Gloucestershire
Safeguarding Children
Board

Learning from the child's experience through Serious Case Reviews

GSCB Roadshows 2015

Happy Birthday GSCB

- The Children Act 2004 set out a requirement for Local Authorities to have a LSCB (Local Safeguarding Children Board.
- 10 years ago the Gloucestershire ACPC (Area Child Protection Committee) became the GSCB (Gloucestershire Safeguarding Children Board)

Responsibilities of LSCB

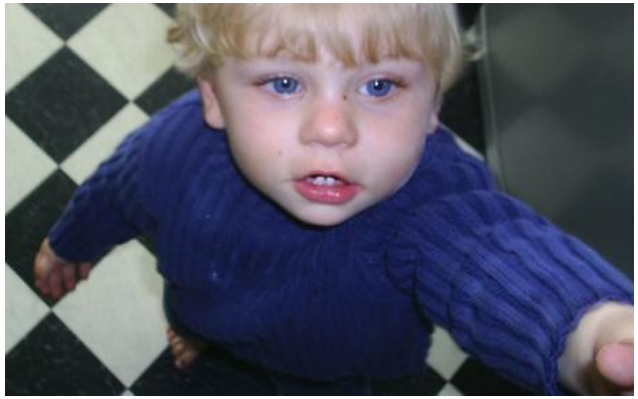
- The LSCB regulations 2006 set out a range of key responsibilities, one of which is:-
  - undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

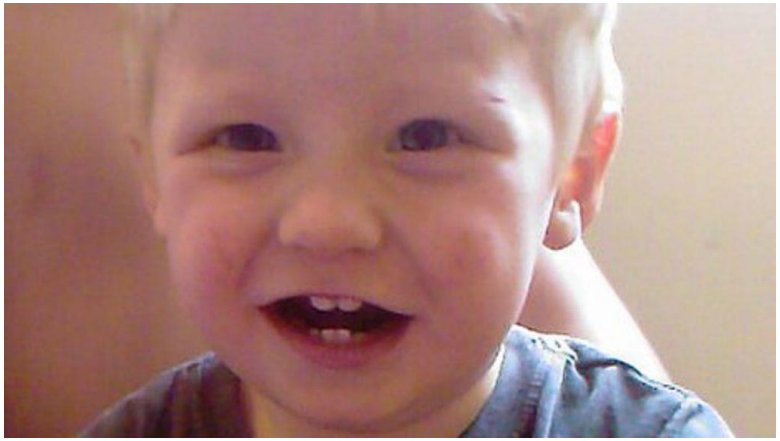
What is a Serious Case Review (SCR)?

- A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future.

- The SCR report provides a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence.

Some SCRs you may remember





Local SCRs from the last 10 years

- There have been nine SCRs published in Gloucestershire since 2005.
- There are currently three in the process of being written in Gloucestershire and one more has just been agreed.
- In the UK this year so far there have been forty four SCRs published.

The Spry Case, 2008

- Victoria Spry is one of the children who lived with Mrs Spry
- Victoria lived in fear and neglect.
- Mrs Spry was intimidating, she used this to keep professionals at bay.
- Victoria was beaten, she was kicked in her ear which was so damaged she needed an operation. She had teeth knocked out and broken.
- She was isolated from friends and other adults who might have been able to protect her.

What does Victoria say?

- Lots of people were concerned about her
- Doctor, dentist, teacher, dinner lady, police, social worker, A&E staff, home education inspector, surgeon, speech therapist…
- Mrs Spry controlled who saw me and when, never alone
- Professionals did not work or act together

Victoria's top tips

- MAKE IT YOUR BUSINESS
- Safeguarding is EVERYBODY'S responsibility.
- ALWAYS consider the plan from a child or vulnerable adults perspective

Abigail's Story

- Abigail lived in a house which was very dirty and unhygienic.
- She did not have her nappies changed very often and she had extremely severe nappy rash which would have been very sore.
- She was not fed the right nutrients, she had severe anaemia and was underweight. This will last a lifetime.
- She wasn't allowed to move about freely, she spent a lot of time in her cot.
- Her mum would hide her from professionals, when they came to see her, they were told she was asleep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What can we learn from Abigail's experience

- Her parents had their own needs and professionals were distracted by these – it prevented professionals from 'seeing the child'
- No one spoke to the children – as part of the SCR an older sibling said that professionals should be persistent in finding the truth.
- Professionals weren't able to see how neglect was impacting on Abigail
- Professionals struggled to get their concerns heard – **need to use the escalation policy**

There are currently 3 Serious Case Reviews being undertaken by the GSCB:

- **Lucy**- Pregnant 16 year old who was murdered by her boyfriend
- **Robbie** - 9 month old baby who died from a suspected non-accidental head injury
- **Philip** - 3 year-old who suffered from significant non-accidental injuries

We are not able to share the full findings at this stage as not all reviews have been finalised and the reports have not yet been published however we can give you a summary of findings of Lucy and Robbie as follows.

Headline Findings “Lucy”:

- Not all professionals understand the key features of teenage relationship abuse
- There are often real challenges for professionals between the young person’s autonomy and the duty to keep them safe
- When a child becomes pregnant the focus often shifts to the unborn baby rather than remaining equally on the child and the unborn baby
- If professionals do not agree with the risk assessment and decision making of another organisation then they need to challenge using the GSCB Escalation Policy

Headline Findings "Robbie"

- Assessment, decision making and support plans do not routinely take sufficient account of the additional vulnerabilities of **premature babies**
- The principles of effective **pre-birth assessments** are not sufficiently embedded in multi agency assessment activity
- Need to develop professionals understanding of the risk factors relating to **shaken baby**
- There tends to be a primary focus on the needs and circumstances of mothers in the antenatal and postnatal period which can leave **Fathers excluded**
- Arrangements and responsibilities for **managing early help** are unclear which can lead to poor planning and decision making
- The rhetoric that **'safeguarding is everybody's business'** is not evidenced in practice

Key messages

- Understand what it is like to be the child – what would it be like to walk in their shoes for a day?
- Talk to the child, or observe them if they can't talk. Don't automatically accept the parents explanation if it doesn't tie with what you hear or see.
- If you continue to be worried about a child – be persistent and inquisitive. Find out the truth. **YOU** might be the only one who see/hears something that indicates help is needed.
- If you don't feel your concerns are being listened to – be persistent – use the Escalation Policy

Over to you……

- What are you going to do differently as a result of this presentation?