

Message from Deborah Lightfoot, LSCB Chair

Welcome to the June edition of the LSCB newsletter. It is with real sadness that this month we report on the death of a young man in Kingston. I know that many practitioners and agencies across the safeguarding communities in Kingston and in Richmond have already been briefed on the findings of the SCR and many actions have already been taken. Please share this briefing widely with your colleagues.

Child B Serious Case Review in Kingston

Child B, a Korean young person, 15 years old, took his own life by jumping from a height in July 2014. The LSCB Chair took the decision to initiate a Serious Case Review (SCR) "as abuse was known or suspected and a child had died". Working Together 2013 5.1.

A multi agency Panel of senior leaders from Kingston met to oversee the learning and improvement review, and also carried out staff interviews of those who had worked with the family.

In July 2014, Child B used his father's credit card to pay for some £500 of online games. He took his own life, the day after this came to light, having told his school that he wanted to kill himself. The school responded appropriately to this information, and communicated with Children's Social Care. In the process of the risk assessment, some information was not fully taken into consideration, and Child B himself said he was happy to go home. Support was planned for the following day. The review has found that Child B's death was not predictable or preventable, but that there is local learning.

The review brought four findings for the LSCB to assure:

1. The functioning of the point of access to Children's Social Care is dependent on the sharing of relevant information with the right people in a timely way, underpinned by procedures or protocols that are known and used by everybody involved;
2. Although some individual practitioners expressed some confidence in their skills and knowledge about young people who express the intent to harm themselves, this confidence is not spread across the multi agency work group. This suggests that more or better training and/or awareness is needed and access to support to assess at primary mental health worker level.
3. If a minority community makes few demands on statutory services, and is not well represented among service users or providers, its culture is liable to remain hidden or poorly understood. The impact is felt when statutory services need to get involved and do so, on the basis of insufficient understanding of the culture, attitudes and beliefs of the service user. There is then a heightened risk of poor outcomes.
4. Critical Incident Stress Management across member agencies and its effectiveness.

The Board was also to ensure good practice around hearing the child's voice; the involvement of parents in case planning; the quality of report writing; and local responses to private fostering.

Child B's father has played a full part in this review, for which the LSCB is very grateful. Child B's father can see how Child B became dislocated from family life, as he became more involved in online gaming, and thinks that Child B died as he had taken money from his father's bank account and knew he should not be doing this. He wants to warn parents about computer games, in order to prevent another such tragedy occurring. He says "Raising Child B, I did not know how to express my love and give him a sense of peace and protection". The review brought out the good practice of Child B's local school, who were immediately supported by the Samaritans after the news of his death was made public. The Assistant Head took a guiding role working with students and parents; there was support from the Educational Psychologist and Health Link Worker. During the school holidays, a support rota was organised and the following new term, students planned a service, a memorial tree and more latterly, an entry in the year book.

More information:

- Please visit www.kingstonandrichmondscb.org.uk to find out more information about the review, dates of multi agency briefings in both boroughs, and to read the LSCB Overview Report and Executive Summary.
- Online Gaming – you can find out more information at <http://kingstonandrichmondscb.org.uk/practitioners/safeguarding-children-online-139.php>

Local learning

The Joint LSCB Board is considering our themes for practitioners from our local learning and audit work. LSCB Board Members will be taking our nine common themes back to their sectors:

1. the Quality of Supervision;
2. Communication;
3. Recognition of Risk;
4. Working with resistance;
5. History;
6. Professional Challenge;
7. Family Culture;
8. "Going Beyond"
9. Hearing the Child's Voice

Participation in practice: Children and young people experiencing domestic abuse – Scottish Women's Aid

Scottish Women's Aid has published a report on learning to listen to children and young people experiencing domestic abuse. It is based on their direct work with children and young people. To ensure children are heard and involved in decisions, the report emphasises the importance of: recognising the fear, control and trauma these children live with; dedicating time, resources and an understanding of the value of participation; and ensuring all views are represented, even when the views of some contradict those of others.

To read the full report please visit: http://www.sccyp.org.uk/news/in-the-news/participation-in-practice-children-and-young-people-experiencing-domestic-abuse?utm_source=twitter&utm_medium=social-media&utm_content=1&utm_campaign=news

Further information: Ears wide open: learning to listen to children and young people experiencing domestic abuse in Scotland (PDF) http://www.sccyp.org.uk/downloads/ears_wide_open_report.pdf

What's the problem? A guide for parents of children and young people who have got in trouble – Lucy Faithfull Foundation

The Lucy Faithfull Foundation has launched a guide to support parents of children who have been in trouble for viewing or sharing sexually explicit images online.

To read the full report please visit:

http://www.parentsprotect.co.uk/files/Parents%20Pack_Whats%20the%20problem_11Mar2015.pdf

Combatting Child Sexual Exploitation Tool

Combating Child Sexual Exploitation is one of a series of measures designed to improve recognition of child sexual exploitation amongst healthcare professionals. The tool addresses the recommendation made in the Health Working Group Report on Child Sexual Exploitation for materials to help NHS staff to take action to make children and young people safe from this abhorrent form of abuse and to prevent it happening.

- NHS staff can access Combating CSE on e-Learning for Health: <http://www.e-lfh.org.uk/programmes/child-sexual-exploitation/>
- Staff working in the wider health system can use the tool from the Brook website, at: <https://www.brook.org.uk/our-work/cse-e-learning-tool>

LSCB Social Media Guidance

The Safeguarding Children Online Subgroup have new guidance around LSCB expectations for agencies' social media policies concerning children and young people.

To read the full guidance please visit: <http://kingstonandrichmondscb.org.uk/news-resources/policies-and-procedures-87/lscb-social-media-policy-164.php>

LSCB FGM Briefing and E-learning Information

- **CPD certified FGM training - Home Office Online Course** - This Home Office online course contains information regarding the role of children's safeguarding and other multi-agency professionals in identifying and tackling FGM. Please visit <https://www.fgmelearning.co.uk/> for more information and to register for the online training.
- **LSCB FGM Briefing for Schools** - the impending summer holidays raise the risk of FGM for children and young people in our local boroughs. This LSCB briefing is a reminder to vigilance for local independent schools. To read the full briefing please visit: <http://kingstonandrichmondscb.org.uk/media/upload/fck/file/News/FGM%20briefings%20to%20Schools.pdf>