Key messages from Croydon Serious Case Reviews 2018-19

CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP

Serious case reviews (SCR) are undertaken when abuse or neglect of a child is known or suspected, and either the child has died, or has been seriously harmed and there is concern as to way organisations worked together* These are the headline messages and summary of case issues from Croydon's recent SCRs; the reports are available on the CSCP website

CHILD A and BABY N

3 week old death associated with head injury and previous injury of sibling

Recording and sharing information, Procedural compliance & Significance of head injuries in pre-mobile children

CHILD L

11 months he suffered cardiac arrest after ingesting cocaine hidden in his cot. Child L recovered. Was subject to a CPP before birth and remained on Plan.

Extent of drug use unknown to CPP
Domestic Abuse
Maternal mental health issues
Housing needs
Cross-borough working

'JOE'

Was subject to a CPP from birth to 2.5 years, then CiN support. At almost 3 years, he was found alone at home having suffered life changing burns

Maternal mental health and drug use
Risks posed by Mum missed - focus was on paternal contact issues
Lack of Professional multi-agency challenge in CPP
Extent of agencies involved with family unknown

CHILD J and K

4 year old admitted to hospital with life threatening malnutrition

Record and analysis of health development
Minor concerns not recorded – missing accumulation of needs
Over reliance on hospital as place of safety

Common practice themes

- **Need to identify and engage professional network early on, share professional analysis as well as information sharing & collaborative working**
- Parental issues often obscuring focus on child (Domestic Abuse, alcohol and/or drug misuse, mental health needs, parental absences)
- **Plans often addressing immediate needs and not underlying issues and early trauma**
- Childs lived experience not understood
- **Missed early intervention opportunities to reduce the risk of significant harm**
- Impact of parental mental health, especially maternal mental health on child
- **Need to improve quality of multi-agency plans make use of professional network for interventions and collaborative working**
- Lack of professional challenge and shared professional perspectives
- **Need for reflective supervision to support practitioners and practice and oversight of decisions**
- Lack of use and awareness of escalation routes
- **Impact of low professional curiosity to identify underlying needs and challenge resistance**
- Need to improve how kinship network is valued and engaged
- **Need to value trusted professional across service boundaries**
- Vulnerability of U5's from early neglect and abuse, and vulnerability of adolescents to contextual safeguarding risk; highlighting connections with school, family or community as possible protective factors

VULNERABLE ADOLESCENT REVIEW

Following tragic deaths of 3 young people in less than a month, review commenced to understand shared factors across cohort of 60 most vulnerable adolescents

Parental absence (Father)
Domestic Abuse
Over half known to Social Care by aged 5
Death of parent
Maternal Mental Health
Child SEMH needs
Black boys disproportionately affected
All girls victim of CSE
Significant school exclusion rate

CHILD Q

Looked after child who died aged 16 following moped crash – at a review he'd asked "where were you when I was 6" suggesting interventions were too little too late

Challenge to match immediate protection needs and address unresolved early trauma & MH
Support to kinship network
Gang involvement and influence
Missed early intervention
Impact of multiple managed moves
Impact of parental criminality
Impact of maternal mental health

CHILD Y

15 year old fatally stabbed, deemed gang related, though unknown if Child Y connected to gangs

Impact of school exclusion
Need for family's voice in assessments, safety & care plans
Need to identify professional network and understand roles
Impact of maternal mental health
Value of trusted professional & impact of loss when service intervention ends

CHILD B

16 year old died as a result of his own actions. B was known to services but extent of his needs were not understood

Impact of bereavement on child's mental health
Impact of child's heavy cannabis use
Impact of missing and suspected but unknown county lines risks
School's relationship with child important resource

*Definition in Working Together 2015 – the CCSP is now working to the definition given in Working Together 18

Croydon Vulnerable Adolescents Review (VAR) Summary

The Croydon VAR sought to identify similarities/differences within the lives of 60 vulnerable adolescents, the review looked at shared data going back to their birth and current experiences.

1 Critical Events

During a 4-week period in Summer 2017, 3 teenage boys died, a further 2 boys died by the end of the year. All 5 were known to services for safeguarding and/or criminal concerns.

Partners were asked which other adolescents were they most worried about. 60 most vulnerable adolescents in Croydon - 23 Girls, 37 Boys were identified.

The Vulnerable Adolescents Review commenced to understand their lives to help inform and improve future plans

2 Presenting safeguarding concerns

Presenting vulnerabilities, safeguarding & wellbeing concerns included those within and outside of the home:

- Perpetrator or victim of knife crime and drug related incidents
- Frequent and high number missing episodes
- Victims of sexual exploitation and/or criminal exploitation
- Perpetrator or victim of crime (incl. thefts, assaults)
- Gang membership or affiliation
- School exclusions and/or poor-attendance
- Concerns about risks to physical or emotional care & family dysfunction
- Known parental vulnerabilities including mental health issues, domestic abuse, criminal behaviour/imprisonment
- ED presentations for assault and stab wounds, or substance misuse

3 Findings of themes from the VA Review

- Early risks and vulnerabilities were known: 51% were first known to social care between 0m-5y old | 22% were first known 6y-11y | 27% were first known at 12y+ | with 27% known to Croydon Social Care specifically before 1y - and 52% before 5y
- Most children in the cohort were affected in some way by complex parental issues including absent father | domestic abuse | parental criminality | parental substance misuse | parental mental health | homelessness | bereavements| parental physical illness
- Working together across children and adult services did not achieve shared understanding or plans to support the child or family
- Often interventions and plans were limited to reacting to presenting behaviours and short term; failing to address the underlying needs of the child and community based risks
- There was over-representation of black boys (Caribbean heritage), parents spoken to challenged if the boys were white, would more be done to help
- There was a high rate of school exclusions, including from Primary School – of the 19 children who had primary school exclusions, all 19 later had criminal convictions
- Transition from primary to secondary was an issue, with many showing a deterioration of behaviour at secondary leading to moves to PRU or AP
- 70% had referrals to CAMHS. Age at referral range: 4y to 14y+
- Being both a perpetrator of criminal behaviour and/or victim of crime was present for most of the cohort - including thefts, assaults, knife crime and drugs offences
- 75% of boys were known to be involved with gangs or gang affiliated. 85% of boys went missing.
- 85% of girls known victims of CSE and 100% of girls went missing
- 25% were subject to more than one CP Plan and 75% of the cohort became looked after at some point, suggesting earlier interventions had failed, were not sustained and didn't respond to emergent risks
- One looked after young person (aged 15y) commented 'Where were you when I was 6?' – suggesting that intervention was too little, too late.

4 Learning

Early Years 0-6: Impacted by early adversities at home relating to their parent's own complex issues & limited capacity of parents to provide nurture, support and attachment needs. Parent and child needs were not integrated and received short-term interventions. Early intervention & prevention needs to address trauma and support attachment needs.

Childhood 6-12: Schools seen as pivotal in life of child, but often unaware of home difficulties. Responses to highly difficult behaviour included exclusions, referrals to range of services. School transition crucial period for child going forward but was not always in planned.

Adolescence 12-16:Pace and complexity of needs drove agency responses, interventions short-term focussed on stability & control. Whole systems approach to integrate needs and services not taken. Risky behaviours seen to increase. Impact of long-term emotional & MH needs, lack of trusted adult relationships influencing behaviours. In the main often treated as perpetrators not victims.

5 Partnership Actions

- Early help & prevention critical
- Recognition & response to child's emotional & wellbeing needed
- Integrated, whole systems approach need across agencies, families and communities
- Schools are the heart of multi-agency interventions
- Disproportionality linked to ethnicity, gender & deprivation requires attention & action

Download full report at www.croydonlscb.org.uk

CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP

Croydon Safeguarding Children Partnership
Learning Review - Child B

1 Critical Events

Child B was 16 year old who died as a result of his own actions (2018).

B was known to Children's Social Care, Police, School and Education Welfare, Housing and Youth Offending.

There was a significant amount of cannabis in his system at the time of his death.

2 Key information and Safeguarding Concerns

- B was in mainstream secondary school and was acknowledged as being a bright and likeable boy, but presented with challenging, angry outbursts for which temporary exclusions were made
- In his local community B had come to be linked to incidents od ASB, criminal behaviours, and Gang association
- There were concerns from his family that B was a daily cannabis user
- B went Missing for 7 days and was suspected to be involved with County Lines

3 Findings

- B's school was an important factor in keeping him in mainstream school and with trusted adults
- School were not informed of B's offending and anti-social behaviour and were not approached as a support resource with these issues
- B's School observed increasingly poor behaviour which led to a number of short exclusions
- School did not attend the missing strategy meeting, therefore were not informed of all risks facing B
- B presented as a victim and possible gang target but did not open up
- It was suspected that he may have been involved with County Lines, but no clear evidence
- B was known to use cannabis, but also denied use
- Early information shared between MASH and LA Gangs Team did not identify B was known to the Police Gangs team
- Agencies did not have a collective picture or response to B's risks and needs
- Interventions were not timely, it was not recognised that B was in need of Early Help; drift and delay CSC assessment and subsequent CiN plans missed opportunities to work together
- B appeared under pressure but was reluctant to discuss, he kept people separate and at a distance
- B experienced the death of 3 friends/peers in a short period of time – this had an affect on B
- There were no indicators that he would harm himself although he was not directly asked, he was sign-posted to counselling
- There was little social or diversionary activity available
- Significant delays between arrest, charge and court appearances may impact a YP perception of sanctions

4 Learning

- Information sharing with schools needs to be clear & proactive
- Schools need to be central to multi-agency interventions
- Contextual Safeguarding approaches could better recognise the need for early help interventions and collaborative working
- Challenges in supporting adolescent mental health, and referring on to counsellors/specialist MH workers may not appeal/be effective –
- Challenges for frontline workers to effectively prevent/reduce drug use or involve specialist services needs increased understanding
- Missing strategy meetings to involve schools and all key agencies to share information and risks
- Understanding of County Lines, its operations, methods and influence needs to be increased
- Effective co-ordination of CSC intervention plans and handover between worker/teams
- Suicide prevention strategies need to consider needs and risks for vulnerable adolescents

5 Achieving Change

Reflect on the findings & discuss the implications for you team/practice

Outline steps you/team will take going forward

Findings of the CSCP Vulnerable Adolescent Review (VAR) are relevant to this review. – download the VAR at www.croydonlscb.org.uk

CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP

Croydon Safeguarding Children Partnership
Serious Case Review Child A & Baby N
Summary learning points

1 Critical Events

Baby N was 3 weeks old when he died. His death was associated with a head injury, further investigation also found fractured knee and skull. Child A (half-sibling) had a history of head injuries including skull fracture

2 Safeguarding Concerns

- Child A at 5months hospitalised with head injury; NAI considered
- Delay in seeking medical attention & inconsistent explanation
- Child A at 11months second head injury; considered non-suspicious
- Second head injury not assessed with first injury
- Baby N at 2 ½ weeks in cardiac arrest and with bleeding between the skull and the brain
- Cause of Baby N's head injury NAI initially considered

3 Findings

- Both children suffered fractured skulls and had episodes of injury which were not assessed against single & multi-agency information
- Poor quality of information sharing, assessment of information and exchange, including feedback and updates between CSC and CUH
- Lack of compliance with London Child Protection Procedures, including lack of strategy discussion
- Poor evidence of management decision making in CSC
- Not pro-actively managing re-referrals or repeat of similar incidents within CUH and MASH
- Insufficient enquiry or using recorded information of fathers & members of household
- Challenges in determining causes of head injury in pre-mobile babies and young infants within safeguarding AND medical contexts

- Insufficient consideration of safeguarding needs of siblings
- Lack of use of recorded history and information to inform and evidence decision making, and plan interventions (led to delayed & unplanned removal of Child A)
- Lack of understanding of medical information by MASH
- Missed opportunities to apply single agency safeguarding knowledge & practice (CSC, CUH & Police)
- Poor record keeping
- Lack of professional curiosity
- Appropriate and good standard referrals to CSC from CUH
- Appropriate use of escalation within CSC

4 Learning

- Compliance with procedures & recording standards to meet children's safeguarding needs
- Quality of communication/dialogue, including use of strategy meetings to give clarity on different professional opinions
- Agency history on family to be actively reviewed, especially with repeat incidents, & discussed across inter-agency and intra-disciplines
- Responding curiously to baby & infant head injuries within context of safeguarding protocols, medical & NAI research
- Recognising indicators of neglect
- Engaging fathers & recording adults in child's household
- Application of professional curiosity & challenge
- Agency feedback / agency follow up on referral submissions

5 Achieving change

Reflect on the findings & discuss the implications for you team/practice

Outline steps you/team will take going forward

The full SCR Report can be downloaded at www.croydonlscb.org.uk

CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP