, however this would then be considered independently by the Board.

Working Together 2013 outlines: The LSCB must conduct a serious case review and consider whether there are any other children that may be at risk or lessons to be learned when:

• A child dies (including by suicide), and abuse or neglect are known or suspected to be a factor, including when a child has been killed by a parent with a mental illness, known to misuse substances or with a history of domestic abuse;

LSCBs may conduct a serious case review and consider whether there are any other children that may be at risk or lessons to be learned when:

• A child sustains a potentially life-threatening injury or serious and permanent impairment of health and development and abuse or neglect are known or suspected to be a factor;

• A child or group of children have been subject to particularly serious sexual abuse;

• A child's parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004;

• A child has been seriously harmed following a violent assault by a child or adult;

The case gives rise to concerns about the ways in which the agencies worked together to safeguard children.

Learning from National SCRs

The DfE (Department for Education) has produced a very helpful series of reports collating the learning from SCRs in the UK over a number of years. A team headed by Marilyn Brandon has brought out the main themes. Find out more here:

- www.education.gov.uk/publications/eOrderingDownload/DFE-RR167.pdf
- www.gov.uk/government/uploads/system/uploads/attachment_data/file/198919/DFE-RB226_Research_Brief.pdf

This series highlights some important considerations:
Children most at risk have been those aged under 2 years old and teenagers aged 14-16. Often practitioners under-estimate the fragility of young babies and over-estimate parents' capacity to cope. For teenagers, their vulnerabilities are often over-looked and their independence prioritised over their needs for stability, emotional support and safety.

Neglect is a key issue in many child deaths and serious incidents;
Children's needs at primary school (age 5-10) can often be overlooked by those who work with them Ofsted has highlighted that disabled children are 3-4 times more likely to be victims of child abuse. Please find out more here: www.gov.uk/government/news/protecting-disabled-children

Since April 2013, LSCBs have been obliged to publish SCRs on their websites, unless there are reasons that this will pose a risk to surviving family members. The NSPCC maintains a library of these SCRs and their Executive Summaries, which can be found here:
www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2014/
library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm=*&Fields=%40&Media=SCR

The NSPCC has also worked to provide summaries of the key issues which are very helpful.

Local Learning

You will find a summary document on our website (www.kingstonandrichmondlscb.org.uk) of our local case reviews in Kingston and Richmond. The key themes are highlighted below:

- **Kingston DHR November 2014**
  A woman was stabbed to death by her partner in 2011; she had a young child. **Key themes: Risk assessment; information sharing; communication; child abduction.**

- **Tom and Vic SCR Kingston 2013**
  Tom and Vic were adolescents injured in 2012 and involved in criminal activity. **Key themes: working with vulnerable adolescents; risk assessments; missing children; evaluation of outcomes when working with children and young people.**

- **Child G Learning Lessons Richmond 2013.** This 7 week old baby died as a result of SIDS (Sudden Infant Death Syndrome). A learning lessons review was undertaken. **Key themes: timely pre-birth assessment; planning for looked after young people, who become parents; working across borough borders; the value of reflective supervision for those who work with vulnerable adolescents.**

- **Child F SCR Richmond 2012.** Child F died of an overdose - he was 13 years old. For many years, he thought that his maternal grandparents were his parents. **Key themes: information sharing; risk assessment for adults with substance misuse concerns who have contact with children; recording and analysing family history; pre-birth assessment; young carers; recognition of risks for agencies working with adults; medicalisation of social concerns; escalations of concerns between agencies.**

National Learning

Child CN – Devon LSCB 2014

In June 2013, the stepfather was convicted and imprisoned for sexual offences against his two stepdaughters. The youngest daughter took part in the serious case review and said it would have made a difference if she had felt that her mother would have listened to, and believed her, so that she could have confided in her. She also said she wished that social workers would have visited the home and so have seen what things were like rather than seeing her at school. There was learning about assessing males in the family home, information sharing, sexual abuse and the rule of optimism.

Further information can be found here: www.devonsafeguardingchildren.org/documents/2014/06/serious-case-review-cn10-report.pdf

Daniel Pelka – Coventry LSCB 2013

Daniel, 4, was the middle child in a Polish family of three children. He was the subject of chronic neglect by his mother, torture and physical abuse by his stepfather. There were concerns of domestic abuse between the couple. School struggled to recognise Daniel's neglect and his mother explained his hunger and weight loss as a genetic concern, which the school did not question. Few attempts were made to hear Daniel's voice. He died as the result of a head injury inflicted by his stepfather. He was found to be severely malnourished.

Further information can be found here: http://www.coventrylscb.org.uk/dpelka.html

Child G – East Sussex LSCB 2013

This young person was involved in a relationship with her school teacher. Despite concerns from school students, the young person's family, and staff at the school did not see this as an abusive situation and considered the teacher to be a victim; the LADO involvement was not effective. Child G was taken abroad by her teacher in 2012 leading to high profile media campaign before she was found and returned to the UK. Her teacher was subsequently convicted and imprisoned for child abduction and sexual offences.

Further information can be found here: www.eastsussexlscb.org.uk/professionals/serious-case-reviews/