7 minute briefing

7 Further Information

This SCR identified a significant amount of learning. Whilst this briefing provides a flavour of the findings, Sefton LSCB would urge all professionals to read the SCR to digest and understand the lived experience of this family. ***(Do not read this briefing in isolation).***

The full SCR report with detailed recommendations can be found **here**

Additional Information & Support

LSCB 7 Minute Briefings—Professional Curiosity & Newsletters
LSCB Escalation Procedure & Flow Chart
Neglect Screening Tool
LSCB Graded Care Profile Training (Nov/Dec 2018)

Further Guidance

Child Abuse and Neglect: Guidance NICE 2017

1 Serious Case Review (SCR)

Sefton LSCB has a statutory duty to undertake a Serious Case Review (SCR) on cases where abuse or neglect is known or suspected and **either:** a child dies; or is seriously harmed and there are concerns about how professionals worked together to safeguard the child. *(Working Together to Safeguard Children—DfE)*

The LSCB reviews these cases to extract learning to help prevent similar incidents occurring in the future.

Sefton LSCB has published a SCR undertaken on 3 children Martha, Mary & Ben *(pseudo names for the purpose of this review)*

2 Background

The SCR involved 3 siblings under the age of 5 years who were found to have suffered severe neglect. The children resided with their Mother and Great Uncle.

The Mother had a learning disability. The Mother was known to Children's Social Care when she was a child.

Substance misuse, criminality, mental health, coercive control and disguised compliance were all features identified with the adults in the family.

Learning from Serious Case Review (SCR1)

3 Key Findings

a) Limited evidence of professional curiosity.
b) Failure to recognised the impact on the children of the hostility and aggression displayed within the family.
c) Shortcomings in single and multi-agency practice, with a tendency to focus on what was observable, rather than taking a more analytical approach.
d) The lived experience of the children was not understood
e) Early recognition and identification of the signs of neglect was lacking
f) Little exploration of the link between the individual and joint histories of the adults involved in the children's lives

4 Key Findings.

g) Communication between different professionals, agencies and organisations was variable.
h) The risk of harm to the children was not effectively assessed.
i) The impact of the family and children's social isolation was not recognised.
j) Insufficient information was not gathered about important aspects of the family's living arrangements and daily life experiences.
k) Relationships between family members was not understood.
l) Professionals did not consider an array of missed health appointments as an indicator of neglect.
m) No evidence of formal professional challenge when decisions reached were not collectively agreed within the Child Protection process.
n) Differing expectations between professionals of what information can be shared between agencies.

5 Lessons

1. Actions agreed at strategy meetings should be understood in relation to Child Protection enquiries.
2. Using the Graded Care Profile (GCP) assessment tool will support the early recognition and identification of signs of neglect.
3. Partner agencies must contribute to the decision making process before the Children in Need (CIN) plan is ended.
4. Professionals should follow the LSCB Escalation Procedure for formal challenge.
5. Information sharing between agencies should be shared willingly and legally.

6 Lessons

6. The impact of drug misuse is a significant aspect of assessment of need and risk of abuse or neglect.
7. Professionals must consider the link between children's tooth decay and/or missed medical appointments as an alert for neglect.
8. Professionals must follow their duties and responsibilities in responding specifically to the needs of an individual, where (learning) disability is known.
9. Professionals must take time and be given the opportunity, to reflect on their practice through professional supervision.

Sefton Local Safeguarding Children Board (LSCB) (July 2018) No 20
www.seftonlscb.org.uk